HEALTH AFFAIRS INSTITUTE

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Case Series

Children's In-Home and Community-Based Services Improvement Evaluation: Phase 4

Prepared by

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Prepared for

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Introduction

Evaluation Overview

Mental and behavioral health of children and youth is critical to the well-being of West Virginia (WV). In partnership with the WV Department of Human Services (DoHS), West Virginia University Health Affairs Institute is evaluating the State's mental and behavioral health system for children and youth. The multi-year, mixed method Evaluation captures perspectives and experiences of stakeholders at all levels of the mental and behavioral health system: organizations and facilities; providers, including cross-sector partners; caregivers; and youth with mental and/or behavioral health needs.

The Evaluation offers insight into the experiences of people who interact with the mental and behavioral health system. During and after data collection, WV DoHS and stakeholders across the system are actively engaged in making changes to policies and practices that are not reflected in the presented data.

This report is focused on the Case Series Interviews and includes data from caregivers and youth who have received services of interest to the Evaluation.

A total of 30 individuals participated in the Case Series Interviews, which included 14 pairs of caregivers and their corresponding youth, as well as one additional caregiver and one youth who was a ward of the State. Participants completed up to five rounds of interviews.

Data presented in the report were collected between February 2022 and May 2024. These specific services were of interest to the Evaluation, including:

- Assertive Community Treatment (ACT)
- Children's Mobile Crisis Response and Stabilization (CMCRS)
- Wraparound Facilitation Services: West Virginia Children's Mental Health Wraparound (CMHW) and Children with Serious Emotional Disorders (CSED) Waiver Wraparound (Wraparound)
- CSED Waiver Mobile Response
- Behavioral Support Services, including Positive Behavior Support (PBS)
- Residential Mental Health Treatment (RMHT)
- Children's Crisis and Referral Line (CCRL)

Findings Overview

Findings are highlighted to provide insight into stakeholder perspectives, share suggestions from respondents for expanding on what's working, and to inform dialogue around opportunities for system improvements. Quotes are used to illustrate themes and/or to highlight unique perspectives.

Evaluation reports and additional information about WV's work related to youth mental and behavioral health can be found online at https://kidsthrive.wv.gov.

In this Evaluation:

- ***Providers*** include stakeholders who deliver youth mental and behavioral health services, healthcare providers, law enforcement officers, judges, attorneys, probation officers, DoHS workers, and school administrators. When findings are unique to a provider type, that is specified.
- ***Caregiver*** is used to refer to biological parents, foster parents, or kinship care providers.
- ***Organizations*** refer to community mental health centers, hospitals, RMHT facilities, and other entities that provide the mental and behavioral health services and interventions of interest to the Evaluation, as reported by organizational leaders and administrators in the Organization and Facility Survey.
- ***Youth*** is used to refer to the continuum of children, youth, and young adults, ages 0-21, who receive or are eligible for the services outlined above.

CASE SERIES

Experiences with Mental & Behavioral Health Services

The Case Series provides insight into the experiences of caregivers and youth over time. Findings include participants' perspectives on service accessibility, engagement, satisfaction with mental and behavioral health services, and changes in youth functioning between 2022 and 2024. Approximately one half were recruited to participate in the Case Series as part of the RMHT sample, and the other half were recruited as part of the community-based sample. There was little variation in Case Series participants' experiences across RMHT and community settings; this might be due to the fact that some youth in RMHT returned to the community in between interviews, and some community-based youth also had experiences with RMHT prior to and/or during data collection. Results of the thematic analysis highlight opportunities to improve and expand on what is working across the system. De-identified quotes were taken directly from interview transcripts to illustrate themes.

Access to Mental and Behavioral Health Services

Caregivers and youth reported that access to mental and behavioral health services was facilitated by exposure to the system, and connections with individuals who could help them navigate the system and coordinate care (hereafter referred to as system navigators). Probation and other court services also facilitated access to mental and behavioral health services for youth involved with juvenile justice.

Two of the biggest barriers to access were lack of awareness and the perceived lack of available services and supports. Caregivers and youth wanted more:

- Mental and behavioral health services across the care continuum, especially community-based serves at higher levels of intensity, and more crisis services, school-based services, and specialized services
- Access to Intellectual and Developmental Disabilities (IDD) Waiver services
- Access to telehealth
- Access to respite services
- Financial assistance, especially around travel and transportation
- Care continuity
- Structured recreational activities and opportunities to obtain job and life skills
- Mentoring (from peers and adults, for caregivers and youth)
- Family and caregiver education and training to promote a better understanding of youth's mental and behavioral health needs, and tools and resources that can help them contribute to youth's well-being at home.
    - This need was especially evident among older caregivers (e.g., grandparents) who felt that they lacked awareness of the current issues that youth face in their schools and communities. This is noteworthy given the number of grandparents offering kinship care in West Virginia.
- Early detection and prevention, including greater access to screenings, assessments, and evaluations, especially at the onset of youth mental and behavioral health needs and/or other important turning points (e.g., as youth transition into or following out-of-home placements, and as youth age out of the system).

