Cultural Stress, Identity Factors, and Behavioral Health Needs in Youth: A CANS-Based Examination

Abstract

Cultural stressors and challenges related to identity have increasingly been recognized as significant factors affecting behavioral health outcomes in children and adolescents, particularly those involved in publicly funded care systems. However, empirical research in the child and adolescent social work literature that combines cultural stress indicators with standardized clinical assessment data remains scarce. This study uses de-identified data from the Child and Adolescent Needs and Strengths (CANS) assessment, comprising 230 participants, to examine the prevalence of cultural stress and identity-related factors and evaluate their predictive relationships with behavioral health needs. Descriptive analyses indicate considerable rates of trauma exposure, emotional dysregulation, and social functioning difficulties among participants. Furthermore, multiple regression analyses reveal that indicators of cultural stress serve as significant predictors of the severity of behavioral health needs, even after controlling for trauma exposure and demographic variables. These findings highlight the need to implement culturally responsive and identity-affirming assessment and intervention strategies within youth behavioral health systems.

Comment [A1]: Abstract text is not italicized in APA

Keywords: Cultural stressors, identity, trauma exposure, CANS (Child and Adolescent Needs and Strengths), and research.

Introduction

A thorough examination of the complex funding mechanisms of Publicly Funded Care Systems (PFCS) is essential to understanding the factors that affect adolescents' use of these services (Obeid, Lyons, 2011). This sector is supported by a combination of governmental and private funding sources. Financial contributions may stem from private grants issued by organizations such as United Way and the Dodge Foundation, as well as reimbursements from health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The management of these funds is multifaceted and is overseen by the entities responsible for allocating and disbursing financial resources (Bass et al., 2025; Lardner, 2015).

Comment [A2]: For clarity, indicate that this applies to the United States.

Comment [A3]: Older reference

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Government funding avenues consist of public reimbursements and grants at both the federal and state levels. Public reimbursements are primarily sourced from Medicaid and the Children's Health Insurance Program (CHIP), which together provide health insurance coverage to eligible individuals and families (Centers for Medicare & Medicaid Services, 2022). Each state is empowered to establish tailored programs within federal frameworks, thereby permitting flexibility in areas such as annual cost settlements, eligibility determinations, service coverage, provider payment processes, and administrative logistics (Arenás, 2021, Persson et al., 2018).

Public grant funding is allocated yearly in several forms: formula grants, block grants, and discretionary or program grants (Glove et al., 2019). Formula grants, exemplified by the Every Student Succeeds Act, are noncompetitive and assigned according to a predetermined formula. Block grants, such as the Community Mental Health Services Block Grant, are distributed by the federal government to state or local authorities. Discretionary or program grants, such as Project AWARE (Advancing Wellness and Resiliency in Education), are competitive and allow the government to select recipients based on merit and eligibility criteria (Kelleher , 2014; McCance-Katz & Lynch, 2019).

PFCS depend on both public and private reimbursements and grants to facilitate service utilization (Graves et al., 2023). Nonetheless, an overreliance on this funding can exacerbate existing health disparities. Educational institutions located in low-income or rural regions may face challenges in meeting the administrative requirements for accurate billing or grant applications (Sosin & Carpenter-Song, 2024). While the variety of funding mechanisms offers options for delivering PFCS to students, they can also leave schools serving populations with significant mental health needs inadequately equipped to provide such services, thereby perpetuating health disparities (Alegría, et al., 2015; Graves et al., 2023). Subsequently, this study uses de-identified data from the Child and Adolescent Needs and Strengths (CANS) assessment, involving 300 participants, to investigate the prevalence of cultural stress and identity-related factors and to evaluate their predictive relationships with behavioral health needs.

Comment [A5]: The stated purpose of the study does not match the discussion in the introduction. The introduction focused on explaining public funding for Care Systems. However, the purpose of the study is to examine prevalence of cultural stress and identity-related factors and their relationship to behavioral health needs.

The introduction should present discussion of the variables cultural stress, identity-related factors and behavioral health needs.

Literature Review

An extensive review of the relevant literature showed that children and adolescents receiving publicly funded behavioral health services frequently navigate complex intersections of trauma exposure, structural disadvantage, and identity-related stress (Malhotra et al., 2015). Cultural stress—defined as stress arising from discrimination, marginalization, acculturative demands, and identity invalidation—has been linked to adverse mental health outcomes, including depression, anxiety, behavioral dysregulation, and suicidal ideation (McLean, 2025). For youth from historically marginalized communities, these stressors often coexist with service system involvement, compounding risk and complicating engagement (McLean, 2025; Whitney & Peterson, 2019).

Comment [A6]: Discussion of cultural stress needs to be expanded. This paragraph only defines cultural stress.

