Lessons Learned from the National Evaluation

Brigitte Manteuffel, Ph.D.

ICF Macro

National Evaluation Team

ICF Macro, WRMA, KAI, USF, FFCMH

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- **ICF Macro**
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- **National Evaluation Team**
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CMHI National Evaluation

- **Begun in 1993 with start of program**
- **Based on CMHI's authorizing legislation**
- **Collects information at multiple levels from multiple sources at multiple waves**
- **Data collected on over 98,000 children and youth**

National Evaluation Studies

Core Studies	
Cross-Sectional Descriptive Study *Local data collection, National protocol*	Comparison Studies *5 paired sites, Service Experience substudy, Sector and Comparison Study*
Child and Family Outcome Study *Local data collection, National protocol*	Treatment Effectiveness Studies *BSFT, CSP, PCIT*
Service Experience Study *Local data collection, National protocol*	Family Education and Support Study *3-tiered practice-based evidence study*
Services and Costs Study *National guidelines for data delivery*	Cultural and Linguistic Competence Studies
System of Care Assessment *National level*	Provider Surveys *Evidence-Based Practices, Provider Practices, Pediatrician Survey*
Sustainability Study *National level*	Other Studies *Conflict Resolution Study (USF), Managed Care Study, case studies, ethnographies, State sustainability study*
Researcher Secondary Data Analyses – ongoing with NIMH–CMHS PA & Data Access Group	

Evaluation Strengths

- **Consistent data collected across years, as well as new data based on evolving needs**
- **Consistent core findings across program years**
- **Multilevel analyses of various types possible**
- **Creative and dedicated staff**

Evaluation Best Practices

- **Consistent data and data sources**
- **Responsiveness to changing program and grantee needs**
- **Participatory process**
- **Technical assistance**
- **Publications and presentations**

Evaluation Questions

- **Are programs implemented according to goals and principles?**
- **Who receives services?**
- **What are the outcomes?**
- **What services are received and how?**
- **What are the costs?**
- **Do programs sustain and why?**

Evaluation Complexity

- **Variability in characteristics of**
  - Grantees
  - Communities, States, Tribal organizations
  - Children and families
  - Services and service experiences
  - Systems and partners
  - Technical assistance
  - Resources for sustainability

Some Lessons Learned

- **Children and families as a whole show improvement in consistent patterns**
- ***But* variability masks specificity**
  - Outcomes relate to inputs
    - This makes sense for individualized services
- **Services and fidelity to treatment impact outcomes**

Some Lessons Learned

- **Site-level differences affect outcomes**
- **Cross-system data are needed to really understand costs of services**
  - Complete cost data are often hard for communities to access, but are needed
- **Most programs are sustained 5 years post-funding**

Some Lessons Learned

- **Evaluation and data use are a participatory process**
- **Collaboration among evaluators, project directors, family members, youth, and social marketers improves investment in data and data use**
- **Evaluators and family members are good partners**

Focus of This Presentation

- **Three system of care principles at the service level and outcomes**
  - **Youth guided**
  - **Family driven**
  - **Cultural and linguistic competence**

Data Used for These Analyses

- Communities initially funded from 2002 to 2006
- Data collected from 2004 through December 2009
- Datasets for each analysis defined by data available for variables of interest

Population Characteristics of Communities Funded 2002–2006

Demographic Characteristics of Children/Youth

Gender	SOC Population[a] 2004–2009	U.S. Population[b] 2006
Male	62.9%	51.2%
Female	37.1%	48.8%
Age Group		
0 to 5 years	13.4%	26.0%
6 to 11 years	30.1%	25.0%
12 to 15 years	37.6%	17.8%
16 to 22 years	18.9%	31.2%

[a] Longitudinal Child and Family Outcome Study, Phases IV and V; aged 0–22 years.

[b] United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Bridged-Race Population Estimates, United States July 1st resident population, compiled from 2000 to 2007 (Vintage 2007) bridged-race postcensal population estimates, on CDC WONDER On-line Database for the year 2006. Accessed at http://wonder.cdc.gov/bridged-race-v2007.html March 2, 2009, 5:14:25 PM .

