Idaho Youth Empowerment Services (YES) Family Survey Results, 2019

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Abstract

Objective**:** This report presents findings of the 2019 Idaho Youth Empowerment Services (YES) statewide family survey. The survey was commissioned by the Idaho Department of Health and Welfare, Division of Behavioral Health (DBH) and completed by investigators at Boise State University's School of Social Work. The overarching aims of the survey were to assess families' experiences and outcomes of care in Idaho's YES system and to guide service improvement efforts.

Method**:** We conducted a population survey of households that had participated in YES services from March 2018 to February 2019. Caregivers of youth were surveyed via postal mail regarding the experiences and outcomes of care for one randomly selected youth within their household. The survey employed an evidence-based 4-step process (pre-survey letter, survey invitation, follow-up post card, final follow-up survey). Survey items addressed the domains of (1) YES principles of care (family-centered, strengths-based, youth-focused), (2) case management quality indicators, (3) youth outcomes of psychosocial functioning, out-of-home placements, caregiver self-efficacy, and satisfaction with services, and (4) utilization of formal services and informal supports. In order to assess the effects of survey length on response rates, a random sample of participants were selected to receive a long format survey (4 pages) vs. the standard short format survey (2 pages). Statistical analyses tested the difference in response rate between short and long survey formats, provided descriptive information on YES participants' experiences and outcomes of care statewide, examined which service experiences were most predictive of youth outcomes, and tested for disparities in outcomes and experiences based on youth gender, ethnicity, and race.

Results**:** A total of 1,087 households were surveyed, yielding a raw response rate of 13% and an effective response rate (excludes returned mail) of 15%. Participants who received the short format survey were significantly more likely to respond compared to those who received the long format survey (16% vs. 8%). Statewide, respondents gave YES services high marks on items assessing family-centered care; however, there was room for improvement in the areas of strengths-based care and youth-focused care. Ratings were high on case management quality indicators of respect for family culture, agreement with treatment goals, and occurrence of meetings at convenient times and locations; ratings were low on development of effective safety plans, proactive responses to ineffective or unhelpful services, and coordination of services across treatment team members. A combination of four experience of care items, labeled *Indicators of Success*, were highly predictive of all youth outcomes and may serve as targets for service improvement (focus on strengths; child is active participant in planning; frequent measurement and monitoring of outcomes; effective safety plan in place). There were no statistically significant differences in service outcomes or experiences based on youth ethnicity or race due in part to extremely small samples of youth of color; however, descriptive data provided some evidence of variation.

Conclusions and Recommendations**:** Results of this survey offer targets for quality improvement of YES services in Idaho and provide a baseline for measuring progress in the future. Recommendations are provided for improving the response rate to future family surveys and for using this data to guide quality improvement efforts.
(July 26, 2019)

1. Introduction

This report presents findings of the 2019 Idaho Youth Empowerment Services (YES) statewide family survey entitled Experiences and Outcomes of Care for Youth and Families (ECO-YF). The survey was commissioned by the Idaho Department of Health and Welfare (IDHW) Division of Behavioral Health, and completed by investigators at Boise State University's School of Social Work. The overarching aims of the survey were to assess families' experiences and outcomes of care in Idaho's YES system and to guide efforts to further improve the system.

The Department launched the YES system transformation initiative in 2014 in response to the Jeff D. Settlement Agreement which was negotiated following the 1980 Jeff D. class action lawsuit. The goals of the Settlement Agreement and the YES transformation are to address deficits in Idaho's mental health service system for youth related to (1) the mixing of adults and juveniles at State Hospital South, and (2) the provision of community-based mental health services to children with Serious Emotional Disturbance (SED).

Youth who experience SED are those whose daily functioning is severely impaired by a mental disorder as determined by a qualified mental health professional based on established criteria (see Box 1). Under the terms of the Settlement Agreement, the State of Idaho is directed to ensure that youth with SED and their families have timely access to a full array of community-based mental health services and supports to meet their needs. In addition, these services and supports are to be delivered in accordance with practice principles as outlined in the Settlement Agreement's Practice Model.

Box 1. Definitions of Serious Emotional Disturbance

US Substance Abuse and Mental Health Services Administration

Pursuant to section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321 "children with serious emotional disturbance" are persons:

a. From birth up to age eighteen (18),
b. who currently or at any time during the past year,
c. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM),
d. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Idaho Administrative Code (16.07.37)

To be eligible for children's mental health services through a voluntary application to the Department, the applicant must:

a. Be under eighteen (18) years of age,
b. reside within the State of Idaho,
c. have a DSM-IV-TR Axis I diagnosis (a substance use disorder alone, or a developmental disorder alone, does not constitute an eligible Axis I diagnosis, although one more of these conditions may coexist with an eligible Axis I diagnosis), and
d. have a substantial functional impairment as assessed by using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Child Functional Assessment Scale (PECFAS) with a full eight (CAFAS) or seven (PECFAS) scale score of 80 or higher with "moderate" impairment in at least one of three areas including: Moods/ emotions, Thinking, or Self-harm.

Continuous quality improvement is an essential aspect of any effective service system, and the goal of the ECO-YF family survey is to aid IDHW in assessing the quality and outcomes of YES so that targets for quality improvement can be identified. The survey was conducted in conjunction with other improvement efforts, and represents only one aspect of the Department's overarching strategy to continually assess and improve the quality and effectiveness of YES. The Department's stated goals in conducting the survey were to:

(1) obtain a statewide cross-sectional assessment of the quality and outcomes of YES services from the perspective of parents and caregivers of youth who participate in the program,
(2) pilot test a mailed survey with follow-ups as one approach for giving parents a voice in system improvement, and
(3) identify targets to improve service quality and outcomes, and
(4) establish a baseline for measuring progress over time.

In this report, we present the results of the ECO-YF family survey and provide recommendations for continued efforts to improve the quality and outcomes of Idaho's YES system. Results of the survey by Idaho Department of Health and Welfare Region are provided in Appendix A, although caution is warranted in interpreting those results given the small sample size within each Region. Idaho Health and Welfare Regions are shown in Figure 1.

Figure 1. Idaho Department of Health and Welfare Regions

2. Method

2.1 Item Development

Items for the ECO-YF survey were developed using an iterative process that included (1) delineation of the key content domains by the Division of Behavioral Health in consultation with the research team, (2) identification of potentially relevant items in the empirical literature, (3) evaluation and modification of item content within each domain by the research team and Division of Behavioral Health partners, (4) review of items and pilot testing with family participants, and clinicians and managers in the Division of Behavioral Health, and (5) final revision of items within each content domain by the research team in partnership with representatives from the Division of Behavioral Health.

In step 1 of the process, Division of Behavioral Health representatives chose four content domains to be assessed by the survey: (1) YES principles of family-centered care, strengths-based care, and youth-focused care (referred to as individualized care in the Settlement Agreement), (2) quality of clinical case management services, (3) formal services and informal supports that youth and families participated in, and (4) outcomes of services. The target respondent group was parents or caregivers of youth who participated in YES services.

In step 2, the research team conducted an in-depth literature review to identify existing scales that assessed each of these content domains, and to identify potential items for use in the survey. This process resulted in an initial pool of 181 items drawn from a variety of instruments assessing system-of-care principles, quality of case management, mental health service use, and youth outcomes.

In step 3, items were winnowed down by the research team based on their applicability to the target content domains and target respondent group. Items that met one criterion but not another were re-worded so that nearly all of the selected items were significantly modified in their content and response format. This process resulted in a list of 76 items which were presented to representatives of the Division of Behavioral Health for evaluation. Members of the Division of Behavioral Health provided feedback on item wording and item selection. In addition, these items were shared with family members who had previously participated in YES services for their feedback on item wording and item selection. Following the incorporation of edits from family members and DBH staff, items were evaluated for their readability and additional edits were made to ensure the survey items and directions were written at no higher than an eighth-grade level.

In step 4, on the basis of feedback from family members and Division of Behavioral Health Staff, a total of 56 items (plus 2 open-ended items and 5 demographic questions) were selected for inclusion in the survey. These items assessed the four essential content domains. Each domain was assessed by at least two items. This version of the survey was used as the Long Format. Following development of the Long Format survey, the research team further narrowed the pool of items so that the survey would take no more than a single page (front and back). Items were eliminated from the Long Format survey to create the Short Format survey which did not include any open-ended questions and had a total of 39 items (plus 5 demographic questions).

2.2 Survey Fielding Procedure

One of the Department’s primary goals in conducting the survey was to protect the privacy and confidentiality of YES participants. In order to accomplish this, the team developed a survey fielding procedure which ensured that (a) Boise State University would not have access to names, addresses, or other identifying information about YES participants, and (b) Division of Behavioral Health staff would not have access to respondents’ answers and therefore would be unable to know how respondents answered the survey questions. This was accomplished by designing the survey so that mail merges and the mailing of the survey invitation letters and survey documents was handled completely by the Idaho Department of Health and Welfare print shop and mail room; thus, researchers at Boise State University did not have access to participants' names and addresses. In order to protect the confidentiality of respondents' answers, survey responses were returned via Business Reply Envelope to Boise State University. This process ensured that the Department of Health and Welfare could not ascertain how any respondent answered the questions. In order to minimize duplicate mailings, each completed survey included a random identifier number for which the Division of Behavioral Health had a key, but Boise State University researchers did not. After the initial survey was mailed out, Boise State researchers compiled the list of random identifiers that had been received and returned it to IDHW, allowing IDHW's mail room to eliminate these addresses from follow-up mailings. In this way, the Department was never able to know how respondents answered the survey, and Boise State researchers never had access to participants' identifying information.

The survey procedure itself was designed based on empirically-supported best practice principles described by Dillman et al. (2009). The survey was fielded from April 2, 2019 to May 3, 2019. The survey began with a pre-survey letter designed to inform participants that the survey would be forthcoming, that it was a legitimate request from the Idaho Department of Health and Welfare, and that their participation was kindly requested. Next, the survey itself was mailed out with an invitation letter and a return envelope. One week after the survey was mailed, a postcard was sent out thanking participants who had completed the survey and serving as a reminder for those who had not yet completed the survey. One week later, a third mailing was sent containing another letter and a new copy of the survey; this mailing was sent only to individuals who had not yet responded (using the procedure described above). In total, participants received four contacts about the survey.

2.3 Sampling Frame

The sampling frame was developed by the Idaho Department of Health and Welfare, Division of Behavioral Health to include all families of youth who had been served by the Division of Behavioral Health (either active or closed cases) from March 2018 to February 2019. The frame excluded youth whose only program enrollment was Person-Centered Planning. The initial draw of this sample included a total of 1,231 youth. After removing duplicate youth (e.g. those served by multiple programs) the sampling frame was reduced to 1,175 youth living in 1,092 households (some households had more than one youth in services). Of these 1,092, five had null values for mailing address, leaving a final sample of 1,087 families (households) in the sampling frame. Of these 1,087 families, 950 were mailed the Short Format Survey and 137 were mailed the Long Format survey.

3. Results

3.1 Youth Sample

A total of 141 ECO-YF surveys were completed by caregivers describing the experiences and outcomes of youth. On average, youth in the sample were 14.4 years old (standard deviation = 2.8 years) with a median of 13 months in services (*SD* = 32.7 months). The sample was evenly split between females (*n*=68, 48%) and males (*n*=68, 48%).[1] The racial and ethnic composition of the sample was highly homogenous; most youth were identified as White (*n*=121, 85%) and non-Hispanic/Latino (*n*=123, 87%). Fewer than five youth were identified in the categories of American Indian/ Alaskan Native, Native Hawaiian/ Other Pacific Islander, Black, Other, Unknown, or multiple reported racial groups; these frequencies are withheld to respect respondents' privacy.

3.2 Response Rates

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[1] Percentages do not sum to 100 due to missing data on some questions. Less than 4% of surveys had missing data on youth demographic variables with the exception of number of months in services which had 7% missing responses.

One of the main goals of this project was to pilot test the feasibility and acceptability of a postal mail survey for obtaining parent and caregiver feedback on the quality and outcomes of YES. Response rate is an important criterion in this regard because a survey cannot yield useful quality improvement data if participants will not respond. To assess the mailed survey's feasibility and acceptability we conducted two tests: (1) a comparison of the response rate of the pilot survey method versus the response rate of a previous baseline postal mail survey conducted by the Department of Health and Welfare using a different method, and (2) a comparison of the response rate for two different versions of the survey—a long format versus a short format. Below, we report these data as well as the overall survey response rates statewide and by Region.

3.2.1 Overall Survey Response Rates

Survey response rates can be calculated in a number of ways, reflecting different types of information. In this section we present two types of response rate:

(a) a *raw response rate*, which uses the total population of interest as the denominator, and
(b) an *effective response rate*, which uses the number of deliverable family addresses as the denominator.

The latter response rate excludes letters that were rejected as undeliverable. These response rates provide different but complimentary information.

The *raw response rate* indicates the percentage of the total potential population who responded to the survey; consequently, it may be most informative for understanding the extent to which the survey sample is representative of the total population.

The *effective response rate* provides information on the percentage of the population who actually received the survey and responded. This information is useful for understanding the likelihood of responding to future survey administrations because only people who actually received the survey can respond.

Table 1 shows the raw survey response rates for the overall sample as well as for the short and long survey formats by region. The overall raw survey response rate was 13% with a range of 11% (Region 7) to 19% (Region 2). The raw response rate for the short survey (14%) was twice that of the long survey (7%). There was not a significant difference in raw response rates across Regions, χ^2_{LR} = 4.87, *df*=6, *p*=.560.[2]

Table 1. Raw Survey Response Rates

Region	N of Households Served	N of Respondents	Overall Raw Response Rate (%)	Raw Response Rate (%)	
				Short Survey Format	Long Survey Format
Region 1	123	21	17%	17%	
Region 2	32	6	19%	19%	
Region 3	112	16	14%	14%	
Region 4	243	32	13%	14%	8%
Region 5	175	19	11%	12%	7%
Region 6	155	21	14%	15%	7%
Region 7	247	26	11%	11%	7%
Total	1,087	141	13%	14%	7%

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[2] The likelihood ratio chi-square test compares the response rates across Regions to determine whether there are statistically significant differences. P-values of less than .05 (i.e., < .05) indicate there is a statistically significant difference in response rates between Regions. χ^2_{LR} = likelihood ratio chi-square test of independence; *df* = degrees of freedom; *p* = probability.