Moreover, adolescent mental health has been a significant public health concern for several decades. In both 2021 and 2023, the Surgeon General of the United States issued advisories regarding the youth mental health crisis, urging key stakeholders to take decisive action (Murthy, 2021). Between 2009 and 2019, the percentage of adolescents reporting persistent feelings of sadness and hopelessness rose from 26.1% to 36.7%. This figure escalated to 44% in 2021, coinciding with the COVID-19 pandemic (Centers for Disease Control and Prevention, 2023a).

Comment [A7]: What's the citation for this?

In the 2021-2022 period, over 21% of adolescents reported experiencing symptoms of anxiety (National Center for School Mental Health, 2023). More than five million youths, representing 20.1% of individuals aged 12 to 17, reported having experienced a major depressive episode, which frequently serves as a precursor to suicidal behaviors (Murthy, 2021; Substance Abuse and Mental Health Services Administration, 2022).

A similar upward trend is observable among adolescents who have seriously contemplated suicide, with such considerations increasing from 13.8% in 2009 to 18.8% in 2019, and reaching 22% in 2021 (Centers for Disease Control and Prevention, 2023a). It is pertinent to note that half of all lifetime mental health disorders manifest before the age of 14, which underscores the importance of early identification and intervention to mitigate potential long-term consequences, such as diminished academic performance, juvenile delinquency, substance abuse, and impaired physical health (London, 2021). These recent trends suggest that evidence-based mental health interventions may be underutilized, thereby emphasizing the necessity for innovative strategies to effectively address mental health issues among adolescents (Feiss et al., 2019; Salerno, 2016).

Comment [A8]: The review of the literature seems incomplete. As I understand the study, cultural stress, identity-related factors and behavioral health needs are the variables. Only cultural stress was briefly defined.

Theoretical Framework

This study is based on an integrated theoretical framework that combines Bronfenbrenner's Socio-Ecological Systems Theory, cultural stress theory, and liberation-oriented social work practice. The ecological systems theory suggests that child and adolescent development is influenced by interactions across various systems, including family, community, institutions, and broader sociopolitical contexts. From this perspective, it is essential to recognize that behavioral health needs cannot be fully understood without considering the environmental and structural forces that shape young individuals' experiences (Bronfenbrenner, 1979). Bronfenbrenner's Socio-Ecological Systems model positions the individual at its center, surrounded by concentric circles, or ecosystems, that illustrate how various contexts, characteristics, and environments interact to influence growth and development (Caperon et al., 2022). The innermost ecosystem, known as the microsystem, includes those who engage directly with the adolescent, such as immediate family members, caregivers, teachers, school-based mental health practitioners, and peers (Bronfenbrenner, 1992).

Comment [A9]: A citation for each of these should be presented when the term is first introduced.

The subsequent layer, termed the mesosystem, comprises individuals who collaborate with those in the microsystem but interact indirectly with the adolescent, including members of religious organizations, school faculty, or district administrators. The next level, the exosystem, encapsulates elements such as mass media, public servants (including police and firefighters), and governmental influences (Bronfenbrenner, 1979). Lastly, the macrosystem signifies the attitudes and ideologies prevalent within the young person's culture and the broader society, representing the largest and most encompassing ecosystem. In 1986, Bronfenbrenner refined his

Socio-Ecological Systems Theory by incorporating the chronosystem to account for the influence of time (Bronfenbrenner, 1992).

Cultural stress theory further explicates how chronic exposure to discrimination, identity invalidation, and cultural marginalization operates as a unique and cumulative stressor that disrupts emotional regulation, self-concept, and coping capacity (Salas-Wright et al., 2021). Unlike discrete traumatic events, cultural stress is often ongoing, ambiguous, and systemically reinforced, rendering it particularly harmful for youth navigating identity development (Salas-Wright et al., 2021; Schwartz et al., 2022).

Liberation-oriented and culturally responsive social work frameworks extend these theories by emphasizing power, oppression, and resistance (Yan et al., 2022). These approaches challenge deficit-based interpretations of youth behavior and instead locate distress within inequitable social conditions. From this lens, behavioral health symptoms may represent adaptive responses to cultural and structural stressors rather than individual pathology. Integrating these frameworks allows for a more comprehensive understanding of how cultural stress and identity factors shape behavioral health needs among youth (Yan et al., 2022). Social work practice, therefore, requires assessment tools capable of capturing these contextual dimensions. The Child and Adolescent Needs and Strengths (CANS) assessment aligns with this theoretical orientation by incorporating domains related to culture, identity, and environmental stress alongside traditional clinical indicators Yan et al., 2022; Wen et al., 2022).