Demographic Characteristics of Children/Youth (cont'd)

Race/Ethnicity	SOC Population[a] 2004–2009	U.S. Population[b] 2006
American Indian or Alaska Native	4.4%	0.9%
Asian	1.3%	3.9%
Black or African American	24.1%	14.6%
Native Hawaiian or other Pacific Islander	1.4%	0.2%
White	40.6%	57.7%
Hispanic/Latino	24.0%	20.2%
Multi-racial	4.2%	2.5%
Federal Poverty Level		
Below poverty	57.6%	17.4%

[a] Longitudinal Child and Family Outcome Study, Phases IV and V; aged 0–22 years.

[b] Race/Ethnicity data taken from U.S. Census Bureau: U.S. population estimates, by age, sex, race, and Hispanic origin: Monthly postcensal resident populations, from July 1, 2000 to July 1, 2006 by age, sex, race, and Hispanic origin. Available from: www.census.gov/popest/national/asrh/2005_nat_res.html [data for April 1, 2000 and July 1, 2006]. Published in National Center for Health Statistics *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: 2007.
Federal Poverty Level data taken from DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica Smith, U.S. Census Bureau, Current Population Reports, P60-233, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, U.S. Government Printing Office, Washington, DC, 2007.

Living Situations at Intake

Living Situation	(*n* = 7,785)
Home	90.87%
Residential Treatment Center/Therapeutic Camp	2.04%
Foster Home	1.94%
Group Home	1.07%
Youth Justice Related	0.80%
Homeless	0.67%
Hospital/Psychiatric or Psychiatric Unit	0.60%
Emergency Shelter	0.58%
Therapeutic/Specialized Foster Home	0.53%
School Dormitory	0.14%
Hospital/Medical	0.09%
Camp	0.08%
Adult Justice Related	0.06%
Other	0.54%

Grant Communities Funded in 2002–06

Mental Health Diagnoses
Most Common Diagnoses at Intake

DSM–IV[a]	SOC Population
Mood Disorders	35.2%
Attention-Deficit/Hyperactivity Disorder (ADHD)	31.7%
Oppositional Defiant Disorder (ODD)	23.3%
Adjustment Disorder	13.9%
PTSD and ASD	8.7%
Anxiety Disorders	7.6%
DC:0–3R[b]	**SOC Population**
Adjustment Disorder	20.7%
Sensory Stimulation-Seeking/Impulse	17.0%
Anxiety Disorders	13.0%
Hypersensitive (Fearful/Cautious, Negative/Defiant)	10.0%
PTSD	6.7%
Deprivation/Maltreatment Disorder	4.6%

Data source: Longitudinal Child and Family Outcome Study, Phases IV and V

[a] Diagnostic Statistical Manual IV (*DSM–IV*)

[b] Revised Zero to Three's Diagnostic Classification of Mental Health & Developmental Disorders of Infancy & Early Childhood (DC: 0–3R)

System of Care Framework

- **Infrastructure**
  - Governance
  - Management and operations
  - Service array
  - Quality monitoring
- **Service Delivery**
  - Entry into service planning
  - Service planning
  - Service provision and monitoring
  - Case review structure

System-Level Characteristics

- **System change assessed in years, 2, 4, and 6 of funding**
- **Systems show improvement on all system of care principles at the infrastructure level**
- **Systems change more slowly at the service delivery level, except in providing least restrictive services**

Youth-Guided Services

Youth Service Experiences and Youth and Caregiver Outcomes

Youth Service Experiences and Outcomes

- **920 youth from 2002–2004 grantee sites**
- **Youth who did or did not participate in developing the treatment plan (intake)**
- **Youth who did (agree, strongly agree) or did not *participate* in treatment (during first 6 months)**
- **Youth who were or were not satisfied with services (during first 6 months)**

Measures

- **Youth Services Survey (YSS)**
- **Behavioral and Emotional Rating Scale (BERS)**
- **Child Behavior Checklist (CBCL)**
- **Columbia Impairment Scale (CIS)**
- **Reynolds Adolescent Depression Scale (RADS)**
- **Revised Child Manifest Anxiety Scale (RCMAS)**
- **Caregiver Strain Questionnaire (CGSQ)**

Youth Services Survey

- **Participation in treatment subscale**

Three Items

- **I helped to choose my services.**
- **I helped to choose my treatment goals.**
- **I participated in my own treatment.**