Note: Empty cells indicate the long survey was not administered in Regions 1, 2, or 3 due to the small population sample in those areas. Chi-square test of independence indicates there was not a significant difference in overall response rates across regions, $\chi^2_{LR} = 4.87$, *df*=6, *p*=.560.

Table 2 presents the effective response rates for the overall survey as well as short and long formats by Region. The overall effective response rate was 15% with a range from 12% to 23%. There was not a significant difference in effective response rate across regions, $\chi^2_{LR} = 6.52$, *df*=6, *p*=.367. Consistent with results above, the effective response rate for the short format (16%) was twice as large as the response rate for the long format (8%).

Table 2. Effective Survey Response Rates

Region	**N of Households Served w/ Valid Addresses**	**N of Respondents**	**Overall Effective Response Rate (%)**	**Effective Response Rate (%)**	
				Short Survey Format	**Long Survey Format**
Region 1	105	21	20%	20%	
Region 2	26	6	23%	23%	
Region 3	96	16	17%	17%	
Region 4	199	32	16%	18%	9%
Region 5	154	19	12%	13%	7%
Region 6	142	21	15%	16%	9%
Region 7	224	26	12%	12%	8%
Total	946	141	15%	16%	8%

Note: Empty cells indicate the long survey was not administered in Regions 1, 2, or 3 due to the small population sample in those areas. Chi-square test indicates there was not a significant difference in overall response rates across regions, $\chi^2_{LR} = 6.52$, *df*=6, *p*=.367.

3.2.2 Comparison of Overall Survey Response Rate from Baseline versus Pilot Surveys

We compared the response rate from the 2019 ECO-YF survey to the response rate for a 2018 baseline survey conducted by the Department to determine whether there were statistically significant differences in response to the two surveys. This test examined whether the ECO-YF pilot methodology, which was sent to all participants who received services during the last year and which included a pre-survey letter and two follow-ups in addition to the survey letter itself, yielded a superior response rate than the baseline methodology, which was sent only to current clients and did not include a pre-survey letter or follow-ups. We attempted to match the surveys on length by examining only the results from the 2019 Short Survey. Thus, the statistical test compares the response rate for the 2019 Short Survey sent to all clients seen within the last year versus the 2018 survey sent to only current clients. Although there was a trend toward a greater response rate for the 2019 survey 15.9% vs. 12.7%) this difference was not statistically significant, $\chi^2_{LR} = 2.41$, *df*=1, *p*=.120. This is likely due to the difference in target populations for the two surveys—surveying current clients only is likely to increase the response rate.

3.2.3 Comparison of Response Rates for Short versus Long Survey Formats

Table 3 presents the effective response rates for the short and long survey formats (these are effective response rates not raw response rates). Results of a chi-square test of independence indicated that the response rate for the short format survey (16%) was significantly better than the response rate for the long format survey (8%), $\chi^2_{LR} = 6.02$, *df*=1, *p*=.014.

Table 3. Effective Response Rates and Number of Respondents by Survey Format

			Did the Participant Respond to the Survey?		
			No	Yes	Total
Survey Format	Short Survey	Count	691	131	822
		% within short survey	84.1%	15.9%	100.0%
	Long Survey	Count	114	10	124
		% within long survey	91.9%	8.1%	100.0%
Total		Count	805	141	946
		% within all survey formats	85.1%	14.9%	100.0%

3.3 Families' Experiences of Care

An essential aspect of Idaho's YES system is the delivery of services and supports to youth and families based on a set of core Principles of Care as outlined in the Settlement Agreement. In partnership with representatives from the Division of Behavioral Health, our research team developed items to assess three of these principles, which were identified as top priorities by the Departmental representatives. The principles we assessed included:

- ***family-centered***,
- ***strengths-based***, and
- ***youth-focused*** (referred to as individualized care in the Settlement Agreement).

In this section, we present results of the survey items designed to measure these principles.

3.3.1 Family-Centered Care

In accordance with the Settlement Agreement, family-centered care was defined in the following way for the purpose of item development:

Principle: Family-Centered

Services and supports are family-centered when they emphasize family strengths and maximize family resources. Family experience, expertise, and perspective are welcomed. Families are active participants in solution and outcome-focused planning and decision-making.

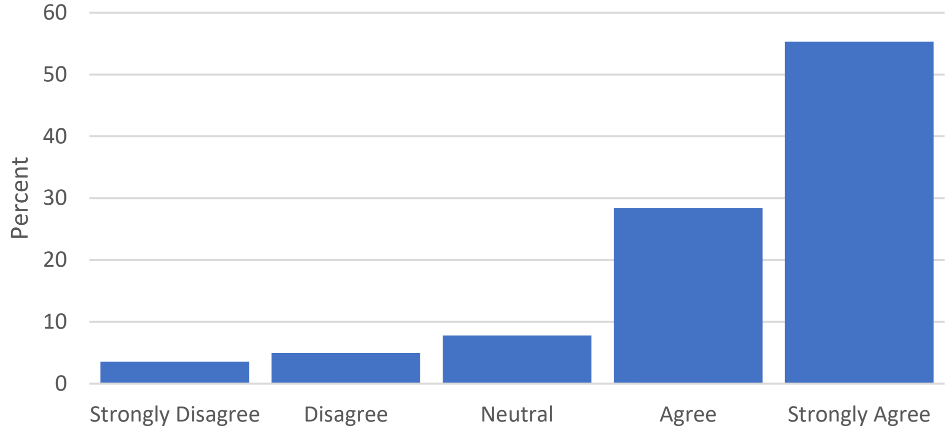
Two items assessed the extent to which parents and caregivers experienced YES services as family-centered:

(1) The CMH clinician encourages me to share what I know about my child/youth's strengths and needs.

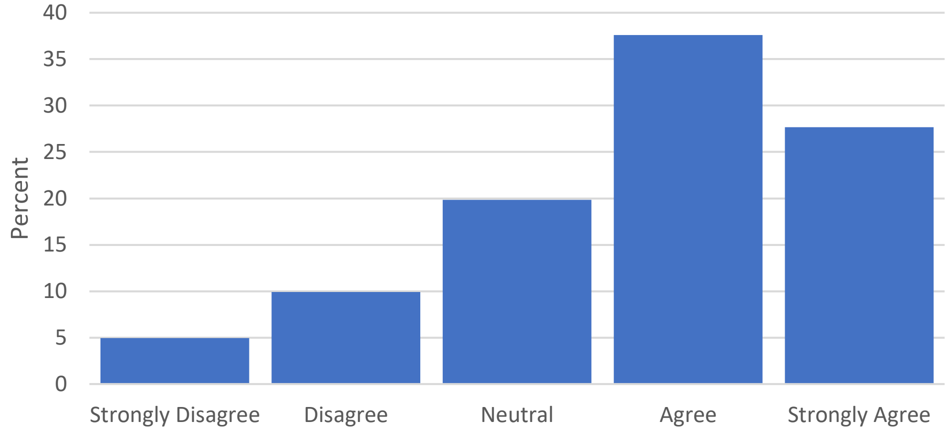
(2) My child and I are the main decision-makers when it comes to planning my child/youth's services.

Respondents were instructed to think about their experiences during the last six months (or however long they had been in services if less than six months) and to rate how much they agreed or disagreed with each statement on a scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree)*. Figure 2 shows the distribution of participants' responses on these items.

Figure 2. Distribution of Family-Centered Principle of Care Items



The CMH clinician encourages me to share what I know about my child/youth's strengths and needs.



My child and I are the main decision-makers when it comes to planning my child/youth's services.

Table 4 shows the average response on each item for the family-centered principle of care as well as the percentage of respondents who either (a) strongly agreed, or (b) disagreed or strongly disagreed. These two categories serve as global assessments of the percentage of respondents who enthusiastically provided the highest possible ranking on the item (*Strongly Agree*) versus those who disagree that the item is true (either *Strongly Disagree* or *Disagree*). In order to provide an assessment of the YES system's performance, we highlight in red those items for which more than 1 in 3 participants (33%) *Strongly Agreed* as this indicates an area of relative strength. In addition, we highlight in red those items for which more than 1 in 5 respondents (20%) *Disagreed* or *Strongly Disagreed* as this indicates a potential area for improvement.

Of all the items on the survey, the item, "The CMH clinician encourages me to share what I know about my child/youth's strengths and needs" had the second highest percentage of *Strongly Agree* responses. In addition, less than 10% of respondents disagreed with this statement, suggesting this is an area of strength for the state in terms of delivering services that actively elicit parent and caregiver knowledge regarding their child/ youth's unique strengths and needs.

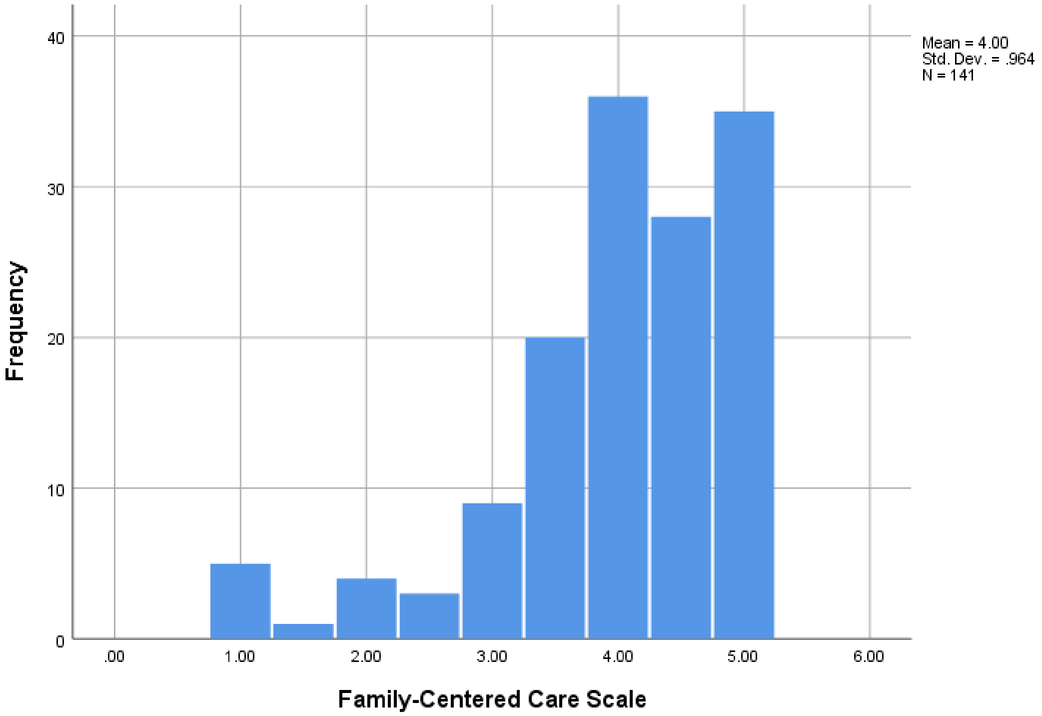
Table 4. Family-Centered Care Items

Item	Mean	Std. Deviation	% Strongly Agree	% Disagree or Strongly Disagree	N Valid (out of 141)
The CMH clinician encourages me to share what I know about my child/youth's strengths and needs.	4.27	1.04	55%	9%	141
My child and I are the main decision-makers when it comes to planning my child/youth's services.	3.73	1.12	28%	15%	141

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement. Items highlighted in red are those for which either (a) 1 in 3 participants (33%) or more *Strongly Agreed*, which indicates an area of relative strength, or (b) 1 in 5 respondents (20%) or more *Disagreed* or *Strongly Disagreed,* which indicates a potential area for improvement.

Using the average of these two items, we generated a Family-Centered Care total score. Figure 3 shows the distribution of the family-centered care scale. The distribution of scores is skewed such that it is apparent that most respondents provided high scores, indicating a positive experience of care in the domain of Family-Centered Care. This scale is used later in the report when we examine how families' experiences of care related to their perceived outcomes of care.

Figure 3. Distribution of Family-Centered Care Scale



3.3.2 Strengths-Based Care

Consistent with the Settlement Agreement, strengths-based care was defined in the following way for the purpose of item development:

Principle: Strengths-Based

Services and supports are strengths-based when they are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child/ youth and his or her family, community, and other team members.

Two items assessed the extent to which parents and caregivers experienced YES services as strengths-based:

(1) The services my child/youth receives focus on what he/she is good at, not just on problems.

(2) The CMH clinician talks with us about how we can use things we are good at to overcome problems.

The distribution of responses to these two items are shown in Figure 4. Table 5 shows the average response on each of the strengths-based principle of care items as well as the percentage of respondents who either (a) strongly agreed, or (b) disagreed or strongly disagreed. Over 20% of the sample disagreed or strongly disagreed with the item “The CMH clinician talks with us about how we can use things we are good at to overcome problems,” suggesting this is an area for quality improvement.