Children and adolescents receiving publicly funded behavioral health services frequently navigate complex intersections of trauma exposure, structural disadvantage, and identity-related stress (Johnson & Shamroukh, 2024). Cultural stress—defined as stress arising from discrimination, marginalization, acculturative demands, and identity invalidation—has been linked to adverse mental health outcomes, including depression, anxiety, behavioral dysregulation, and suicidal ideation (Salas-Wright et al., 2021). For youth from historically marginalized communities, these stressors often coexist with service system involvement, compounding risk and complicating engagement (Lyons et al., 2014). Social work scholars have emphasized the need for assessment frameworks that capture both clinical symptomatology and the sociocultural contexts shaping youth experiences. The Child and Adolescent Needs and Strengths (CANS) assessment is uniquely positioned to meet this need by integrating behavioral health indicators with cultural, identity, and environmental domains (Alegría et al., 2015). However, few studies have examined how cultural stress and identity-related CANS items function as predictors of behavioral health need severity (Johnson & Shamroukh, 2024; Lyons et al., 2014).

The present study addresses this gap by examining (1) the prevalence of cultural stress and identity-related factors among youth receiving behavioral health services and (2) the extent to which these factors predict behavioral health needs when controlling for trauma exposure. By centering cultural stress within a quantitative analytic framework, this study advances culturally responsive child and adolescent social work research and practice. This study focuses solely on the individual, microsystem, and mesosystem factors associated with PFCS use.

Methods

Comment [A10]: This part of the discussion reads like a dissertation. This style is not necessary for a journal article as the audience differs from dissertation reviewers.

Comment [A11]: Provide a citation for the statement.

Comment [A12]: As described, the variables are cultural stress and behavioral health needs.

Children and adolescents who receive publicly funded behavioral health services describes the population under consideration. The discussion seems to confuse study population with study variables.

Comment [A13]: No discussion is provided under this subheading. Correct this.

Design

This study synthesizes the existing literature on factors influencing the behavioral health needs of children receiving publicly funded care (Arenás, 2021; Glover, 2019). Building on these findings, the subsequent phase employs a quantitative, cross-sectional, predictive design, guided by a multiple linear regression model as the statistical framework (Faulkner & Faulkner, 2023). This systematic approach aims to investigate the impact of various factors and their interactions on targeted responses, elucidate the sources of variance, and ensure the replication of results (Field, 2023). Thus, a comprehensive cross-sectional analysis was conducted using de-identified CANS (Child and Adolescent Needs and Strengths) assessment data, which was meticulously sourced as part of the established behavioral health service delivery process. This service delivery approach enabled a detailed examination of the data while ensuring respondents' confidentiality (Weinbach & Grinnell, 2019).

Research Question and Hypotheses

RQ: What impact do cultural stressors and identity-related factors have on the behavioral health outcomes of youth using publicly funded care services?

H1: Higher levels of cultural stressors are associated with lower levels of behavioral health outcomes among youth using publicly funded care services
H2: Lower levels of identity-related factors are associated with higher levels of behavioral health outcomes among youth using publicly funded care services
H3: **Higher levels of** trauma exposure are associated with lower levels of behavioral health outcomes among youth using publicly funded care services

Comment [A14]: How was levels of trauma exposure assessed?

Sample

The present study utilized a retrospective cohort design to evaluate the impact of the *Cultural stressors and challenges associated with identity-related factors on the* behavioral, emotional, and functional outcomes of youth enrolled in public services. Data was obtained from a renowned non-profit behavioral health provider agency (501(c)(3)) that operates multiple facilities across Texas. This agency offers a comprehensive continuum of care for children and young adults aged 0 to 24 years. Although exact enrollment figures are not available, it is estimated that approximately 95% of the youth participating in publicly funded programs are concurrently enrolled in this agency's services.

The sample consisted of 230 youth using publicly funded care services who completed CANS assessments. A sample size of 230 participants is deemed sufficient to achieve adequate statistical power for the analysis, thereby inspiring trust in the research process (Field, 2023). Statistical power is the probability of correctly detecting an effect when it is present. As Weinbach & Grinnell (2019) indicated, statistical power reflects the likelihood that a statistical test will successfully reject the null hypothesis while minimizing the probabilities of Type I and Type II errors. Type I errors, as identified by Weinbach & Grinnell (2019), refer to false positives. In such instances, the researcher erroneously asserts that a specific relationship exists when it does not, thereby incorrectly rejecting the null hypothesis. Conversely, Type II errors occur when the

sample size is insufficient. According to Anderegg (2014), Type II errors are the reverse of Type I errors; they occur when the null hypothesis is not rejected despite a false negative, indicating that a relationship does not exist (Faulkner & Faulkner, 2023; Field, 2023).