Scale: Strongly disagree, disagree, undecided, agree, strongly agree

Youth Characteristics

- **Participated in service planning?**
  - Slightly older, higher referrals from juvenile justice
  - 2 or more living placements in past 6 months (39.2%/29.5%) more likely
- **Participated in treatment?**
  - No difference in age, gender, race/ethnicity, referral source, custody, number of living situations, poverty level, intake CBCL or CIS

Youth Characteristics

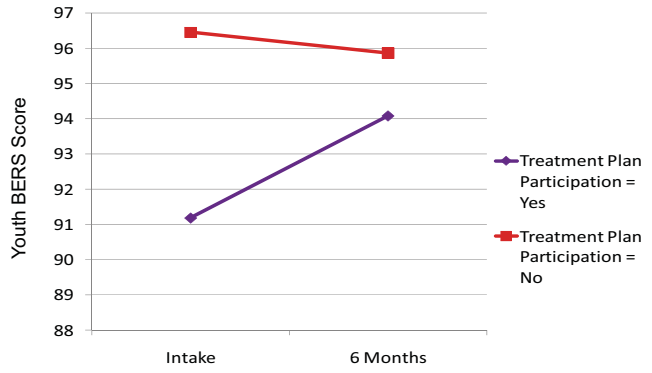
	Participated in Service Plan Development *n* = 798	Did Not Participate in Service Plan Development *n* = 122	High Treatment Participation *n* = 441	Lower Treatment Participation *n* = 479
Youth age: M (*SD*)	13.8 (1.8)	13.2 (1.8)	13.8 (1.8)	13.6 (1.8)
Gender = Male	61.4%	63.1%	63.0%	60.1%
Race/Ethnicity				
White	39.5%	38.8%	40.5%	38.5%
Black	30.4%	29.8%	32.0%	28.7%
Hispanic	18.6%	13.2%	17.7%	18.0%
Other	11.5%	18.2%	9.8%	14.9%
One bio parent	53.9%	45.8%	51.4%	54.2%
Two or more placement	39.2%	29.5%*	36.5%	39.1%
Below poverty	52.2%	56.0%	55.6%	50.0%

* $p < .05$

Youth Treatment Planning Participation and Youth Strengths

- **Youth who participated in developing the service plan had**
  - Lower strengths at intake.
  - Improved in strengths while those who did not participate made no change.
- **Rate of change did not differ for youth clinical or functional outcomes, or caregiver outcomes. Both groups improved.**

Youth Treatment Planning Participation and Youth Strengths

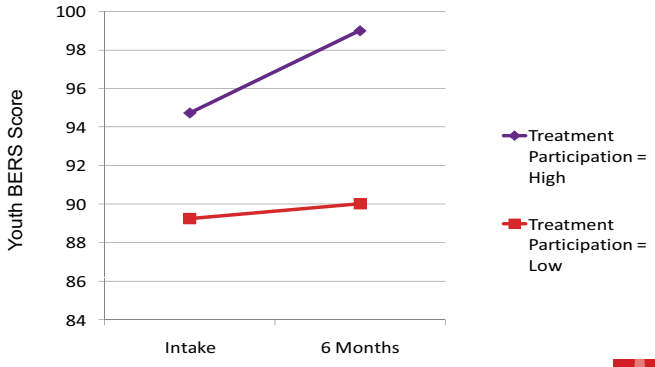


Within Subjects X Time: $F = 5.638$, $p = .018$
Between Subjects: $F = 6.048$, $p = .014$
Strength Index on the BERS–2Y ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Youth Treatment Participation and Youth Strengths

- **Youth with high treatment participation show greater increase in strengths.**
- **Youth with high treatment participation or satisfaction with treatment**
  - Had higher strengths at intake.
  - Improved in strengths while those who were less satisfied made no change.
- **Caregivers agree.**

Youth Treatment Participation and Youth Strengths

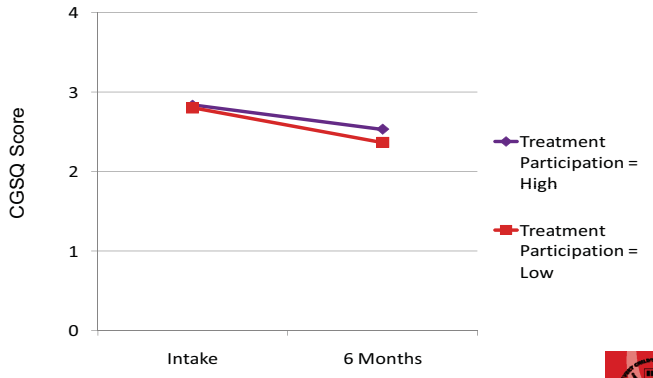


Within Subjects X Time: $F = 12.326$, $p < .001$
Between Subjects: $F = 58.361$, $p < .001$
Strength Index on the BERS–2Y ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Youth Treatment Participation and Youth Strengths