Figure 4. Distribution of Responses to Strengths-Based Principle of Care Items

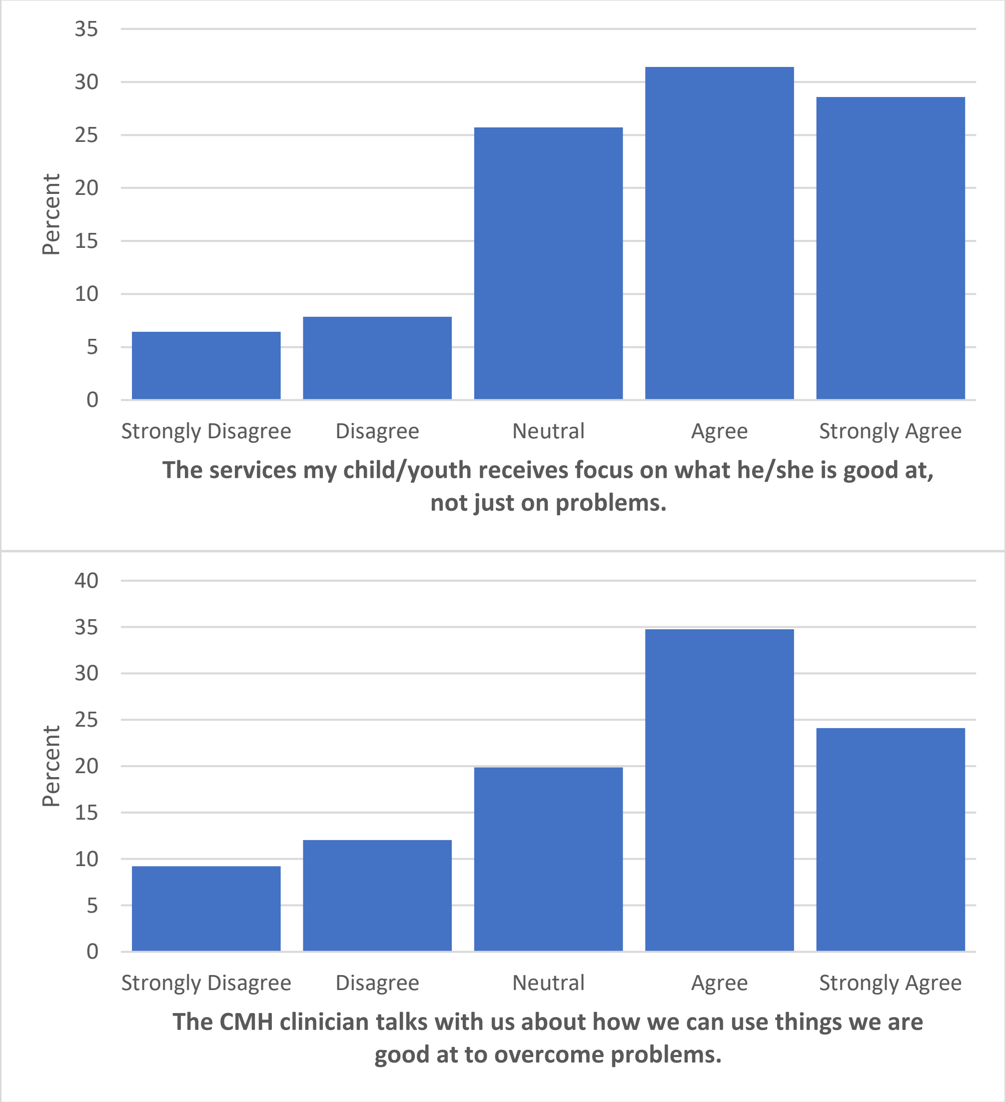


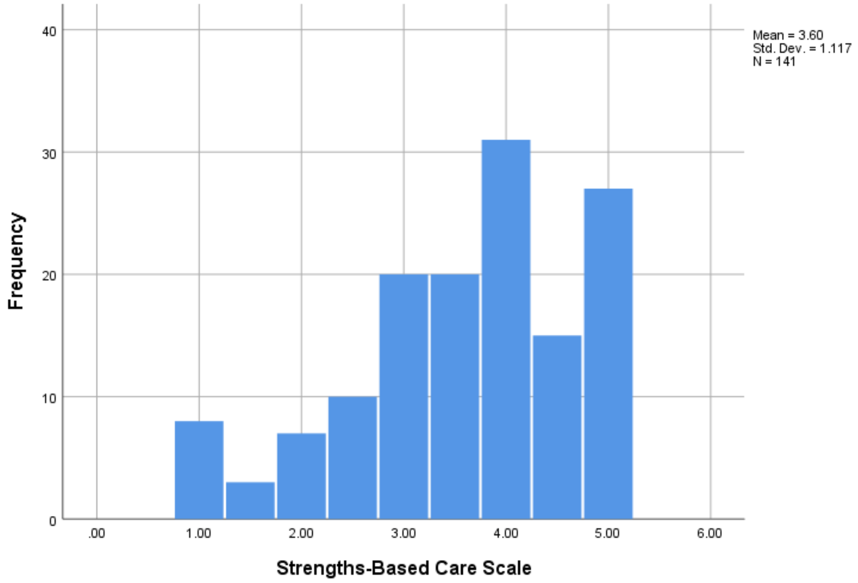
Table 5. Strengths-Based Principle of Care Items

Item	**Mean**	**Std. Deviation**	**% Strongly Agree**	**% Disagree or Strongly Disagree**	**N Valid (out of 141)**
The services my child/youth receives focus on what he/she is good at, not just on problems.	3.68	1.16	29%	14%	140
The CMH clinician talks with us about how we can use things we are good at to overcome problems.	3.52	1.24	24%	21%	141

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement. Items highlighted in red are those for which either (a) 1 in 3 participants (33%) or more *Strongly Agreed*, which indicates an area of relative strength, or (b) 1 in 5 respondents (20%) or more *Disagreed* or *Strongly Disagreed,* which indicates a potential area for improvement.

Using the average of these two items, we generated a Strengths-Based Care total score. Figure 5 shows the distribution of this scale score. In contrast to the Family-Centered Care scale, scores on the Strengths-Based Care scale are less skewed toward the positive end of the distribution. This indicates that caregivers' responses to the Strengths-Based Care scale were not as positive as their responses to the Family-Centered Care scale.

Figure 5. Histogram of Strengths-Based Care Scale



3.3.3 Youth-Focused Care

Consistent with the Settlement Agreement's definition of individualized care, youth-focused care was defined in the following way for the purpose of item development:

Principle: Youth-Focused

Services, strategies, and supports are youth-focused when they are individualized to the unique strengths and needs of the youth. The youth's experience, expertise, and perspective are welcomed. The youth is an active participant in planning and decision-making.

Two items assessed the extent to which parents and caregivers experienced YES services as youth-focused:

(1) My child/youth is an active participant in planning his/her services.

(2) When decisions are made about services, my child/youth has the opportunity to share his/her own ideas.

Figure 6 shows the distribution of these two items and Table 6 presents means and standard deviations. The item "My child/ youth is an active participant in planning his/her services," was among the most predictive of outcomes including child functioning, occurrence of new out-of-home placement, psychiatric hospitalization in the last six months, and family satisfaction with services. Importantly, over 20% of respondents disagreed or strongly disagreed with this statement, suggesting this is an important area of service improvement.

Figure 6. Distribution of Youth-Focused Care Items

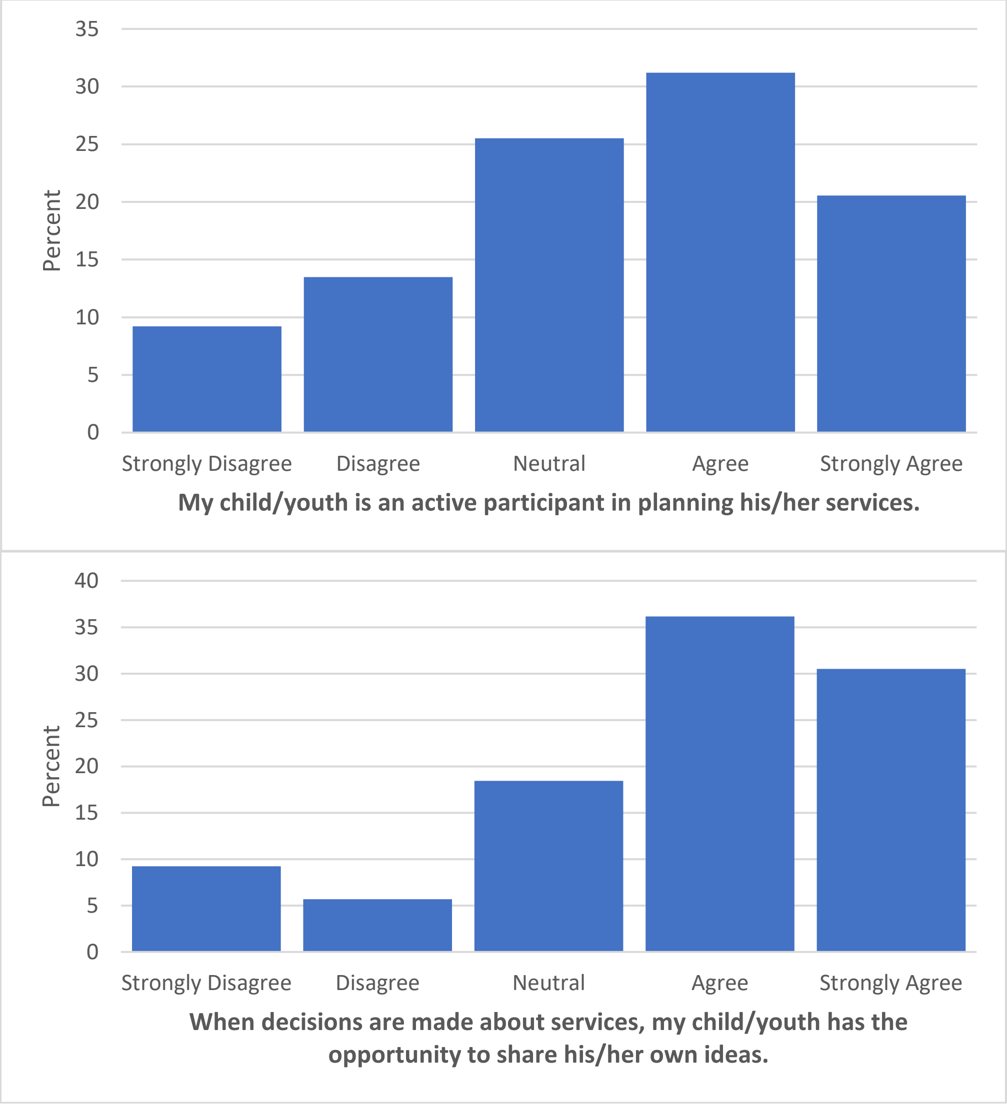


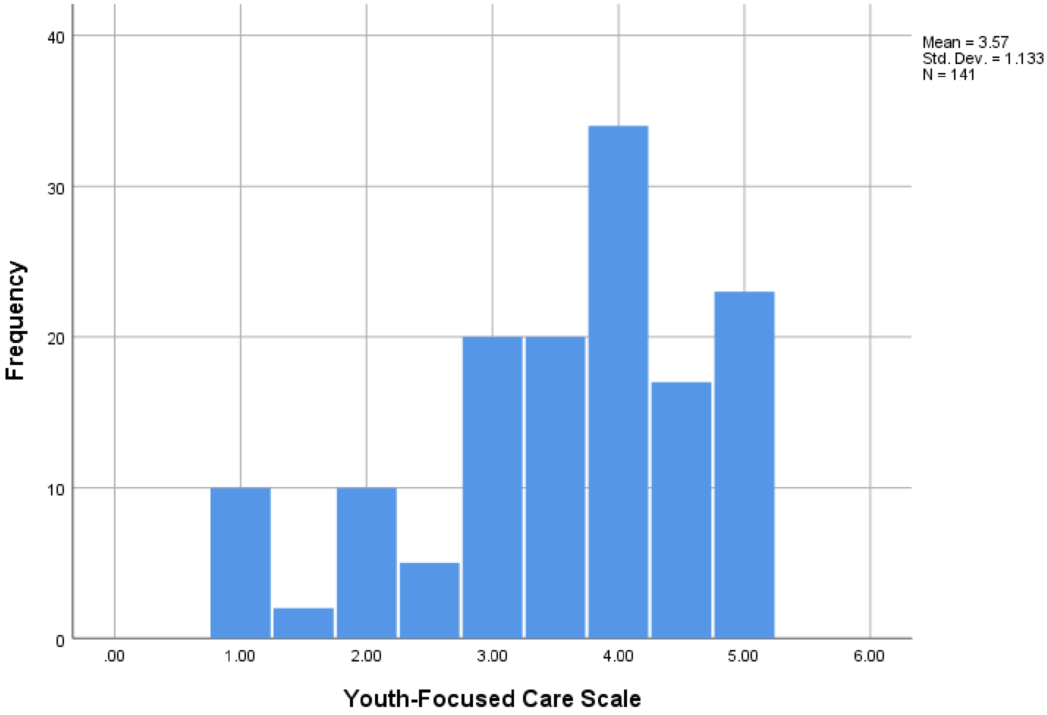
Table 6. Youth-Focused Principle of Care Items

Item	Mean	Std. Deviation	% Strongly Agree	% Disagree or Strongly Disagree	N Valid
My child/youth is an active participant in planning his/her services.	3.40	1.22	21%	23%	141
When decisions are made about services, my child/youth has the opportunity to share his/her own ideas.	3.73	1.22	30%	15%	141

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement. Items highlighted in red are those for which either (a) 1 in 3 participants (33%) or more *Strongly Agreed*, which indicates an area of relative strength, or (b) 1 in 5 respondents (20%) or more *Disagreed* or *Strongly Disagreed,* which indicates a potential area for improvement.

Using the average of these two items, we generated a Youth-Focused Care total score. Figure 7 shows the distribution of this scale. Scores on the Youth-Focused Care scale were less skewed than those on the Family-Centered Care scale, indicating potential room to improve the extent to which services are Youth-Focused.

Figure 7. Distribution of Youth-Focused Care Scale



3.3.4 Case Management Quality Indicators

Building on the Practice Model outlined in the Settlement Agreement, as well as on the literature on quality indicators for clinical case management, the investigative team and representatives from the Division of Behavioral Health developed 12 items to assess the quality of clinical case management provided to YES participants. These items were developed iteratively through review of the literature and feedback from content experts at the Department, and in consultation with families who participated in YES. The box below shows how we defined the content domain for these items. These items reflect principles of effective case management as well as core case management functions of:

- assessment,
- service planning,
- linking,
- advocating,
- coordinating,
- monitoring, and
- safety planning.

Case Management Quality Indicators

Quality indicators are criteria that define and operationalize high quality case management services. They address the extent to which core case management principles and functions are implemented as intended.

Table 7 presents descriptive statistics for the 12 items addressing case management quality indicators. The Table shows means and standard deviations for each item as well as items for which more than 1 in 3 respondents (33%) strongly agreed and for which more than 1 in 5 respondents (20%) disagreed or strongly disagreed. Items that fall into these categories can be considered areas of strength (i.e., if more than a third of respondents Strongly Agreed) or weakness (i.e., if one fifth of respondents Disagreed or Strongly Disagreed) in terms of case management quality statewide. Items that appeared as strengths or weaknesses are highlighted in red.