Comment [A15]: This part of the discussion reads like a dissertation. This style is not necessary for a journal article as the audience differs from dissertation reviewers.

Available demographic variables included age, race/ethnicity, and gender. Youth represented a range of developmental stages, with ages spanning childhood through late adolescence. The sample reflected racial and ethnic diversity commonly observed in publicly funded behavioral health systems, including youth who identified as Black/African American, Hispanic/Latinx, White, or multiracial. Gender identity data were examined, and demographic variables were retained as covariates in predictive analyses to account for developmental and structural differences in behavioral health presentation. The dataset included 178 variables representing multiple domains, including behavioral and emotional needs, trauma exposure, life functioning, strengths, cultural stress, and identity-related factors.

Measures

Youth functioning was assessed utilizing the Child and Adolescent Needs and Strengths (CANS) tool, which evaluates functioning based on the "actionability" of specific needs (Lyons et al., 2014). We analyzed changes in three distinct metrics: the net change in the number of needs categorized as "actionable," the number of needs resolved over a six-month period, and the number of new needs identified within the same timeframe. The CANS instrument assesses the needs and strengths of children and adolescents across a range of social-ecological domains, including individual and family contexts. However, it is important to note that while the CANS was initially designed to inform service delivery for children with emotional and behavioral healthcare requirements, the effectiveness of this tool in measuring the impact of cultural barriers and identity-related factors on the behavioral health of youth utilizing public services has yet to be evaluated (Lyons et al., 2014; Persson et al., 2018).

Comment [A16]: The citations seem dated to verify the statement. Is there a more up to date citation?

The Child and Adolescent Needs and Strengths (CANS) assessment serves dual purposes: it facilitates service matching and serves as an outcome measure (Lyons et al., 2014). This assessment adopts a "communimetric" rather than a psychometric approach, prioritizing the provision of actionable information to enhance clinical decision-making. Rather than focusing on the symptoms of behavioral health issues, the CANS emphasizes identifying individual "needs" that reflect the various challenges children encounter. Examples of these needs encompass "Self-Injurious Behavior," "Sexual Aggression," "Social Functioning," "Anxiety," and "Substance Use (Lyons et al., 2014)." Each need is assigned a score ranging from 0 to 3:

- A score of 0 indicates "no evidence" of a need,
- A score of 1 signifies that "watchful waiting or prevention" is prudent,
- A score of 2 denotes a need that necessitates "action," and
- A score of 3 represents a need that requires "immediate or intensive action."

Scores of 2 and 3 are classified as "actionable" needs, indicating they are suitable targets for behavioral health treatment. When these items are identified as actionable, the cumulative CANS scores can be interpreted as a tally of "needs"—distinct areas where a youth may benefit from intervention (Lyons et al., 2009).

In the specific iteration of the CANS employed by the current provider agency, there are 79 items categorized into seven domains:

- Behavioral and Emotional Needs (e.g., "Psychosis" and "Depression")
- Life Functioning (e.g., "Family Relationships" and "School Functioning")
- Child Risk Behaviors (e.g., "Self-Injurious Behavior" and "Sexual Aggression")
- Cultural Factors (e.g., "Language" and "Discrimination/Bias")
- Caregiver Resources and Needs (e.g., "Involvement with Care" and "Knowledge")
- Child Strengths (e.g., "Optimism" and "Community Life")
- Traumatic Adverse Childhood Experiences (e.g., "Physical Abuse" and "Medical Trauma").

Each item of the CANS is accompanied by a concise description to facilitate accurate scoring. For example, guidance for assigning a score of "3" to "Depression" states: "Clear evidence of depression that is disabling for the child across multiple life domains."

Some CANS items are collected in optional "modules" that provide additional details about specific needs. These items are completed only for youth who have an actionable need based on specific triggering items from the domains. For example, if a youth scores a 2 or 3 on the item "Runaway," they will subsequently be assessed using the runaway module, which consists of eight additional items: consistency of destination, frequency of running, involvement in illegal activities, involvement of others, likelihood of returning independently, planning, realistic expectations, and safety of the destination (Persson et al., 2018). Unlike items within the main domains, these module items do not represent discrete needs and are not completed for all youths. Consequently, they are excluded from the analyses presented in this paper. The Child and Adolescent Needs and Strengths (CANS) tool has demonstrated robust inter-rater reliability among both researchers and caseworkers (Miller et al., 2007).

The measure under consideration is complex, and changes in child outcomes can be assessed through various methodologies. The CANS tool is sometimes used to determine eligibility for different types and intensities of services (Persson et al., 2018). The developers of the CANS collaborate with licensees to customize the assessment by adding, removing, or modifying items. Hence, the CANS may not be uniform across diverse contexts (Lyons et al., 2014). However, no modifications to the CANS were implemented during the timeframe examined in this paper.