- Youth with high treatment participation improved in their functioning (CIS). Those with lower participation did not improve.
- Caregivers of youth with high treatment participation had slightly greater reduced strain.

Youth Treatment Participation and Caregiver Strain



Within Subjects X Time: $F = 4.737$, $p = .03$
Between Subjects: $F = 2.329$, $p = .127$

Youth Treatment Participation and Other Outcomes

- Differences in changes on CBCL, RADS, RCMAS were not significant. Both groups improved.
- Higher externalizing problems and higher depression at intake among those with less treatment participation.

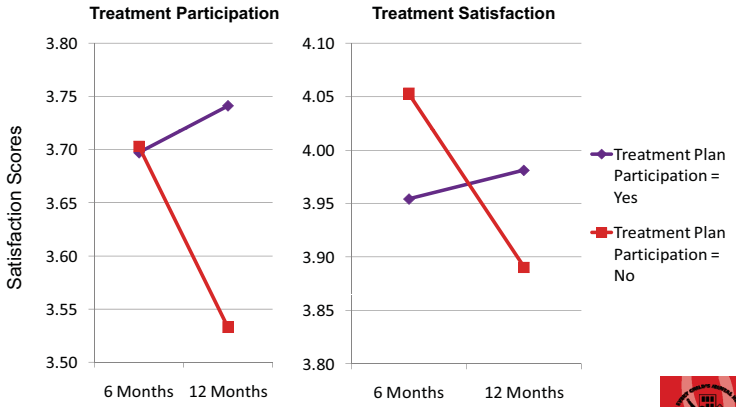
Youth Treatment Planning and Treatment Participation

- Youth with and without participation in treatment planning have the same level treatment participation at 6 months.
- Youth who don't participate in treatment planning decrease treatment participation from 6 to 12 months
- Treatment planning participants continue to increase in treatment participation.

Youth Treatment Planning and Treatment Satisfaction

- Youth who participate in treatment planning have lower treatment satisfaction at 6 months and their satisfaction increases to 12 months.
- Youth who don't participate in treatment planning have higher treatment satisfaction at 6 months and then dramatically reduce satisfaction to 12 months.

Youth Treatment Planning, Participation, Satisfaction, and Youth Strengths



Within Subjects X Time: $F = 5.568$, $p = .019$
Between Subjects: $F = 1.573$, $p = .21$

Within Subjects X Time: $F = 5.030$, $p = .025$
Between Subjects: $F = 0.003$, $p = .954$

Summary

- Youth strengths increase for those who participate in treatment planning and in treatment.
- Youth functioning and caregiver strain improve for youth who participate in treatment.
- Youth who participate in planning may be better able to assess the quality of their treatment.

Summary

- Youth may be included in treatment planning, but substantive involvement in treatment may not follow.
- Substantive involvement in treatment has a stronger relationship to some outcomes than participation in treatment planning alone.

Some Recommendations

- Train service providers to better engage youth in services.
- Develop or strengthen treatments that promote youth participatory process.
- Ask youth about quality of services received along the way.

Family-Driven Services

Caregiver Service Experiences and Child/Youth and Caregiver Outcomes

Caregiver Service Experiences and Outcomes

- 1,195 caregivers of youth 11 and older from 2002–2004 grantee sites
- Caregivers who did or did not participate in treatment planning
- Caregivers who did (agree, strongly agree) or did not participate in treatment
- Caregivers who were or were not satisfied with treatment.

Youth Services Survey for Families

Participation in Treatment Subscale

Three Items

- I helped to choose my child's services.
- I helped to choose my child's treatment goals.
- I participated in my child's treatment.