Table 7. Case Management Quality Indicator Items and Descriptive Statistics

Item	Mean	Std. Deviation	% Strongly Agree	% Disagree or Strongly Disagree	N Valid
Services we receive are respectful of our family's language, religion, race/ethnicity, and culture.	4.40	0.95	61%	6%	141
The goals we are working on with the children's mental health (CMH) clinician are the ones I believe are most important for my child/youth.	4.01	1.14	42%	13%	139
Meetings with the CMH clinician occur at times and locations that are convenient for me.	3.94	1.16	41%	12%	140
The assessment completed by my CMH clinician accurately represents my child/youth’s needs.	3.95	1.00	30%	9%	138
The CMH clinician makes specific suggestions about what services might benefit my child/youth.	3.71	1.22	29%	19%	139
The CMH clinician suggests changes in my child/youth’s treatment plan or services when things aren’t going well.	3.57	1.27	29%	21%	141
The CMH clinician makes sure everyone on my child’s treatment team is working together in a coordinated way.	3.55	1.28	28%	21%	141
The CMH clinician often works with our family to measure my child/youth's progress toward his/her goals.	3.55	1.23	26%	20%	141
When services are not helping, the CMH clinician leads my child/youth’s team in a discussion of how to make things better.	3.29	1.25	19%	26%	141
My child/youth has a safety plan that I believe will help us in times of crisis.	3.34	1.23	19%	26%	140

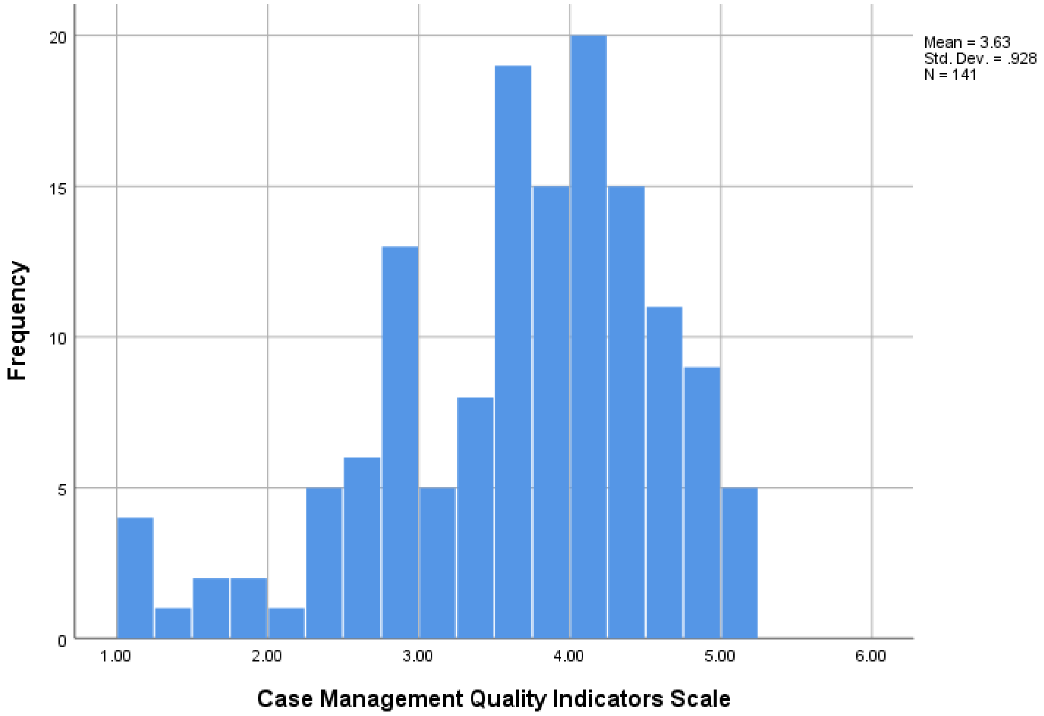
Table 7 (continued).

Item	Mean	Std. Deviation	% Strongly Agree	% Disagree or Strongly Disagree	N Valid
In times of crisis, my child/youth's CMH clinician is one of the first people I (would) call.	3.06	1.34	18%	37%	141
I know who to contact for help if I have a complaint about my child/youth's CMH clinician.	3.25	1.43	24%	36%	140

Note: Scores on each item range from 1 to 5 with higher scores indicating greater agreement. Items highlighted in red are those for which either (a) 1 in 3 participants (33%) or more *Strongly Agreed*, which indicates an area of relative strength, or (b) 1 in 5 respondents (20%) or more *Disagreed* or *Strongly Disagreed,* which indicates a potential area for improvement.

In order to evaluate the quality of care management services delivered to each youth, we calculated a total Case Management Quality Indicators score based on the mean of these 12 items. Figure 8 shows the distribution of the Case Management Quality Indicators Scale. Although scores on this scale tended to be in the higher range, indicating positive ratings of case management services, there is also considerable variability and many scores in the lower range, indicating the potential need to improve the quality of case management services.

Figure 8. Distribution of Case Management Quality Indicator Scale Scores



3.4 Service Outcomes for Youth

One key aim of the ECO-YF survey was to assess the outcomes of YES services from the perspective of parents and caregivers of youth. Outcomes were defined as the results or consequences of services. To assess YES outcomes, our research team developed items assessing five domains, which reflect domains outlined in the literature on mental health service outcomes for youth, as well as the perspectives and priorities of representativeness of the Division of Behavioral Health and family participants. The outcomes we assessed included:

- Satisfaction with services,
- Youth psychosocial functioning and well-being,
- Caregiver self-efficacy to access services and supports,
- Youth psychiatric hospitalizations, and
- Youth out-of-home placements

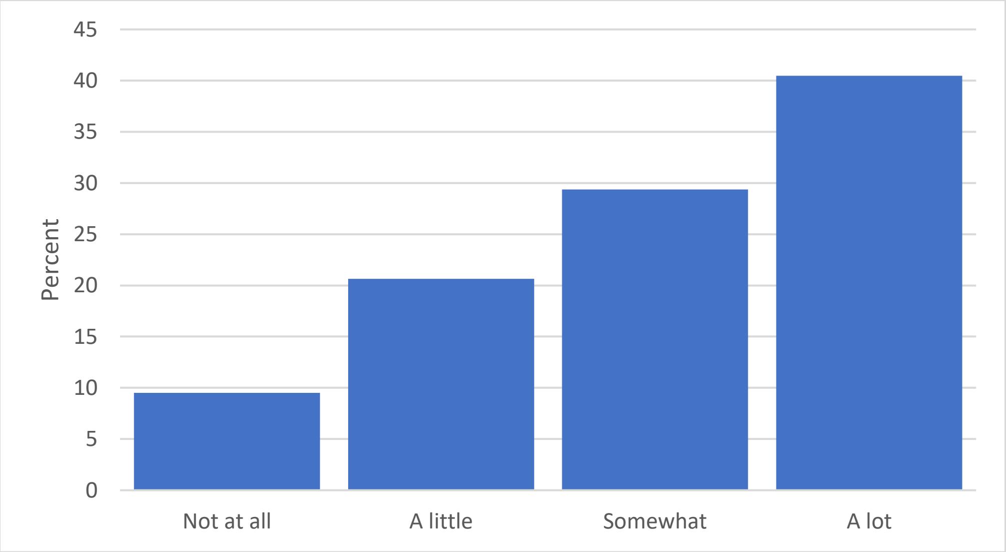
3.4.1 Satisfaction with Services

Satisfaction can be defined as the fulfillment of one's wishes, expectations, or needs. In the context of mental health services, it involves the extent to which services met the family and youth's expectations or need to receive help with the youth's mental health condition. We assessed family's satisfaction using a single item:

(1) In the last 6 months, how much was your child/youth helped by the mental health and/ or case management services he or she got?

Response options included: *Not at all, A little, Somewhat,* or *A lot.* Figure 9 shows the distribution of responses across Idaho.

Figure 9. Distribution of Caregiver Satisfaction with Services



In the last 6 months, how much was your child/ youth helped by the mental health and/ or case management services he or she got?

Response	Frequency	Percent
Not at all	12	8.5
A little	26	18.4
Somewhat	37	26.2
A lot	51	36.2
Total	126	89.4
Missing	15	10.6
Total	141	100.0

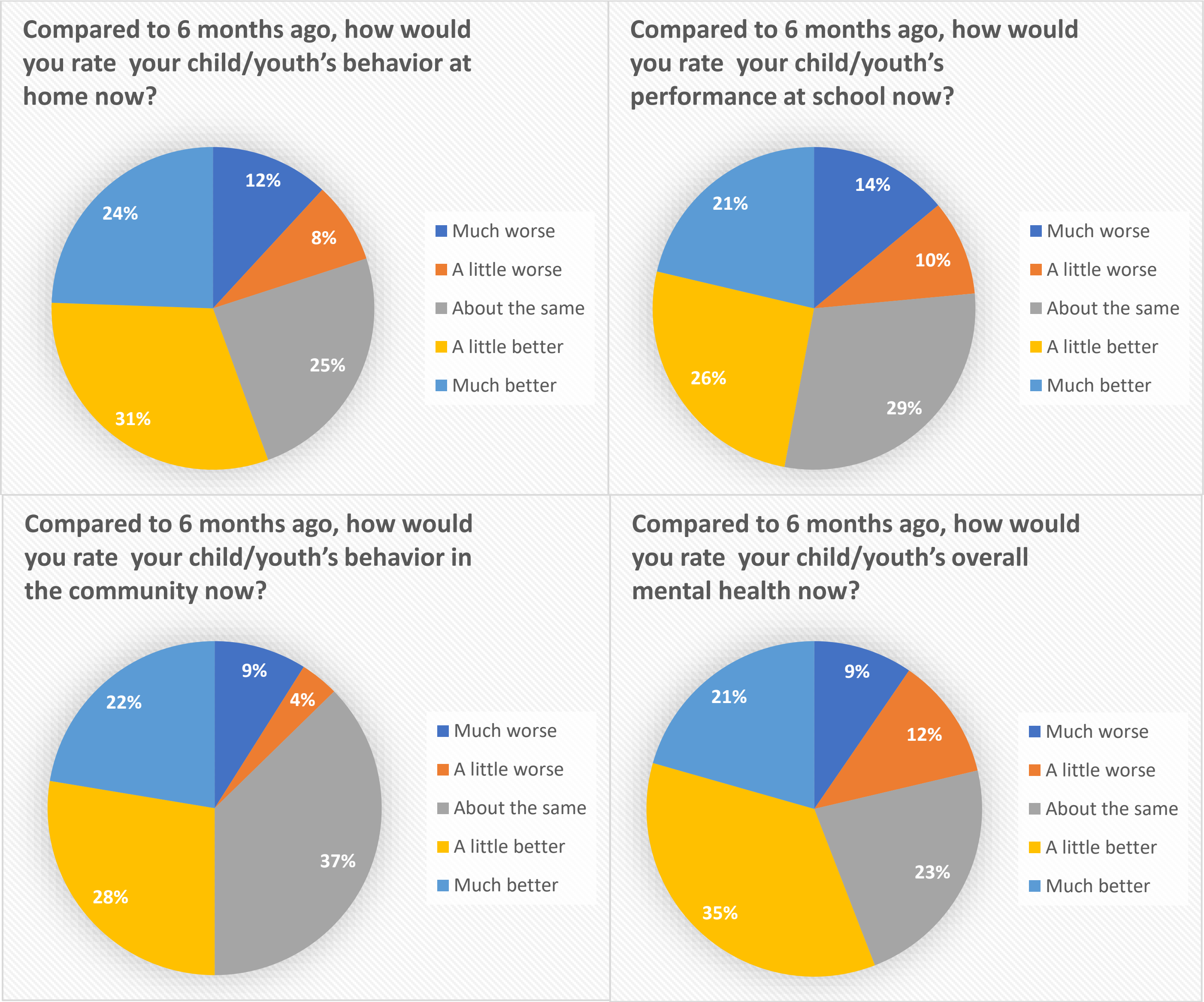
3.4.2 Youth Psychosocial Functioning and Well-being

Youth's psychosocial functioning and well-being was assessed using four items which addressed the youth's functioning at home, at school, and in the community, as well as his or her overall mental health. Items assessing these domains were:

(1) Compared to 6 months ago, how would you rate your child/youth's behavior at home now (e.g., getting along with family members, following rules, helping around the house)?
(2) Compared to 6 months ago, how would you rate your child/youth's performance at school now (e.g., attendance, behavior, grades)?
(3) Compared to 6 months ago, how would you rate your child/youth's behavior in the community now (e.g., behavior in public places, participation in positive activities, involvement with law enforcement)?
(4) Compared to 6 months ago, how would you rate your child/youth's overall mental health now?

Figure 10 shows the ratings provided by caregivers across the State.

Figure 10. Youth Functioning and Well-Being Scores



Compared to 6 months ago, how would you rate your child/youth's behavior at home now?

Compared to 6 months ago, how would you rate your child/youth's performance at school now?

Compared to 6 months ago, how would you rate your child/youth's behavior in the community now?

Compared to 6 months ago, how would you rate your child/youth's overall mental health now?

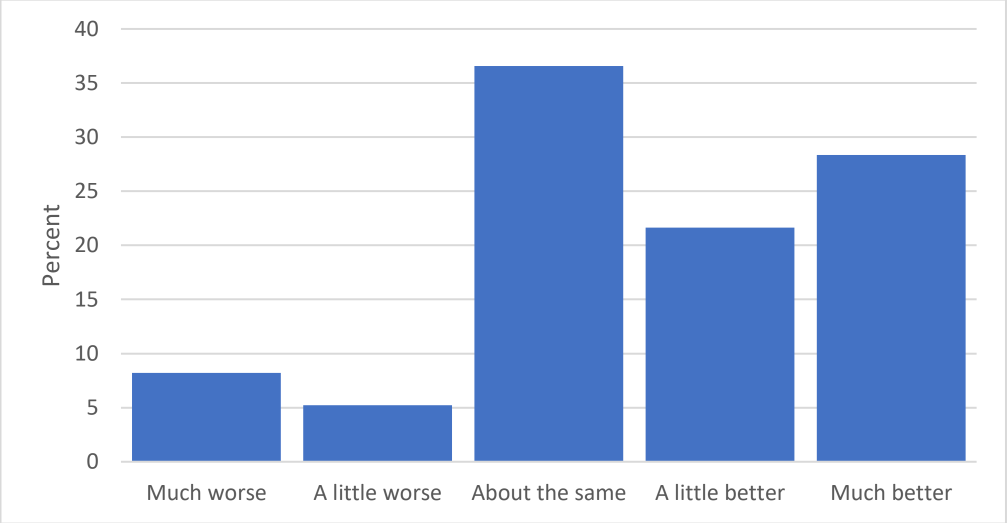
3.4.3 Caregiver Self-Efficacy to Access Services and Supports

Empowerment of caregivers is an essential aspect of an effective system-of-care. Accordingly, one important outcome is caregivers' level of self-efficacy, that is, personal confidence in their ability to access formal and informal services and supports that their child or youth needs. We assessed the extent to which services had aided caregivers in developing this sense of self-efficacy via the question:

(1) Compared to 6 months ago, how would you rate your ability to effectively access services and supports your child/youth needs?