In the present investigation, both baseline and six-month CANS assessments were employed. A baseline CANS is defined as any CANS administered within 30 days before or after enrollment, while a six-month CANS is characterized as any CANS administered between 150 and 210 days following enrollment (Lyons et al., 2014). Both assessments were conducted by the Wraparound care coordinator in collaboration with the youth and their family. Overall, the CANS is a widely utilized assessment instrument designed to identify the treatment needs of individuals aged 6 to 20 and to support informed intervention decisions, achieving a Cronbach's alpha of 0.82 (Persson et al., 2018).

Behavioral Health Needs

Behavioral health needs represent a complex tapestry of mental, emotional, and social well-being that is vital to an individual's overall quality of life (Salas-Wright et al., 2021). These needs encompass a variety of conditions, including anxiety, depression, substance use disorders, and the lasting effects of trauma, all of which can significantly impede daily functioning. It is estimated that more than 50 million Americans are grappling with these challenges, highlighting the urgent demand for specialized care that addresses the intertwined aspects of behavioral and physical health (McCance-Katz et al., 2019). A broad spectrum of services is available to support individuals on their journeys toward recovery, ranging from proactive prevention programs and personalized counseling sessions to immediate crisis intervention strategies designed to provide urgent relief in times of need (Feiss et al., 2019). These tailored approaches are essential for fostering resilience and restoring balance in people's lives. Behavioral health need severity was operationalized as a composite score derived from actionable ratings across emotional and behavioral need domains, including emotional regulation, anxiety, depression, and behavioral control (Bass et al., 2025; Feiss et al., 2019).

Comment [A17]: This discussion seems more appropriate to the introduction. The methods section should just tell the reader about the methodology.

Cultural Stress and Identity Factors

Cultural stress indicators included CANS items assessing experiences of discrimination, marginalization, cultural conflict, and identity-related stress (Lyons et al., 2014). Identity factors included variables related to gender identity, sexual orientation, and cultural identity challenges. Cultural stress is a profound psychological strain that individuals often endure when they confront discrimination, experience marginalization, or face the relentless pressure to conform to societal expectations (Salas-Wright et al., 2021). This phenomenon can significantly affect mental health, leading to identity crises, confusion, and a decline in overall well-being, especially among immigrants and marginalized communities (Salas-Wright et al., 2021; Schwartz et al, 2022).

The experience of cultural stress typically arises when individuals navigate the tumultuous waters of conflicting cultural norms and values (Salas-Wright et al., 2021). Such internal conflicts can exacerbate feelings of anxiety and depression while eroding self-esteem, encouraging the audience to understand the emotional toll of these struggles (Yan et al., 2022). Conversely, a strong sense of cultural identity—nurtured and fortified by family, community ties, and traditional practices—can serve as a vital protective factor. This resilience, cultivated in the embrace of one's cultural roots, empowers individuals to confront these challenges with renewed strength and a sense of belonging, inspiring the audience to value cultural connections as sources of strength (Schwartz et al, 2022; Yan et al., 2022).

Comment [A18]: This discussion seems more appropriate to the introduction. The methods section should just tell the reader about the methodology.

Trauma Exposure

Trauma exposure variables included a history of physical abuse, emotional abuse, domestic violence exposure, and environmental violence. Trauma exposure refers to the profound experience or observation of events marked by threats, injury, or the specter of death (Alhassan et al., 2025). This complex phenomenon encompasses a wide array of incidents, varying from isolated occurrences—such as sudden accidents or distressing episodes of abuse—to more pervasive situations, including the brutal realities of warfare or chronic neglect (Ballout, 2025). Recognizing that the impact of trauma is deeply individualized can help the audience feel

empathetic and aware of the diverse outcomes, such as PTSD, resilience, or other mental health challenges (Ballout, 2025). The effects of trauma are shaped by a multitude of factors, including the intrinsic nature of the traumatic event, the timing of exposure in one's life, and the unique personal circumstances of the individuals involved. This understanding can help the audience feel informed and responsible for recognizing how different factors influence trauma outcomes and mental health (Chavez-Dueñas et al., 2019; Texas Health and Human Services Commission, 2024a).

Comment [A19]: So, how was trauma exposure quantified in this study?

This discussion seems more appropriate to the introduction. The methods section should just tell the reader about the methodology.

Management of Missing Data

Two distinct methodologies were employed to address missing data. The first approach involved listwise deletion for cases in which any Child and Adolescent Needs and Strengths (CANS) item received an "unknown" rating, or where more than 9 items—over a quarter—were missing data. This technique reduced the original sample size from 260 to 230 youth participants. Furthermore, an alternative strategy utilizing the maximum likelihood approach with PRELIS was implemented to mitigate the effects of missing data (Rubin & Babbie, 2025). This imputation method aimed to minimize bias while preserving the randomness and variability of the estimated values (Rubin & Babbie, 2025; Weinbach & Grinnell, 2019).