Scale: Strongly disagree, disagree, undecided, agree, strongly agree

Youth Services Survey for Families

Satisfaction with Services Subscale

Six Items

- **Overall, I am satisfied with services my child received.**
- **The people helping me stuck with me no matter what.**
- **I felt my child had someone to talk to when he/she was troubled.**
- **The services my child and/or family received were right for us.**
- **My family got the help we wanted for my child.**
- **My family got as much help as we needed for my child.**

Scale: Strongly disagree, disagree, undecided, agree, strongly agree

Caregiver Characteristics

	High Treatment Participation *n* = 942	Lower Treatment Participation *n* = 253	Satisfied With Services *n* = 769	Not Satisfied With Services *n* = 423
CG age: M (*SD*)	42.0 (9.5)	42.5 (10.2)	42.1 (10.2)	42.1 (8.6)
Bio/foster/adoptive parent	88.3%	87.4%	86.5%	91.0%
Custody = One bio parent	55.4%	47.4%*	53.7%	53.9%
Female caregiver	93.4%	90.5%	92.8%	92.7%
Race/Ethnicity = White	42.5%	48.2%	41.5%	47.9%*
High school or less	54.2%	53.2%	57.2%	48.1%**
Below poverty	55.1%	51.1%	56.2%	50.6%

* $p < .05$; $p < .001$

Caregiver Characteristics

	High Treatment Participation *n* = 942	Lower Treatment Participation *n* = 253	Satisfied With Services *n* = 769	Not Satisfied With Services *n* = 423
Worked in past 6 months	56.0%	54.5%	52.9%	60.7%*
If yes, Days missed work due to child's problems	7.0 (15.1)	6.6 (9.9)	6.5 (15.3)	7.6 (12.0)
If no, Would have job if child didn't have problems	34.8%	36.0%	30.8%	44.7%*

* $p < .05$

Caregiver Characteristics

- **Participated in service planning?**
  - Caregivers who did or did not participate did not differ on characteristics in table.
- **Participated in treatment?**
  - Youth more likely to be in the custody of one biological parent
- **Satisfied with services?**
  - Caregivers in the satisfied group were
    - More likely to be non-White, less educated, less likely to be working, less likely to work if youth did not have problems.

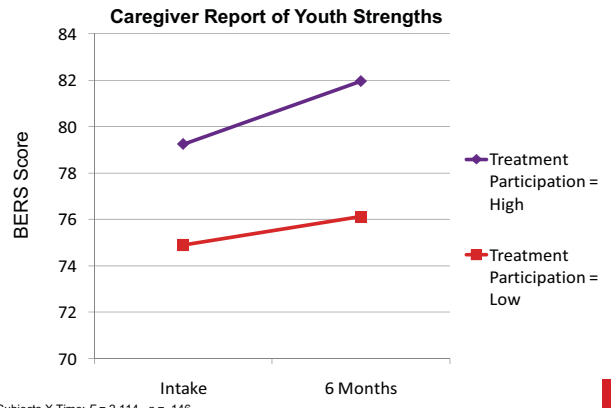
Caregiver Treatment Planning Participation and Outcomes

- **Caregivers who did not participate in treatment planning was very small (n=83).**
- **Youth and caregivers in both groups improved on outcomes.**
- **Groups did not differ in change in outcomes.**

Caregiver Treatment Participation and Outcomes

- **Caregiver treatment participation shows similar pattern for change in strengths and functioning as for youth participation, but does not reach significance.**
- **Youth of caregivers who participated in treatment or who were more satisfied with services had higher strengths at intake.**

Caregiver Treatment Participation and Youth Strengths

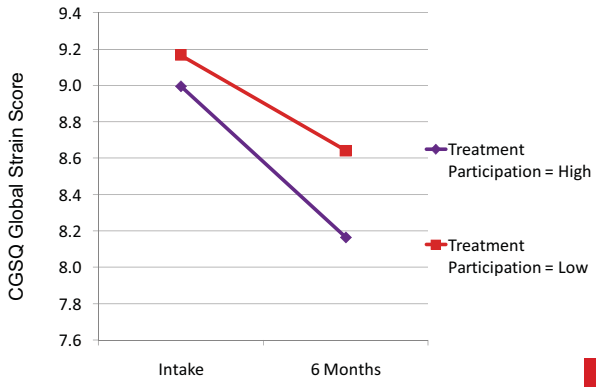


Within Subjects X Time: $F = 2.114$, $p = .146$
Between Subjects: $F = 22.596$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Caregiver Treatment Participation and Caregiver Strain