Figure 11 shows the distribution of participants' responses to this question.

Figure 11. Distribution of Caregiver Self-Efficacy to Access Services Scores



Compared to 6 months ago, how would you rate your ability to effectively access services and supports your child/youth needs?

Rating	Frequency	Percent	Cumulative Percent
Much worse	11	7.8	7.8
A little worse	7	5.0	12.8
About the same	49	34.8	47.6
A little better	29	20.6	68.2
Much better	38	27.0	95.2
Total	134	95.0	
Missing	7	5.0	
Total	141	100.0	

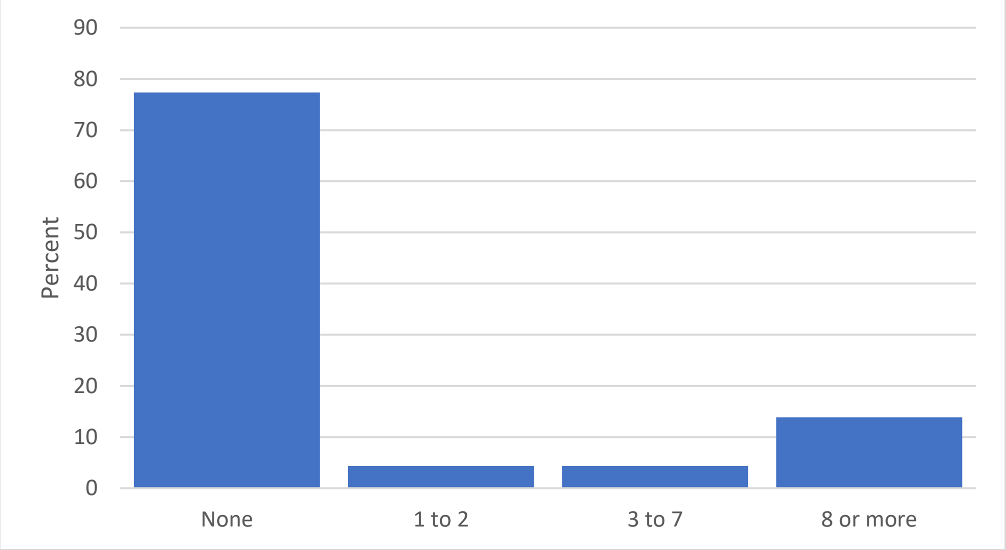
3.4.4 Youth Psychiatric Hospitalizations

An important goal of any system-of-care is to reduce the number of times youth are placed in restrictive out-of-home placements such as psychiatric hospitalization. While hospitalizations can play a key role in stabilizing youth and aiding in the recovery process, effective systems-of-care find ways to support youth in the community so that the frequency of re-entry into hospitals is minimized. In this section, we present data on caregivers' reports of the number of times their youth were hospitalized for a psychiatric issue during the last six months. Respondents answered the question:

(1) In the last 6 months, how many total nights did your child/youth spend in a hospital due to problems with behaviors or feelings?

Figure 12 shows the distribution of hospital stays for the state.

Figure 12. Total Number of Nights Youth Spent in the Hospital for Psychiatric Reasons



In the last 6 months, how many total nights did your child/youth spend in a hospital due to problems with behaviors or feelings?

# of Nights	Frequency	Percent	Cumulative Percent
None	106	75.2	75.2
1 to 2	6	4.3	79.5
3 to 7	6	4.3	83.8
8 or more	19	13.5	97.3
Missing	4	2.8	
Total	141	100.0	

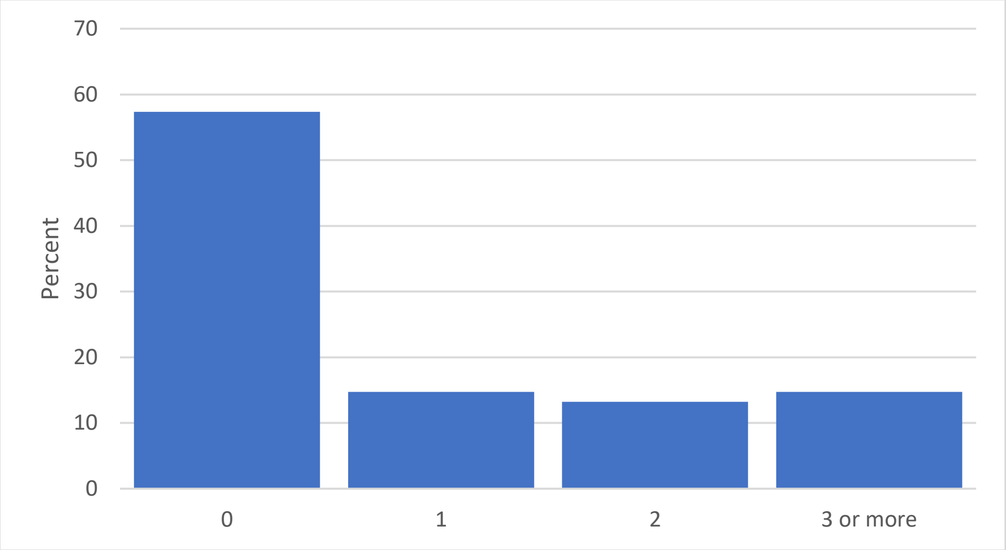
3.4.5 Youth Out-of-Home Placements

A key outcome indicator for systems-of-care is the extent to which youth can live successfully in the community rather than in an out-of-home placement. Out-of-home placements can occur when a youth is removed from her or his home, or when a youth has an unsuccessful placement at one out-of-home placement and is moved to a new placement. We asked caregivers to report on the number of new out-of-home placements their youth had experienced in the last six months (or since beginning services) with the following question:

(1) In the last 6 months, how many times has your child/ youth had a new out-of-home placement (such as juvenile detention, psychiatric hospital, or treatment center) OR moved between out-of-home placements?

This question has some built in redundancy with other service usage questions on the survey, but it provides an overall index of the number of new out-of-home placements youth experienced during the rating period. Figure 13 shows frequencies for the number of youth who experienced new out-of-home placements during the rating period. Overall, 41.1% (*n*=58) of youth experienced a new out-of-home placement during the rating period.

Figure 13. Frequency Distribution for the Number of New Out-of-Home Placements for Youth During the Last Six Months



In the last 6 months, how many times has your child/ youth had a new out-of-home placement (such as juvenile detention, psychiatric hospital, or treatment center) OR moved between out-of-home placements?

# of Nights	Frequency	Percent	Cumulative Percent
0	78	55.3	55.3
1	20	14.2	69.5
2	18	12.8	82.3
3 or more	20	14.2	96.5
Missing	5	3.5	100.0
Total	141	100.0	

3.5 Services and Supports Accessed by Youth and Families

In this section, we present data related to youth and families' use of formal and informal mental health services and supports. Services and supports were defined in two categories, including: formal services (i.e., organized therapeutic activities and interventions delivered by a professional provider) and informal supports (i.e., activities designed to aide a youth in achieving desired outcomes which occur as a result of family, faith, or community involvement).

3.5.1 Out-of-Home Services

Table 8 shows the total number of nights youth spent in out of home services by service type during the last six months based on caregivers' reports. In all, 64% (*n*=90) of youth had zero out-of-home services, 21% (*n*=29) participated in one type of out-of-home service, and only 2 caregivers (1.4%) reported that their youth participated in all four types of out-of-home services.

Table 8. Total Nights Youth Spent in Out-of-Home Services in the Last Six Months

	In a hospital due to problems with behaviors or feelings		In a crisis shelter for problems with behavior or feelings	
# of Nights	Frequency	Percent	Frequency	Percent
None	106	75	125	89
1 to 2	6	4	5	4
3 to 7	6	4	2	1
8 or more	19	13	3	2
Total	137	97	135	96
Missing	4	3	6	4
Total	141	100	141	100
	In Treatment foster care		In a residential treatment center or group home	
# of Nights	Frequency	Percent	Frequency	Percent
None	130	92	111	79
1 to 30	3	2	4	3
31 to 60	1	1	1	1
61 to 90	0	0	2	1
91 or more	2	1	20	14
Total	136	96	138	98
Missing	5	4	3	2
Total	141	100	141	100

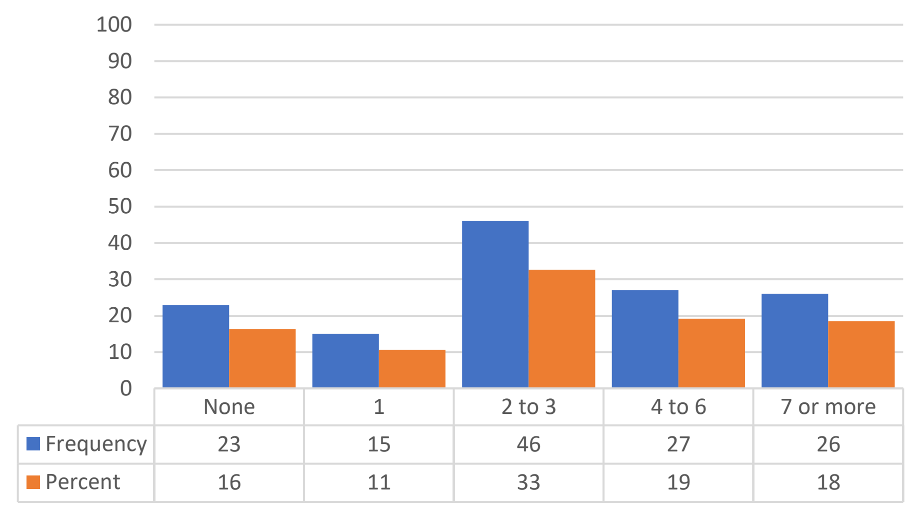
3.5.2 Community-based Services

Community-based services are a critical aspect of a system-of-care. The Department prioritized four different types of community-based services to assess with the survey:

- Outpatient visits with a physician or other prescriber for psychotropic medications,
- Face-to-face crisis visits with a mental health professional at the time and location of the crisis,
- Use of services for substance use disorders, and
- Use of Wraparound services.

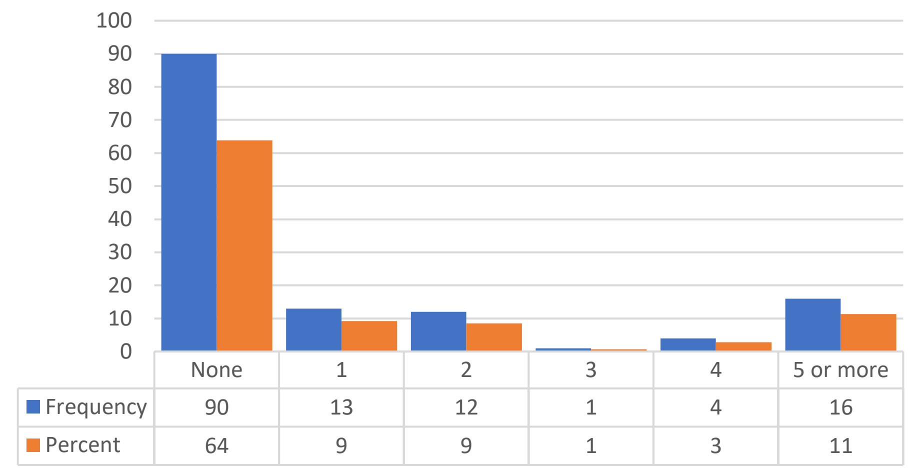
Figure 14 shows the frequency at which youth participated in each of these services.

Figure 14. Frequency of Youth Use of Community-Based Services in the Last Six Months



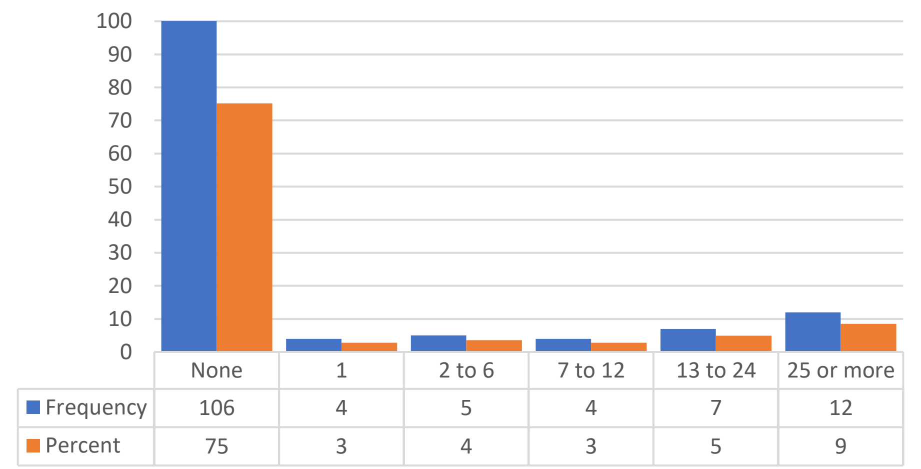
	None	1	2 to 3	4 to 6	7 or more
🟦 Frequency	23	15	46	27	26
🟧 Percent	16	11	33	19	18

# of visits with a physician or other prescriber in the last 6 months



	None	1	2	3	4	5 or more
🟦 Frequency	90	13	12	1	4	16
🟧 Percent	64	9	9	1	3	11

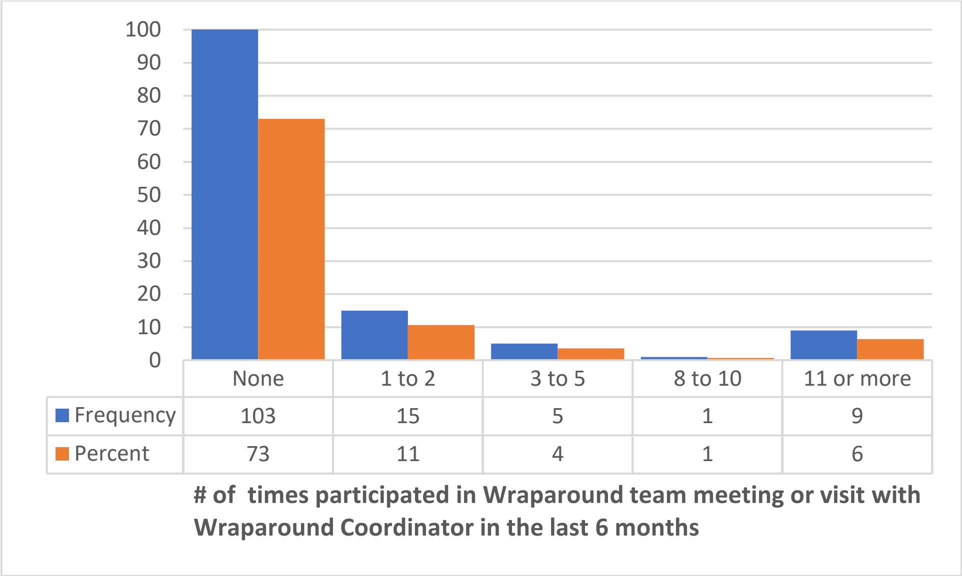
# of face-to-face visits with a professional at the time and location of a crisis in the last 6 months



	None	1	2 to 6	7 to 12	13 to 24	25 or more
🟦 Frequency	106	4	5	4	7	12
🟧 Percent	75	3	4	3	5	9

# of times participated in treatment for drug or alcohol problems in the last 6 months

Figure 14 (continued).