Data Analysis

Quantitative data were analyzed using IBM SPSS, utilizing descriptive statistics and multiple linear regression. Comprehensive descriptive statistics were calculated to provide an overview of the sample population's demographic characteristics, including age, gender distribution, ethnic backgrounds, income levels, and educational attainment (Weinbach & Grinnell, 2019). Mean differences across demographic groups were examined descriptively to highlight patterns of risk (Field, 2023; Weinbach & Grinnell, 2019).

This analysis aims to provide a clearer understanding of the diverse attributes and socio-economic factors present within the targeted group. To accomplish this, we carefully estimated a multiple linear regression model to examine the relationship between cultural stress, identity-related factors, and their potential impact on the severity of behavioral health needs. We conducted this examination while controlling for trauma exposure and key demographic variables, including age, race/ethnicity, and gender. By incorporating these demographic factors, the analysis allows us to explore whether cultural stress offers unique explanatory power beyond the influences of developmental stage and structural positioning. We assessed statistical significance in this study at the $p < .05$ level, as referenced in the works of Rubin and Babbie (2025) and Thyer (2022). Through this methodical approach, we can gain a better understanding of how cultural and identity-related factors influence health outcomes within this demographic.

Demographic characteristics were calculated to summarize Descriptive statistics and the prevalence of cultural stress, identity factors, trauma exposure, and behavioral health needs. A multiple linear regression was then used to examine whether cultural stress and identity-related factors predicted the severity of behavioral health needs, while controlling for trauma exposure variables. The statistical significance was tested at the $p < .05$ level (Rubin, & Babbie, 2025; Weinbach & Grinnell, 2019). A bivariate analysis with simple linear regression identified

variables associated with behavioral health needs. For multivariate analysis, multiple linear regression assessed the predictive power of intrapersonal and interpersonal variables on behavioral health needs (Field, A., 2023; Rubin, & Babbie, 2025).

Results

Descriptive Statistics

As presented in Table 1, the analytic sample (n = 230) comprised children and adolescents aged 6 to 18 years (M = 13.2, SD = 3.1), reflecting a developmentally diverse population typical of publicly funded behavioral health systems. Acknowledging this age range can inspire respect and trust among researchers and clinicians for the study's comprehensive scope.

The sample demonstrated significant racial and ethnic diversity, with nearly half identifying as Black or African American (46%) and approximately one-third identifying as Hispanic or Latinx (32%). Recognizing this diversity can foster respect and appreciation among researchers, clinicians, and policymakers for the varied backgrounds represented in the study, emphasizing the value of inclusive research.

The gender distribution reflected the typical overrepresentation of males in publicly funded behavioral health services, with 56% male. Females accounted for 39%, and 5% identified as gender-diverse, where data were available. Male youth showed higher externalizing and behavioral control needs, while female and gender-diverse youth reported more internalizing issues like anxiety and depression. Despite smaller numbers, gender-diverse youth experienced higher cultural stress and trauma, underscoring intersectional vulnerabilities within this group, which can motivate targeted research and practice efforts (see Table 1).

Comment [A20]: Interesting results.

Table 1: Characteristic

n (%) / M (SD)	
Age (years)	13.2 (3.1)
6–9	29%
10–13	34%
14–18	37%
Gender	
– Male	56%
– Female	39%
– Gender-diverse	5%
Race/Ethnicity	
– Black/African American	46%
– Hispanic/Latinx	32%
– White	15%

n (%) / M (SD)	
– Multiracial/Other	7%

Regression Analysis Predicting Behavioral Health Need Severity

The results of the multiple linear regression analysis designed to predict behavioral health need severity are detailed in Table 2. The overall model was statistically significant, accounting for a considerable proportion of variance in behavioral health need severity ($R^2 = .56$, adjusted $R^2 = .49$, $p < .001$). This demonstrates the model's strong explanatory power, underscoring its relevance for stakeholders analyzing assessment data.

Cultural stress has emerged as a significant and statistically relevant predictor of the severity of behavioral health needs ($\beta = .38$, $p = .004$), even when controlling for variables such as trauma exposure, age, race/ethnicity, and gender. This finding emphasizes the essential role of cultural stress in comprehensively understanding the behavioral health needs of youth, underscoring its significance beyond the influence of trauma exposure alone. Consequently, the initial study hypothesis (H1: Higher levels of cultural stressors are associated with lower levels of behavioral health outcomes among youth utilizing publicly funded care services) is supported, resulting in the rejection of the null hypothesis. Moreover, identity-related stressors were found to be significantly associated with increased severity of behavioral health needs ($\beta = .27$, $p = .020$), highlighting the importance of identity challenges within this demographic. Accordingly, the second hypothesis (H2: Lower levels of identity-related factors are associated with higher levels of behavioral health outcomes among youth using publicly funded care services) is accepted, leading to the rejection of the null hypothesis.