- **Caregivers satisfied with treatment made greater reductions in strain except subjective internalized strain (negative feeling such as worry, guilt, fatigue).**

Caregiver Treatment Participation and Caregiver Strain

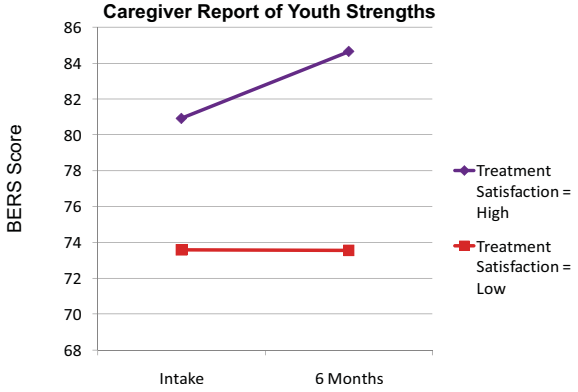


Group X Time: $F = 3.971$, $p = .047$
Group main effect: $F = 3.782$, $p = .052$

Caregiver Satisfaction With Services and Outcomes

- **Satisfaction with services is related to rates of improvement on youth strengths, functioning and problems, and caregiver strain.**
- **Improvement is greater among satisfied group on all measures.**
- **Youth strengths are higher, functional impairment and problems are lower, and caregiver strain is less severe at intake among those who are satisfied.**

Caregiver Satisfaction With Services and Youth Strengths



Within Subjects X Time: $F = 18.307$, $p < .001$
Between Subjects: $F = 108.375$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Caregiver Treatment Participation and Satisfaction

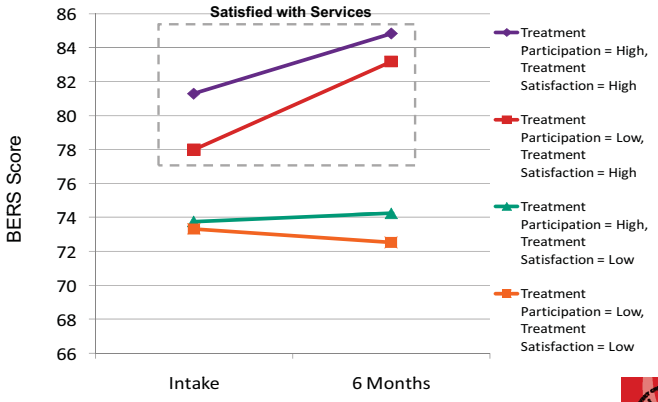
- **How do satisfaction with services and participation relate to outcomes?**
- **Constructed four groups**
  - Satisfied with participation and services
  - Satisfied with participation, not with services
  - Satisfied with services, not with participation
  - Not satisfied with services or participation

Caregiver Satisfaction With Participation and Services

- **Four groups differ in outcomes.**
- **Youth whose caregivers are satisfied with services and whose caregivers participate in treatment enter services with greater strengths.**
- **Youth of caregivers dissatisfied with services enter services with lower strengths.**

Satisfaction With Participation and Services and Youth Strengths

Caregiver Report of Youth Strengths



Within Subjects X Time: $F = 6.694$, $p < .001$
Between Subjects: $F = 37.049$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Caregiver Satisfaction With Participation and Services

- **Youth whose caregivers participated in treatment and were satisfied with services**
  - Entered services with the highest strengths and had the best outcomes.
- **Youth whose caregivers were satisfied with services but did not participate in treatment made greater gains in strengths.**

Caregiver Satisfaction With Participation and Services

- **Youth whose caregivers were not satisfied with services**
  - Entered services with lowest strengths and made no change in strengths.
  - *However*, if caregiver participated in treatment, there seems to be a slight trend in the positive direction.
- **This pattern was similar for youth functioning and behavioral and emotional problems.**
- **Caregivers differed similarly in improvements in strain.**

Summary

- **Most caregivers participate in treatment planning.**
- **Caregiver assessment of treatment participation is probably not a sufficient assessment of treatment experience to understand the relationship of the role of caregivers in services and outcomes.**
- **Satisfaction with services is highly related to outcomes.**