	None	1 to 2	3 to 5	8 to 10	11 or more
🟦 Frequency	103	15	5	1	9
🟧 Percent	73	11	4	1	6

3.5.3 Informal Supports

One of the goals of a system-of-care is to link youth and their families to naturally occurring resources and supports that can sustain the youth and family's well-being. We asked caregivers to report whether or not their youth had received or participated in various naturally-occurring supports including:

- A support group for youth who experience a mental health condition,
- A sports team or event (e.g., YMCA, volleyball, fun run, baseball, etc.),
- Visits with an informal adult mentor (e.g., Big Brother Big Sister),
- Participation in a club or activity (e.g., Boy/ Girl Scouts, 4H, FFA, etc.),
- Attendance at a camp (e.g., band camp, summer camp, etc.), and
- Participation in a religious service, group, or activity (e.g., youth group).

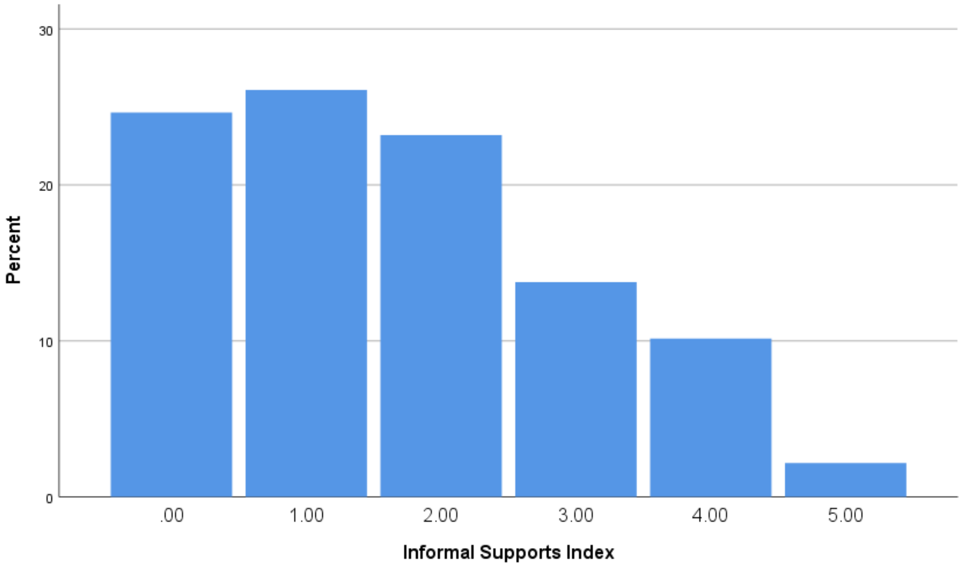
Table 8 shows the number of youth and the percent of the sample that participated in each type of informal support. Overall, 74% of youth participated in at least one type of informal support. The median number of supports youth participated in was 1. About 50% of the sample participated in 1 to 2 supports.

Table 8. Frequency and Percentage of Youth who Participated in Informal Supports

Type of Informal Support	Frequency	Percent
Attended a support group for youth who experience a mental health condition	30	21
Participated in a sports practice, game, or event (e.g., YMCA, volleyball, fun run, etc.)	47	33
Visited with a formal or informal adult mentor (e.g., Big Brother Big Sister)	32	23
Attended a club meeting, event, or activity (e.g., Boy/ Girl Scouts, 4H, FFA, etc.)	33	23
Attended a camp for youth (e.g., band camp, summer camp, etc.)	13	9
Participated in a religious service or activity (e.g., youth group)	73	52
Participated in at least 1 type of informal support	104	74

For each youth, we calculated an Informal Supports Index which equaled the sum of their total informal supports. The distribution of these scores is shown in Figure 15.

Figure 15. Distribution of Informal Support Index Scores



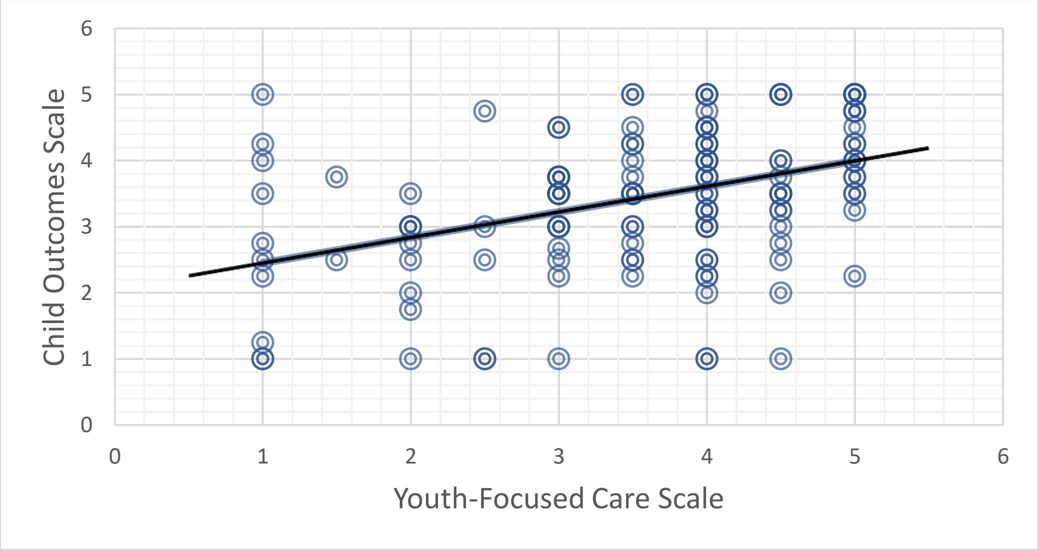
3.6 Relationships Between Experiences of Care and Youth Outcomes

This section presents analyses showing the relationships between scales measuring participants' experiences of care and youth outcomes. Survey measures are most valuable for identifying areas of service improvement when the items are associated with improvement in youth outcomes.

3.6.1 Relationships Between YES Principles of Care, Case Management Quality Indicators, and Youth Outcomes

Table 9 shows the bivariate correlations (Spearman's correlations) between scales measuring YES principles of care, case management quality indicators, and the suite of YES outcomes described above. Statistically significant correlations are indicated with an asterisk(s). A statistically significant correlation indicates that there is a reliable relationship between two variables such that, if we know the value of one variable, we can more accurately predict the value of the second variable. For example, Figure 16 shows a scatterplot of the relationship between youths' scores on the Youth-Focused Care scale and the overall Youth Outcomes scale.

Figure 16. Scatterplot Showing the Correlation Between Youth-Focused Care and Child Outcomes Scales



The correlation between these scales is positive and statistically significant, which means that as the score on Youth-Focused Care increases (indicting higher caregiver perceptions that the care they received was youth-focused), youth outcomes also improve. Correlations range in value from +1 to -1. The strength of a correlation does not depend on its sign (i.e., +/-) but rather on its absolute value. For example, a correlation of -.6 is much stronger than a correlation of +.04. The sign of a correlation indicates the direction of the relationship and the value of the correlation indicates the magnitude of the relationship. In Table 9, the Experiences of Care scale with the strongest correlation to the outcome is highlighted in green, and the Experiences of Care scale with the second strongest correlation with each outcome is shown in yellow. According to well-established guidelines from Cohen (1988), correlations can be interpreted as follows: |.10| = small, |.30| = moderate, and |.50| large. Thus, a correlation of .48 or -0.48 would be considered moderate-to-large and any correlation with an absolute value greater than or equal to .30 would be considered moderate in practical terms. Table 10 provides more detail by showing the correlations between each item on the Experiences of Care scales and the YES outcomes. In Table 10, cells highlighted in green are those which have correlation values ≥ |.30| which indicates a moderate (or stronger) relationship between the item and the outcome; items with more green cells are related to more outcomes of interest than items with fewer green cells.

Table 9. Bivariate Correlations between Experiences of Care Scales and YES Outcome Indicators

	Experiences of Care Scales				
Outcome Indicator	**Family-Centered Care**	**Strengths-Based Care**	**Youth-Focused Care**	**CM Quality Indicators**	**Indicators of Success (Items 3, 6, 11, 16)**
Youth had a psychiatric hospitalization in the last 6 months	-0.11	-0.09	-0.14	-0.12	-.19*
Youth had a new out-of-home placement in the last 6 months	-0.16	-0.16	-.22*	-0.09	-.25**
# of new youth out-of-home placements in the last 6 months	-.18*	-.18*	-.24**	-0.13	-.29**
Child Outcomes Scale total score	.28**	.35**	.41**	.36**	.48**
Youth behavior at home (item)	.27**	.36**	.33**	.32**	.43**
Youth performance at school (item)	0.15	.20*	.35**	.28**	.36**
Youth behavior in the community (item)	.33**	.34**	.40**	.41**	.48**
Youth's overall mental health (item)	.27**	.34**	.38**	.31**	.45**
Caregiver's self-efficacy to access services and supports (item)	.39**	.44**	.42**	.50**	.54**
Satisfaction with services (item)	.37**	.37**	.39**	.49**	.43**
Informal Supports Index	0.01	0.03	.19*	0.03	0.06

Note: *N*s range from *N* = 126 to *N* = 137 due to missing values on some cases. Values in the table are Spearman correlations which range from +1 to -1. Higher values indicate stronger relationships regardless of the sign (+/-). A positive correlation indicates that as one variable increases the other variable also increases; for example, higher levels of Youth-Focused Care are associated with more positive Child Outcomes total scores. A negative correlation indicates that as one variable increases the other variable decreases; for example, higher values on the Youth-Focused Care scale are associated with a lower likelihood of a new out-of-home placements in the last 6 months. For each outcome, the Experiences of Care scale with the strongest correlation is highlighted in green, and the Experiences of Care scale with the second strongest correlation with the outcome is highlighted in yellow.

** Correlation is significant at the $p < .01$ (2-tailed)

* Correlation is significant at the $p < .05$ (2-tailed)

Table 10. Bivariate Correlations between Experience of Care Items and YES Outcome Indicators

Item	Psych hosp.	Out-of-Home Placement	# of new out-of-home placements	Child Outcomes Scale	Youth's behavior at home (item)	Youth's performance at school (item)	Youth's behavior in the community (item)	Youth's overall mental health (item)	Caregiver self-efficacy (item)	Satisfaction (item)	Informal Supports Index
1. The goals we are working on with the children's mental health (CMH) clinician are the ones I believe are most important for my child/youth.	-0.10	-0.09	-0.11	.19*	.20*	.18*	0.17	.20*	.19*	.41**	-0.04
2. The CMH clinician encourages me to share what I know about my child/youth's strengths and needs.	0.01	-0.08	-0.09	.17*	.20*	0.06	.21*	0.15	.31**	.38**	-0.01
3. The services my child/youth receives focus on what he/she is good at, not just on problems.	-0.10	-0.17	-0.16	.31**	.32**	0.15	.28**	.31**	.42**	.31**	0.04
4. The assessment completed by my CMH clinician accurately represents my child/youth's needs.	-0.01	-0.09	-0.07	.21*	.20*	.20*	.22*	0.16	.28**	.35**	-0.01
5. Meetings with the CMH clinician occur at times and locations that are convenient for me.	-0.02	-0.06	-0.10	.20*	.19*	0.08	.28**	.18*	.33**	.31**	0.00
6. My child/youth is an active participant in planning his/her services.	-0.13	-.28**	-.31**	.37**	.28**	.31**	.37**	.34**	.39**	.33**	0.15
7. In times of crisis, my child/youth's CMH clinician is one of the first people I (would) call.	0.02	-0.01	-0.04	.24**	.23**	.17*	.24**	.20*	.32**	.47**	0.03
8. The CMH clinician makes sure everyone on my child's treatment team is working together in a coordinated way.	-0.09	0.01	-0.01	.25**	.19*	.21*	.29**	.21*	.47**	.47**	-0.01
9. My child and I are the main decision-makers when it comes to planning my child/youth's services.	-0.16	-0.13	-0.16	.27**	.23**	.17*	.32**	.28**	.37**	.27**	0.03

Table 10 (continued).