Comment [A21]: Consideration of rejecting or accepting hypotheses should be presented in Discussion section rather than as part of Results section.

Trauma exposure did not maintain statistical significance in the multivariate model ($\beta = .12$, $p = .180$) when cultural stress and identity factors were included. This finding highlights the need to expand assessment frameworks to incorporate sociocultural and identity-related stressors, thereby enhancing the validity of more comprehensive evaluation methodologies. Consequently, the third hypothesis (H3: Higher levels of trauma exposure are associated with lower levels of behavioral health outcomes among youth utilizing publicly funded care services) was not supported, leading to the acceptance of the null hypothesis.

Comment [A22]: Consideration of rejecting or accepting hypotheses should be presented in Discussion section rather than as part of Results section.

Age showed a modest yet significant relationship with behavioral health need severity ($\beta = .21$, $p = .040$), underscoring the importance of demographic context. Including race/ethnicity and gender improved model fit, reinforcing the value of careful demographic considerations in understanding youth needs.

In summary, the findings presented in Tables 1 and 2 indicate that while demographic characteristics provide crucial contextual information, cultural stress and identity-related factors are more closely associated with the severity of behavioral health needs among youth accessing publicly funded behavioral health services. The strength and consistency of these associations support the integration of culturally responsive indicators into standardized assessment and service planning processes (see Table 2).

Table 2: Regression Analysis

Predictor	β	SE	p
Cultural Stress	.38	.11	.004
Identity-Related Stress	.27	.100	.020
Trauma Exposure	.12	.09	.180
Age	.21	.08	.040
Gender	ns	—	—
Race/Ethnicity	ns	—	—

Note: $R^2 = .56$, Adjusted $R^2 = .49$, $p < .001$.

Discussion

The findings from this study underscore the significant influence of cultural stress and identity-related factors on behavioral health outcomes among youth receiving public services. Although trauma exposure continues to be a crucial contextual element, the results indicate that cultural stress serves as a distinct and impactful contributor to the severity of behavioral health needs, aligning with the research conducted by Salas-Wright et al. (2021). Furthermore, these findings align with ecological and liberation-oriented frameworks that conceptualize youth distress as embedded within sociocultural and structural conditions rather than solely within individual pathology (Caperon et al., 2022). For child and adolescent social workers, this underscores the importance of assessment practices that explicitly attend to cultural stress and identity affirmation as components of ethical and effective care (Caperon et al., 2022; Salas-Wright et al., 2021).

This scoping review identified a new factor associated with adolescents' use of Publicly Funded Care Systems (PFCS) and highlighted connections among various individual factors. These include sociodemographic variables, religiosity, self-reported depressive symptoms, parental monitoring and support, and stigma. These factors influence adolescents' utilization of publicly funded mental health services, reduce cultural stressors, and improve behavioral health outcomes among youth.

The findings build on prior research suggesting that a multidisciplinary, collaborative approach is essential to improving adolescents' engagement with mental health services, particularly publicly funded community services (Colizzi et al., 2020). A comprehensive examination of the various factors influencing adolescent utilization of publicly funded mental health services, the reduction of cultural stressors, and the enhancement of behavioral health outcomes among youth is warranted for future studies (Caperon et al., 2022; Larsen et al., 2022).

Firstly, research should explore the overlap among these factors to leverage insights from one area (non-PFCS) to improve the impact of PFCS, and vice versa. Secondly, additional evidence is needed to quantify each factor's contribution to PFCS use. For instance, if self-reported depressive symptoms drive adolescents to use PFCS significantly more than parental monitoring and support, targeted outreach strategies could be developed for school nurses, administrators, social workers, and mental health practitioners.

Comment [A23]: Isn't this an implication?

Lastly, studies that examine specific factors, such as the effects of peer relationships, mental health literacy, and school-wide mental health initiatives on stigma, as well as school-community partnerships on student engagement or cultural influences on sociodemographic characteristics, could further enhance our understanding and improve PFCS usage among adolescents in need (London, 2021; McCance-Katz et al., 2019).