Implications

- **More information is needed about**
  - The nature of caregiver involvement in treatment.
  - The relationship of demographic characteristics and perception of services.
- **Expectations may change with service involvement.**
- **More information about services may be needed by some caregivers.**

Culturally Competent Services

Caregiver Preferences, Service Experiences, and Child/Youth and Caregiver Outcomes

Cultural Competence and Outcomes

- **3,872 caregivers and children/youth from 2002–2006 grantee sites**
- **Caregivers who considered cultural competence of service provider important (very, extremely) or less important**
- **Caregivers assessment of primary service provider's as always or less than always culturally competent**

Measures

- **Cultural Competence and Service Provision Questionnaire (CCSP)**
- **Behavioral and Emotional Rating Scale (BERS)**
- **Columbia Impairment Scale (CIS)**
- **Caregiver Strain Questionnaire (CGSQ)**

Cultural Competence and Service Provision Questionnaire

- **Importance of cultural competence**
  - Service provider who understands the customs, practices, and traditions of child's racial or ethnic groups.
  - Beliefs, traditions, and practices of child's racial or ethnic group be included in service planning and provision.
  - Provider seen most often is of the same racial or ethnic group as child.

Scale: Not at all important, somewhat important, moderately important, very important, extremely important

Cultural Competence and Service Provision Questionnaire

- **Assessment of cultural competence of provider practices**
  - Compared caregivers who rated their primary service provider as always culturally competent, to caregivers who reported their provider to be less than always culturally competent

Scale: Never, not very often, sometimes, most of the time, always

Caregiver Characteristics

- **Caregivers who rated importance of cultural competence as high were more likely to be**
  - Of a race/ethnicity other than White.
  - Speaking a language other than English at home.
  - Living in poverty.
  - Slightly older (but not significant).
  - Receiving services from a provider of the same race/ethnicity as child/youth.

Group Differences

Provider understands child's culture is important

	Understand Child's Culture High, Cultural Competence High n = 783	*Understand Child's Culture High, Cultural Competence Low n = 1,032*	*Understand Child's Culture Low, Cultural Competence High n = 515*	*Understand Child's Culture Low, Cultural Competence Low n = 902*
CG age: M	54.1	48.2	46.8	44.9
CG English*	86.2%	84.8%	95.1%	93.9%
Race/Ethnicity*				
White	29.4%	24.8%	57.0%	52.7%
Black	34.8%	40.1%	19.5%	20.2%
Hispanic	22.2%	22.9%	14.4%	16.2%
Native American	3.9%	3.4%	2.7%	2.5%
API	3.5%	3.6%	1.6%	1.8%
Below poverty*	62.8%	60.0%	51.2%	51.1%
Provider same race/ethnicity*	62.5%	54.8%	65.3%	61.9%

* $p < .001$

Group Differences

Provider same racial or ethnic group is important

	Provider Same Culture High, Cultural Competence High n = 291	*Provider Same Culture High, Cultural Competence Low n = 414*	*Provider Same Culture Low, Cultural Competence High n = 1,008*	*Provider Same Culture Low, Cultural Competence Low n = 890*
CG age: M	54.4	45.8	50.9	45.9
CG English*	72.3%	74.0%	94.8%	93.1%
Race/Ethnicity*				
White	16.5%	16.5%	47.3%	43.6%
Black	35.4%	38.3%	26.7%	28.8%
Hispanic	33.7%	32.7%	14.8%	16.3%
Native American	4.1%	4.6%	3.2%	2.5%
API	5.5%	4.4%	1.6%	2.4%
Below poverty*	65.1%	66.6%	56.2%	53.0%
Provider same race/ethnicity*	75.7%	63.8%	60.2%	56.6%

* $p < .001$

Group Differences

- **Caregivers rate importance of understanding culture and including culture in services similarly**
- **Fewer caregivers endorse same race/ethnicity of provider as important**
  - For those who do, groups differs from those constructed with the other two importance measures with an increase of children/youth who are not White, while White children/youth decrease
  - If caregivers found services to be highly culturally competent, most had providers who were of the same race/ethnicity
  - Those who rate importance and cultural competence as low were least likely to have providers of the same race/ethnicity.