Item	Psych hosp.	Out-of-Home Placement	# of new out-of-home placements	Child Outcomes Scale	Youth's behavior at home (item)	Youth's performance at school (item)	Youth's behavior in the community (item)	Youth's overall mental health (item)	Caregiver self-efficacy (item)	Satisfaction (item)	Informal Supports Index
10. Services we receive are respectful of our family's language, religion, race/ethnicity, and culture.	-0.03	0.05	0.03	0.13	0.10	0.12	0.15	0.08	.24**	.29**	0.05
11. The CMH clinician often works with our family to measure my child/youth's progress toward his/her goals.	-0.11	-0.15	-0.17	.33**	.28**	.28**	.32**	.27**	.47**	.39**	0.03
12. When services are not helping, the CMH clinician leads my child/youth's team in a discussion of how to make things better.	-0.08	-0.08	-0.10	.36**	.30**	.29**	.38**	.30**	.48**	.41**	0.05
13. The CMH clinician talks with us about how we can use things we are good at to overcome problems.	-0.06	-0.13	-0.15	.33**	.34**	.21*	.32**	.32**	.39**	.40**	0.02
14. When decisions are made about services, my child/youth has the opportunity to share his/her own ideas.	-0.14	-0.11	-0.13	.39**	.32**	.33**	.37**	.37**	.36**	.37**	.19*
15. The CMH clinician suggests changes in my child/youth's treatment plan or services when things aren't going well.	-0.06	-0.04	-0.06	.24**	.22*	0.14	.30**	.24**	.39**	.38**	0.07
16. My child/youth has a safety plan that I believe will help us in times of crisis.	-.22**	-0.15	-.22*	.41**	.39**	.33**	.41**	.40**	.39**	.34**	-0.04
17. The CMH clinician makes specific suggestions about what services might benefit my child/youth.	-0.09	-0.11	-0.15	.29**	.28**	.21*	.36**	.26**	.46**	.40**	0.10
18. I know who to contact for help if I have a complaint about my child/youth's CMH clinician.	-0.13	0.03	0.02	0.16	0.04	.19*	.24**	0.09	.37**	.27**	0.09

Note: *N*s range from *N* = 126 to *N* = 137 due to missing values on some cases. Values in the table are Spearman correlations which range from +1 to -1. Higher values indicate stronger relationships regardless of the sign (+/-). A positive correlation indicates that as one variable increases the other variable also increases; for example, higher levels of Youth-Focused Care are associated with more positive Child Outcomes total scores. A negative correlation indicates that as one variable increases the other variable decreases; for example, higher values on the Youth-Focused Care scale are associated with a lower likelihood of a new out-of-home placement in the last 6 months. Cells highlighted in green are those which have correlation values $\geq |.30|$ which indicates a moderate relationship between the variables from a practical standpoint. Each green cell indicates a moderate, statistically significant relationship between the item and one outcome of interest; items with more green cells are related to more outcomes of interest than items with fewer green cells.

** Correlation is significant at the $p < .01$ (2-tailed)

* Correlation is significant at the $p < .05$ (2-tailed)

Another way to examine the relationship between youth outcomes and experiences of care is to dichotomize each of the Experiences of Care scales into high versus low groups. For each respondent, scores were dichotomized on each Experience of Care scale into one of two groups, either: (a) a *High group* (scale score $\geq$ 4.5), or (b) a *Low/Average group* (scale score < 4.5).[3] Classification into the *High group* required an average response of *Strongly Agree* on all items for a particular scale, indicating a high level of performance for that domain.

Following the dichotomization procedure, approximately 20-25% of all respondents were classified into the *High group* on each Experiences of Care scale. The percentage of respondents who met the *High* criterion for each scale were as follows:

- Family-Centered Care, 25% (*n*=35);
- Strengths-Based Care, 30% (*n*=42);
- Youth-Focused Care, 28% (*n*=40),
- Case Management Quality Indicators, 18% (*n*=25).

As is shown in Figure 17, 59% of youth (*n*=83) had no High scores on any experience scale, 11% of youth (*n*=16) had one high score on an experience scale (e.g., family-centered or strengths-based), 13% of youth (*n*=18) had High scores on two experience scales (e.g., family-centered *and* strengths-based), 4% of youth (*n*=6) had High scores on three experience scales (e.g., family-centered, strengths-based, and case management quality indicators), and 13% of youth (*n*=18) had High scores on all four experience scales (i.e., family-centered, strengths-based, youth-focused, and case management quality indicators).

Figure 17. Percentage of Youth Scoring in the High Range on Experiences of Care Scales

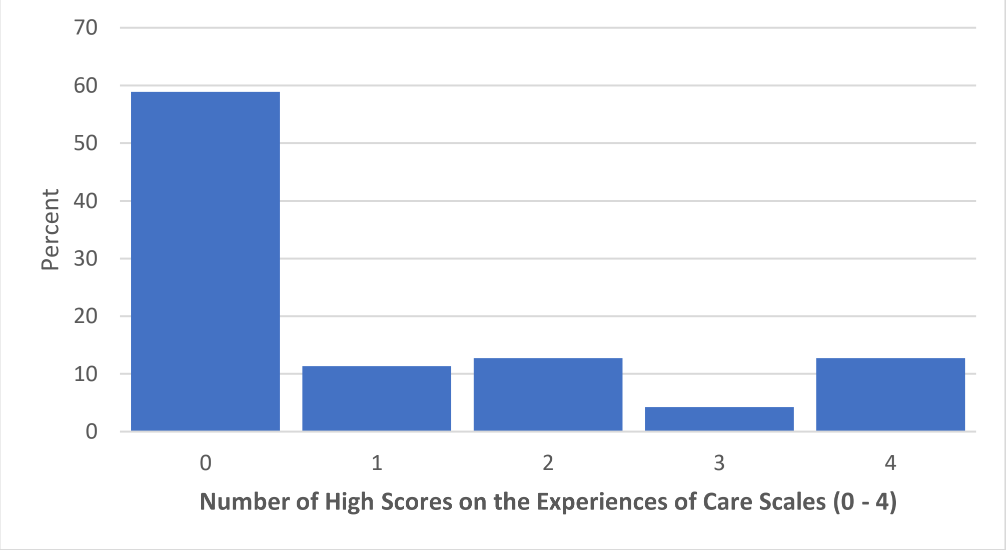


Table11 shows the percentage of youth who experienced a new out-of-home placement in the last six months for the *High* and *Low/Average* groups on each experiences of care scale. Youth who were in the *High* group on Family-Centered Care were less likely to experience an out-of-home placement in the last six months (26.5% of youth) compared to their peers who scored in the Low/Average group (48% of youth), $\chi^2_{LR} = 5.04$, $df = 1$, $p = .025$. The same was true for youth whose experience of care scored in the *High* group on Youth-Focused Care (29% vs. 48%), $\chi^2_{LR} = 4.16$, $df = 1$, $p = .041$, and Case Management Quality Indicators (25% vs. 46%), $\chi^2_{LR} = 3.90$, $df = 1$, $p = .048$, with a similar trend evident for the Strengths-Based Care scale (32% vs. 47%), $\chi^2_{LR} = 2.93$, $df = 1$, $p = .087$.

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[3] For the Family-Centered Care scale the cutoff for being classified as *High* was set at 5 due to the skewed distribution of scores. Consequently, respondents in the High group for Family-Centered Care averaged a perfect 5 (i.e., *Strongly Agree*) on both items.

Table 11. Percentage of Youth Experiencing a New Out-of-Home Placement by High vs. Low/Average Scores on Experiences of Care Scales

			Child had New Out-of-Home Placement in Last 6 Months		
			No	Yes	Total
Family-Centered Care scale score	Low/ Average	Count	53	49	102
		% within Low/Average group	52.0%	48.0%	100.0%
	High	Count	25	9	34
		% within High group	73.5%	26.5%	100.0%
Total		Count	78	58	136
		% within all groups	57.4%	42.6%	100.0%

			Child had New Out-of-Home Placement in Last 6 Months		
			No	Yes	Total
Youth-Focused Care scale score	Low/ Average	Count	51	47	98
		% within Low/Average group	52.0%	48.0%	100.0%
	High	Count	27	11	38
		% within High group	71.1%	28.9%	100.0%
Total		Count	78	58	136
		% within all groups	57.4%	42.6%	100.0%

			Child had New Out-of-Home Placement in Last 6 Months		
			No	Yes	Total
Case Management Quality Indicator scale score	Low/ Average	Count	60	52	112
		% within Low/Average group	53.6%	46.4%	100.0%
	High	Count	18	6	24
		% within High group	75.0%	25.0%	100.0%
Total		Count	78	58	136
		% within all groups	57.4%	42.6%	100.0%

			Child had New Out-of-Home Placement in Last 6 Months		
			No	Yes	Total
Strengths-Based Care scale score	Low/ Average	Count	50	45	95
		% within Low/Average group	52.6%	47.4%	100.0%
	High	Count	28	13	41
		% within High group	68.3%	31.7%	100.0%
Total		Count	78	58	136
		% within all groups	57.4%	42.6%	100.0%

3.6.2 Indicators of Success Scale

Based on an item-by-item analysis, we identified four items that had the strongest correlations with youth out-of-home placements, new psychiatric hospitalizations, youth psychosocial functioning, parent self-efficacy, and client satisfaction with services. These four items were combined into a scale called the *Indicators of Success* scale. Items on the *Indicators of Success* scale come from domains of strengths-based care, youth-focused care, and case management quality indicators; they include:

Indicators of Success Scale Items

- The services my child/youth receives focus on what he/she is good at, not just on problems.
- My child/youth is an active participant in planning his/her services.
- The CMH clinician often works with our family to measure my child/youth's progress toward his/her goals.
- My child/youth has a safety plan that I believe will help us in times of crisis.

As is shown in Table 12, the Indicators of Success scale is highly predictive of youth outcomes. In addition, the High versus Low/Average categorization of this scale (cut score = 4.5, 18% of respondents, N=26) was a strong predictor of whether a youth received a new out-of-home placement in the last 6 months, $\chi^2_{LR} = 6.91$, $df = 1$, $p = .009$. As is shown in Table X, only 20% of youth (*n*=5) who received a High score on the Indicators of Success scale experienced a new out-of-home placement in the last 6 months, compared to 48% of youth (*n*=53) who received a Low/Average score.

Table 12. Relationship between Indicators of Success High and Low/Average Scores and Out-of-Home Placements

			Child had New Out-of-Home Placement in Last 6 Months		
			No	Yes	Total
Indicators of Success scale score	Low/Average group	Count	58	53	111
		% within Low/Average group	52.3%	47.7%	100.0%
	High group	Count	20	5	25
		% within High group	80.0%	20.0%	100.0%
Total		Count	78	58	136
		% within all groups	57.4%	42.6%	100.0%

3.7 Assessment of Disparities in Youth Outcomes by Demographic Groups

An important indicator of success in systems-of-care is that services are provided in a culturally competent manner that meets the needs of all youth and families. When services are provided in this way, youth and families' experiences and outcomes of care should not differ based solely on the youth's demographic characteristics such as gender, race, or ethnicity. In this section, we present analyses comparing mean scores of the experiences of care and outcome scales by youth gender, race, and ethnicity. Because of the extremely small sample sizes of youth who are members of minority ethnic and racial groups, these analyses cannot provide definitive answers regarding disparities in experiences of care and outcomes due to low statistical power; however, they can provide an indication of areas where there appear to be disparities. Because of the small sample size and low statistical power to detect significant group differences where they exist, in our summary below we report tests of statistical significance as well as measures of effect size. Effect size measures indicate the magnitude of the difference between group means. We use the well-established effect size measure suggested by Jacob Cohen called Cohen's *d* where values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

3.7.1 Experiences and Outcomes of Care by Youth Gender

Table 13 presents the analyses comparing male versus female YES participants on each of the experiences of care scales and the outcome scales. Caregivers of female YES participants reported significantly higher self-efficacy to access services and supports (*p* = .019), and this represented a medium effect size, *d* = .41. In addition, there was a trend toward male participants experiencing a higher proportion of new out-of-home placements (*p* = .069), representing a small effect size difference of *d* = .32. Overall, these results suggest there are not disparities in youths' experiences of YES services based on their gender, although there are some possible disparities in outcomes. These differences in outcomes may be explained by the higher rates of externalizing disorders among males which might lead to greater risk for out-of-home placements.

Table 13. Variation in Experiences and Outcomes of Care by Youth Gender

Scale	**Youth Gender**	***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Family-Centered Care Scale	Male	70	4.01	1.06	-0.05	136	0.962	-0.01
	Female	68	4.02	0.86				
Strengths-Based Care Scale	Male	70	3.64	1.20	0.21	136	0.832	0.04
	Female	68	3.60	1.01				
Youth-Focused Care Scale	Male	70	3.62	1.21	0.40	136	0.691	0.07
	Female	68	3.54	1.06				
Case Management Quality Indicators Scale	Male	70	3.67	0.98	0.45	136	0.656	0.08
	Female	68	3.60	0.89				
Indicators of Success Scale	Male	70	3.52	1.03	0.23	136	0.815	0.04
	Female	68	3.48	0.89				
Child had New Out-of-Home Placement in Last 6 Months	Male	70	0.50	0.50	1.84	132	0.069	0.32
	Female	64	0.34	0.48				
Youth had psychiatric hospitalization in last 6 months	Male	70	0.23	0.42	0.02	134	0.986	0.00
	Female	66	0.23	0.42				
Child Outcomes Scale	Male	70	3.33	1.10	-1.18	134	0.238	-0.20
	Female	66	3.55	1.05				
Youth's behavior at home (item)	Male	70	3.36	1.31	-1.21	132	0.227	-0.21
	Female	64	3.63	1.24				
Youth's performance at school (item)	Male	69	3.17	1.28	-1.19	133	0.237	-0.20
	Female	66	3.44	1.31				

Table 13 (continued).

Scale	**Youth Gender**	***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Youth's behavior in the community (item)	Male	70	3.43	1.15	-0.83	132	0.408	-0.14
	Female	64	3.59	1.15				
Youth's overall mental health (item)	Male	70	3.39	1.18	-0.69	134	0.490	-0.12
	Female	66	3.53	1.26				
Caregiver's self-efficacy to access services and supports (item)	Male	69	3.33	1.31	-2.38	132	0.019	-0.41
	Female	65	3.82	1.00				
Satisfaction with services (item)	Male	63	1.89	1.03	-1.26	122	0.212	-0.23
	Female	61	2.11	0.97				

Note: Cells highlighted in green have a Cohen's effect size greater than or equal to |.3| which indicates a small practical difference. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

3.7.2 Experiences and Outcomes of Care by Youth Ethnicity

We examined differences in youth and families' experiences of care and outcomes based on the youth's ethnicity; that is, whether or not the youth identified as Latino or Hispanic. Only 9% (*n*=13) of caregivers identified their youth's ethnicity as Latino/Hispanic, resulting in extremely low statistical power to detect differences between groups. Because of this, interpreting the measures of effect size was focused on, which gives a better indication of whether or not these two groups of participants had different experiences and outcomes. Results of a series of independent samples t-tests (see Table 14) indicate that youth who identified as Latino/ Hispanic consistently reported more negative experiences of care, with small effect sizes ranging from *d* = -0.23 to *d* = -0.26; however, these participants also reported higher satisfaction with services (medium effect size of *d* = 0.41).