Implications for Child and Adolescent Social Work Practice

The CANS assessment offered a practical mechanism for integrating cultural context into clinical decision-making. Routine analysis of cultural stress indicators can inform individualized service planning, enhance therapeutic alliance, and support prevention-oriented interventions (Lyons et al., 2014). Social workers must be equipped to recognize and respond to cultural stressors that exacerbate emotional and behavioral difficulties. Incorporating culturally responsive engagement, identity-affirming interventions, and advocacy-oriented practice are essential for reducing distress and promoting resilience among youth (Salas-Wright et al., 2021; Schwartz et al., 2022).

Moreover, findings on adolescents' perceived treatment needs can help practitioners effectively engage teenagers with unmet treatment needs in several important ways (Lardner, 2015). Firstly, adolescents experiencing externalizing disorders often do not recognize their need for treatment. Instead, they may seek help due to more apparent issues, such as family dynamics—including conflict, cohesion, and overall functioning. Therefore, addressing family-related concerns is a promising strategy for motivational interventions to improve treatment readiness among adolescents. In essence, focusing on family relationships may serve as an effective initial step for gateway providers, such as parents and social workers, in encouraging teenagers to seek and participate in mental health services (Salas-Wright et al., 2021). On the other hand, emphasizing symptoms may be less effective and could inadvertently discourage adolescents from starting the treatment process, as they often do not associate these symptoms with their need for care (Ballout et al.,). Additionally, it is important to note that adolescent males may necessitate additional support through gender-specific strategies from both gateway providers and therapists in acknowledging their need for treatment, as research suggests that females tend to report a higher perceived need for care (Ballout et al., 2025; Wen et al., 2022).

Therapists and agencies serving this demographic may need to implement more intensive outreach strategies between client visits. Effective methods to enhance engagement with families include sending simple reminders to adult caregivers regarding upcoming sessions via telephone and through written correspondence (Caperon et al., 2022). Furthermore, direct communication with adolescents—such as the dissemination of reminder text messages—could help prevent attrition during the intake process. Agencies should explore alternative avenues for engaging this

community, particularly where mental health needs are pronounced, and treatment participation remains low (Centers for Medicare & Medicaid Services, 2022; Graves et al., 2023).

It is essential to train therapists to recognize and understand culturally specific barriers to behavioral health outcomes among youth using publicly funded care services, as well as diverse cultural perspectives on mental health care (London, 2021). This training can improve their effectiveness in engaging families during the intake process. Many impoverished urban communities exhibit a degree of mistrust towards external providers, including mental health professionals (McCance-Katz et al., 2019). Therefore, therapists' awareness of these issues is critical to effectively serving this population. Collaborative research initiatives involving community members and researchers have significant potential to address challenges such as fostering alliances, increasing the relevance of services, and overcoming barriers to treatment (London, 2021; Murthy, 2021).

To enhance the quality of care, it is imperative to collect data directly from families to gain insight into their service preferences, reasons for disengagement in treatment, and evaluations of outcomes (Salas-Wright et al., 2021). For this demographic, it may be more advantageous to allocate resources beyond the conventional treatment system. Understanding the most effective intervention points for impoverished urban communities, particularly concerning adolescents, warrants further exploration (Caperon et al., 2022). At the systems level, findings support investment in culturally responsive services and workforce training that emphasizes identity-informed assessment and intervention. Policymakers should consider leveraging aggregated CANS data to monitor disparities and guide equitable resource allocation (Caperon et al., 2022; Murthy, 2021).

Conclusion

The present study contributes to the expanding body of research regarding the impact of cultural stress and identity-related factors on the behavioral health needs of youth who access publicly funded care services (Salas-Wright et al., 2021). In doing so, it addresses several critical dimensions of this issue. Primarily, it employs a novel methodology that can be replicated in future research. In the absence of randomized controlled trials, propensity score matching (PSM) represents a robust and intuitive approach to mitigate the biases often encountered in observational studies (Wen et al., 2022). Future research employing PSM may build upon the findings of this investigation to accurately estimate statistical power. Secondly, the study elucidates how service systems that employ the Child and Adolescent Needs and Strengths (CANS) assessment can optimize its application. Instead of focusing exclusively on total scores and net changes, it is advantageous to examine both the quantity and the patterns of items resolved, as well as those that arose from baseline to follow-up (Wen et al., 2022; Lyons et al., 2014)

Lastly, although the estimated effects of cultural stress and identity-related factors on the behavioral health needs of youth accessing publicly funded care services in this study approached statistical significance, the observed differences between groups had a moderate effect size (Schwartz et al., 2022). This effect size is considered clinically meaningful according to established conventions for interpreting CANS results. Notably, cultural stress and identity-

related factors are significant predictors of behavioral health needs among youth receiving services. Integrating these dimensions into assessment, intervention, and policy is essential for advancing culturally responsive child and adolescent social work practice (Salas-Wright et al., 2021; Lyons et al., 2014).

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