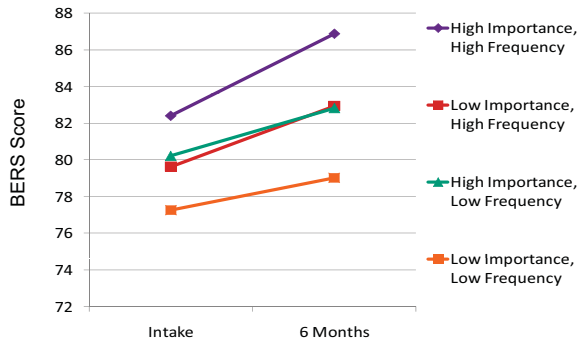
Cultural Competence Importance and Experience and Youth Strengths

- **Compared these four groups on**
  - Child/Youth Strengths (Caregiver report)
  - Functional Impairment (CIS)
  - Caregiver Strain (CGSQ)

Cultural Competence Importance and Experience and Youth Strengths

Caregiver Report of Youth Strengths

Provider understands child's culture is important.

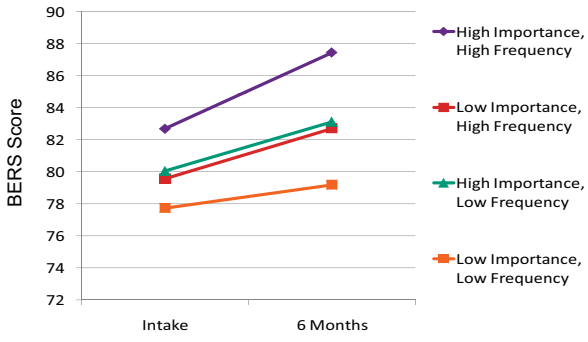


Within Subjects X Time: $F = 5.315$, $p < .01$
Between Subjects: $F = 24.429$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Cultural Competence Importance and Experience and Youth Strengths

Caregiver Report of Youth Strengths

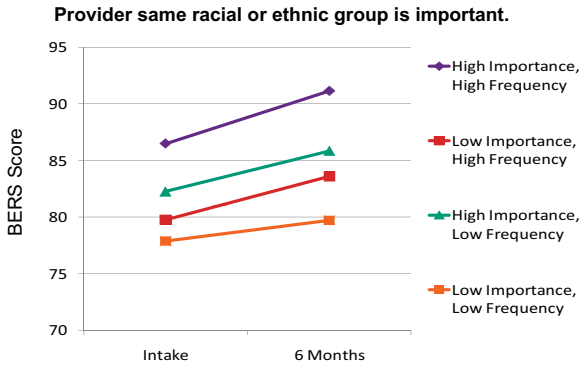
Services include culture/traditions is important.



Within Subjects X Time: $F = 7.453$, $p < .001$
Between Subjects: $F = 25.153$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Cultural Competence Importance and Experience and Youth Strengths

Caregiver Report of Youth Strengths



Within Subjects X Time: $F = 5.916$, $p < .01$
Between Subjects: $F = 40.584$, $p < .001$
Strength Index on the BERS–2C ranges from 38 to 161 with an average index between 90 and 110. A higher index indicates greater overall strengths.

Cultural Competence Importance and Experience and Youth Strengths

- Youth strengths differ at intake and show different rates of change to 6 months.
- Youth strengths make greatest gains when cultural competence is important to the caregiver and services are rated as highly culturally competent.
- Youth strengths are lowest when importance and experience of cultural competence are both lower.

Cultural Competence Importance and Experience and Strengths

- While importance and experience of matching race/ethnicity of provider differentiates groups, the rates of change in strengths are slower for groups differentiated by importance of matching provider to child/youth by race/ethnicity.

Cultural Competence Importance and Experience and Outcomes

- Improvement in functioning differed significantly among groups and in a similar pattern to strengths changes.
- Caregivers had similar intake differences in strain and reductions in strain but did not differ in improvement across groups.

Implications

- Assessing the importance of culturally based services to families at intake may assist in addressing potential challenges in outcomes.
- Understanding why culture is of low importance to some families may help in addressing service needs.

What's Next?

- Examine how youth and caregiver participation, and cultural competence contribute together to outcomes.
- Apply evaluation findings to mental health treatment, services, and program development.

Additional Information

- www.cmhi-library.org
- www.macrointernational.com/projects/CMHI
- Brigitte.A.Manteuffel@macrointernational.com

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