Table 14. Variation in Experiences and Outcomes of Care by Youth Ethnicity

Scale	**Youth Ethnicity**	***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Family-Centered Care Scale	Non-Latino	124	4.03	0.94	0.51	135	0.611	-0.15
	Latino	13	3.88	1.18				
Strengths-Based Care Scale	Non-Latino	124	3.63	1.08	0.89	135	0.375	-0.26
	Latino	13	3.35	1.30				
Youth-Focused Care Scale	Non-Latino	124	3.60	1.13	0.78	135	0.438	-0.23
	Latino	13	3.35	1.21				
Case Management Quality Indicators Scale	Non-Latino	124	3.66	0.90	0.90	135	0.371	-0.26
	Latino	13	3.41	1.25				

Table 14 (continued).

Scale	**Youth Ethnicity**	***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Indicators of Success Scale	Non-Latino	124	3.52	0.95	0.83	135	0.406	-0.24
	Latino	13	3.29	1.13				
Child had New Out-of-Home Placement in Last 6 Months	Non-Latino	121	0.43	0.50	0.09	131	0.931	-0.03
	Latino	12	0.42	0.51				
Youth had psychiatric hospitalization in last 6 months 1=yes 0=no	Non-Latino	122	0.22	0.42	-0.70	133	0.485	0.20
	Latino	13	0.31	0.48				
Child Outcomes Scale	Non-Latino	122	3.43	1.07	-0.16	133	0.877	0.05
	Latino	13	3.48	1.24				
Youth's behavior at home (item)	Non-Latino	120	3.46	1.28	-0.42	131	0.675	0.12
	Latino	13	3.62	1.33				
Youth's performance at school (item)	Non-Latino	121	3.29	1.31	-0.25	132	0.803	0.07
	Latino	13	3.38	1.33				
Youth's behavior in the community (item)	Non-Latino	120	3.53	1.14	0.42	131	0.678	-0.12
	Latino	13	3.38	1.33				
Youth's overall mental health (item)	Non-Latino	122	3.44	1.21	-0.27	133	0.789	0.08
	Latino	13	3.54	1.39				
Caregiver's self-efficacy to access services and supports (item)	Non-Latino	120	3.58	1.19	0.35	131	0.729	-0.10
	Latino	13	3.46	1.27				
Satisfaction with services (item)	Non-Latino	112	1.96	1.00	-1.29	121	0.199	0.41
	Latino	11	2.36	1.03				

Note: Cells highlighted in green have a Cohen's effect size greater than or equal to |.3| which indicates a small practical difference. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

In order to obtain more specific information on service differences between Latino and non-Latino youth, differences between these groups were tested on all 18 items assessing youths' experiences of care. These analyses revealed that the following items had effect sizes |> 0.3|indicating a small or larger practical difference in experiences of care between Latino vs. non-Latino youth. For all items, Latino youth rated their experience of care as less positive than non-Latino youth:

- Services we receive are respectful of our family's language, religion, race/ethnicity, and culture. (*d* = -0.57)

- The assessment completed by my CMH clinician accurately represents my child/youth's needs. (*d* = -0.38)
- I know who to contact for help if I have a complaint about my child/youth's CMH clinician. (*d* = -0.31)
- My child/youth has a safety plan that I believe will help us in times of crisis. (*d* = -0.31)

3.7.3 Experiences and Outcomes of Care by Youth Race

Table 15 shows differences in youths' experiences and outcomes of care by youth race. Due to the very small number of youth who were in non-white racial groups, we combined all non-majority racial groups into a single category for these analyses. Due to the very small number of youth who identified as non-White, these analyses have extremely low statistical power to detect significant differences where they exist. Consistent with above, scales that showed small to medium effect size differences between the two groups are highlighted in green in Table 22. These analyses indicate that non-White youth had more negative outcomes in the domain of psychosocial functioning compared to White youth, with effect sizes ranging from small (*d* = -0.36) to medium (*d* = -0.48).

Table 15. Variation in Youth Experiences and Outcomes of Care by Youth Race (White vs. non-White)

Youth Identifies as White?		***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Family-Centered Care Scale	No	15	3.90	0.76	-0.46	134	0.649	-0.12
	Yes	121	4.02	0.99				
Strengths-Based Care Scale	No	15	3.77	1.15	0.64	134	0.526	0.17
	Yes	121	3.57	1.10				
Youth-Focused Care Scale	No	15	3.53	0.93	-0.16	134	0.875	-0.04
	Yes	121	3.58	1.17				
Case Management Quality Indicators Scale	No	15	3.71	0.88	0.38	134	0.707	0.10
	Yes	121	3.61	0.95				
Indicators of Success Scale	No	15	3.65	0.90	0.67	134	0.503	0.18
	Yes	121	3.47	0.97				
Child had New Out-of-Home Placement in Last 6 Months	No	14	0.36	0.50	-0.59	130	0.554	-0.17
	Yes	118	0.44	0.50				
Youth had psychiatric hospitalization in last 6 months	No	15	0.20	0.41	-0.30	132	0.762	-0.08
	Yes	119	0.24	0.43				
Child Outcomes Scale	No	15	3.03	1.09	-1.50	132	0.135	-0.41
	Yes	119	3.47	1.07				
Youth's behavior at home (item)	No	15	3.33	1.29	-0.41	130	0.679	-0.11
	Yes	117	3.48	1.28				
Youth's performance at school (item)	No	15	2.73	1.44	-1.76	131	0.081	-0.48
	Yes	118	3.36	1.27				
Youth's behavior in the community (item)	No	15	3.13	1.30	-1.32	130	0.190	-0.36
	Yes	117	3.55	1.13				
Youth's overall mental health (item)	No	15	2.93	1.33	-1.72	132	0.087	-0.47
	Yes	119	3.50	1.19				

Table 15 (continued).

Youth Identifies as White?		***n***	**Mean**	**Std. Deviation**	***t***	***df***	**Sig. (2-tailed)**	**Cohen's *d***
Caregiver's self-efficacy to access services and supports (item)	No	15	3.40	1.45	-0.55	130	0.582	-0.15
	Yes	117	3.58	1.16				
Satisfaction with services (item)	No	14	1.64	1.15	-1.35	120	0.178	-0.38
	Yes	108	2.03	0.98				

Note: Cells highlighted in green have a Cohen's effect size greater than or equal to |.3| which indicates a small practical difference. Values of *d*=0.1 to 0.3 are considered small, *d*=0.4 to 0.7 are considered medium, and 0.8 or above are considered large.

4.0 Summary of Findings and Targets for Quality Improvement

Survey Procedure. The effective response rate (*N* of responses / *N* of delivered surveys) for this survey was 15% which is in line with national averages but still lower than desired. There is considerable room for improvement if the State wishes to use a family survey methodology in the future. Options for improving the response rate include:

- It may increase the survey response rate if CMH staff hand-deliver the first introductory letter and survey directly to participants. The Department could select one month during the year to implement this procedure and could still complete follow-ups via web, postcard, mail, or hand delivery. This procedure will produce representative results if all respondents are equally likely to attend an appointment with their CMH clinician each month.
- Another option is for CMH clinicians to deliver the survey to families immediately after their second or third visit.
- Electronic survey administration via email or text message may improve the response rate. Implementing this would require the State to begin routinely collecting email addresses and/ or updated phone numbers for all participants.
- Response rates may be improved if CMH clinicians inform the family that they will be receiving a survey in the mail about their experience. If CMH clinicians provide some type of information and education to YES participants about the survey process, as well as answer questions about the survey and inform respondents about the protections in place to guard their privacy, this may improve the response rate.
- Some participants expressed confusion about who they were being asked to rate and which services they were being asked to assess. Future surveys should clarify these points to ensure the most accurate and useful data for quality improvement.

Survey Design. Results of our internal experiment, which tested long versus short formats of the survey, indicated that use of a shorter survey doubled the response rate (16% vs. 8%). We also found that the use of follow-ups in this pilot study increased the response rate compared to a previous survey in which no follow-ups were used (15% vs. 8%). Based on these results, future surveys should be short in duration (i.e., 1-page front and back or less) and should use multiple follow-ups.

YES Principles of Care. Statewide, participants gave YES services high marks on items assessing the extent to which care was family-centered; consequently, this appears to be an area of relative strength across the State. For example, 55% of respondents gave the highest possible rating of *Strongly Agree* to the item asking whether the CMH clinician encouraged them to share what they know about their child/youth.

In contrast to the high marks for family-centered care statewide, there appears to be room for improvement in the extent to which YES services are youth-focused. A total of 48% of respondents were *Neutral*, *Disagreed*, or *Strongly*

Disagreed with the statement "My child/youth is an active participant in planning his/her services." This is especially important, since this item was a strong predictor of youth outcomes including youth functioning and out-of-home placements. Providing training to clinicians in strategies for engaging youth alongside their caregivers may result in higher ratings in this area.

Case Management Quality Indicators. Statewide, several strengths were noted in the area of quality indicators for case management; specifically, the following items received the highest possible rating of *Strongly Agree* from over one third (33%) of respondents:

- Services are respectful of our family's language, religion, race/ethnicity, and culture (61% *Strongly Agree*),
- The goals we are working on are the ones I believe are most important for my child/youth (42% *Strongly Agree*),
- Meetings occur at times and locations that are convenient (41% *Strongly Agree*).

Statewide, there were quality indicators for case management that may require attention based on more than 1 in 5 respondents (>20%) giving a rating of *Disagree* or *Strongly Disagree*, including:

- The clinician suggests changes in services or treatment when things aren't going well (21% *Disagree* or *Strongly Disagree*)
- The clinician makes sure everyone on my child's treatment team works together in a coordinated way (21% *Disagree* or *Strongly Disagree*),
- When services are not helping the clinician leads my child's team in a discussion of how to make things better (26% *Disagree* or *Strongly Disagree*),
- My child/youth has a safety plan that I believe will help in times of crisis (26% *Disagree* or *Strongly Disagree*),
- In times of crisis, my child/youth's CMH clinician is one of the first people I (would) call (37% *Disagree* or *Strongly Disagree*),
- I know who to contact for help if I have a complaint about my child/youth's CMH clinician (36% *Disagree* or *Strongly Disagree*).

Low marks on the item related to the helpfulness of the youth's safety plan in times of crisis are especially concerning given that higher scores on this item were significantly related to superior youth outcomes on nearly all indicators, including the occurrence of fewer psychiatric hospitalizations in the last six months.

Satisfaction with Services. In this survey, satisfaction was operationalized based on the extent to which caregivers believed their youth had been helped by participating in YES services. When asked how much their child/youth had been helped, just over 60% of respondents indicated Somewhat (26%) or A lot (36%).

Improved youth functioning. The average score on the Youth Outcomes Scale, which assessed youth functioning across all domains, corresponded to an improvement rating of *About the Same* (Ave. = 3.44, standard deviation = 1.07). This suggests that many respondents do not perceive YES services as significantly improving the functioning of their child or youth. Exploring the reasons for this and finding ways to improve youths' daily functioning at home, at school, and in the community represents an important area for service improvement in the State.

In all, 75% of respondents reported their youth had not experienced a psychiatric hospital stay during the last 6 months. This is an indicator of success and a baseline for future assessments. Overall, 41% of youth experienced an out-of-home placement (or change in out-of-home placement) during the last 6 months.

Crisis Support. Overall, 66% of respondents indicated they had never received a face-to-face visit from a mental health professional at the time and location of a crisis during the last 6 months. While not all youth require this type of support during a 6-month period, the large percentage of families reporting they have never experienced this type of support suggests a potential need to improve access to face-to-face crisis support.

Informal Supports. On average, youth experienced or participated in 1.65 informal supports during the last 6 months out of a possible 7 supports included in the survey. To the extent that YES emphasizes the development and use of informal supports in a youth’s plan of care, this may represent an area for improvement.

Experiences of Care that are Associated with Youth Outcomes. Of the three scales that assessed YES principles of care (i.e., family-centered, strengths-based, youth-focused), youth-focused care was the strongest predictor of youth outcomes. Targeting these items for improvement may do the most to improve youth well-being.

In addition, this study identified four items, labeled key *Indicators of Success*, that together were significantly predictive of all youth outcomes including psychiatric hospitalizations, new out-of-home placements, youth functioning, caregiver self-efficacy, and satisfaction (i.e., helpfulness of services). These items were:

- The services my child/youth receives focus on what he/she is good at, not just on problems.
- My child/youth is an active participant in planning his/her services.
- The CMH clinician often works with our family to measure my child/youth's progress toward his/her goals.
- My child/youth has a safety plan that I believe will help us in times of crisis.

Targeting these four items for improvement might do the most to improve youth outcomes in Idaho. In support of this point, when respondents rated their experiences of care on these scales using the highest possible rating of *Strongly Agree* (approximately 20% to 25% of respondents), youth were significantly less likely to experience a new out-of-home placement compared to youth who scored in the low to average range on these scales (e.g., risk for out-of-home placement = 20% for the high scoring group vs. 48% for the low/average scoring group).

Disparities in Outcomes. Minimizing disparities in youth outcomes based on youth gender, race, or ethnicity, is an important goal of all systems of care including YES. Although the sample size was too small to detect significant differences where they existed between youth of majority and minority racial/ethnic groups, there was some evidence that youth of Hispanic/Latino origin had more negative service experiences than their non-Hispanic/Latino peers. Specifically, youth identified as Hispanic/Latino had lower scores on the extent to which services were respectful of the family’s language, religion, race/ethnicity, and culture, the accuracy of the assessment completed by the CMH clinician, and the helpfulness of the youth’s safety plan in times of crisis. This last item is important due to the link between this item and youth out-of-home placements.

In addition, although the sample size was too small to detect significant differences where they existed, there was evidence that youth of non-White racial backgrounds had more negative service outcomes than their White peers. Youth identified as non-White showed lower levels of improvement in psychosocial functioning at school and in the community, overall mental health, and caregiver satisfaction with services; these differences represented medium effect sizes and therefore represent an area for potential improvement of services.

Caveats. Limitations of this study include the low response rate and the small sample size within each Region. Findings should be interpreted within the context of these limitations.

4.1 Conclusion

This report presents the experiences and outcomes of YES services from the perspective of caregivers who completed the 2019 Idaho Youth Empowerment Services family survey. Findings of the survey indicate several areas of strength as well as areas for improvement to continue building an effective system-of-care for Idaho youth who experience emotional and behavioral disorders and their families.