Caregivers who were fostering or who had adopted youth felt that they had access to mental and behavioral services and interventions (e.g., screenings and assessments, therapy, counseling, and mental and behavioral health medications) when youth transitioned into their homes but had difficulties accessing additional services after they were settled in. These caregivers reported little support for accessing interim and longer term mental and behavioral health services, and felt that the process was cumbersome and frustrating at times.

Caregivers also expressed the need for easier and timely access to RMHT and other out-of-home placements. In fact, **many caregivers indicated that RMHT was the right place for their youth, and despite difficulties with access, they were grateful that youth were able to receive these services** (See page 7 for additional details).

Another set of barriers to service accessibility was centered on issues with eligibility and insurance. Ongoing challenges included:

- Youth age (e.g., some youth were too young for services).
- Significant behavioral issues (e.g., aggression, flight risk) that limited youth's access to certain services or out-of-home placements.
- Ability to find services in-state that were covered under WV Medicaid.

For example, one caregiver stated:

> *We're a very rural county up here. Services... are few and far between. [A nearby county in Pennsylvania] has some wonderful resources, but we can't access them because they are a nonadjacent county. Which is a ridiculous situation.*

Some Case Series participants also had difficulties around diagnoses. Diagnoses-related difficulties ranged from not having a diagnosis (thereby limiting the services that youth were eligible for) to not having the right diagnosis and/or having too many diagnoses. In fact, caregivers reported that co-occurring disorders and/or specialized, complex needs led to "shuffling" of some youth though community-based services and in-state facilities until the "right" supports were identified. This was a major contributing factor to caregiver perceptions that out-of-home and out-of-state placements were the best fit for their youth.

Youth reluctance or hesitation to engage in treatments and services also emerged as a barrier to access (see page 9 for additional details).

CASE SERIES

Awareness of Mental and Behavioral Health Services and Resources

Overall awareness of mental and behavioral health services was low. During initial interviews, caregivers and youth expressed a general lack of awareness of available services, a lack of understanding of how to access services and resources, and uncertainty about which services could meet youth's complex needs. Identifying services that could promote sustainable improvements in youth functioning was a major priority. In more recent interviews, many caregivers and youth mentioned that they wished they had heard of and/or could have initiated mental and behavioral health services earlier than they did.

Caregivers and youth generally lacked awareness of mental and behavioral health crisis services, which led to the reliance on hospitals (and emergency rooms), and the police and other legal interventions when youth needs escalated (see more on page 7).

Case series participants gained awareness of mental and behavioral health services through personal experience (i.e., exposure to the mental and behavioral health system), and by word of mouth. Some caregivers and youth became aware of services from natural supports (e.g., family and friends, and in some cases peer support from others receiving services within the children's mental and behavioral health system).

A vast majority relied on a specific provider who helped them navigate the system and coordinate care; DoHS staff and juvenile justice partners (e.g., attorneys and probation officers) were regularly mentioned. System navigators were particularly valued when they acted as advocates for youth and families, by amplifying caregiver and youth voices, and facilitating referrals.

CASE SERIES

Use of Mental and Behavioral Health Services

All caregivers expressed a commitment to finding the right services that can meet youth needs, including out-of-home placements as appropriate. Case Series participants reported the use of "Wraparound," "CSED," "CMCRS," and "Safe at Home," as well as specific mental and behavioral health interventions (mostly therapy, counseling, and medication management), with increasingly positive experiences over time. There was no discussion of ACT or Behavioral Support Services (including PBS) throughout the Case Series Interviews. There were some mentions of "crisis centers," but not the CCRL specifically (see Use of Crisis Services below for more information).

Caregivers and youth reported positive experiences with RMHT and other out-of-home placements. They appreciated the intensity of services offered in RMHT, and the structure, supervision, and security afforded by out-of-home placements in general. However, they found that discharge planning was lacking, and that more step-down services were needed to help transition youth back home. Case Series participants were most familiar with and reported the greatest use of different types of therapy and counseling services:

- Individualized and family-based therapy were particularly helpful in transitioning youth back into their homes and communities after RMHT or other out-of-home placements, when it was available.
- Medication management was also commonly mentioned, although several discontinued the use of mental and behavioral health medications due to lack of perceived benefit and/or side effects.

Use of Crisis Services

Many caregivers and youth relied on hospitals and the police when youth were experiencing mental or behavioral health crises. They attributed this to a general lack of awareness of other crisis services, and/or inconsistent (timely) access to mobile response teams. Some caregivers mentioned difficulties reaching someone when they called "crisis centers" but more information is needed to determine what they were referencing specifically. It is worth noting, though, that Case Series participants were provided information about the CCRL (844-HELP4WV) when they indicated that mental or behavioral health crisis services were needed but were perceived as lacking.

Of the community-based services of interest to the Evaluation, Wraparound and CSED Waiver services were commonly mentioned in terms of helping to de-escalate crisis situations. One caregiver stated:

> *Safe at Home was one of our biggest helps. [The worker] was amazing...Whenever we had a crisis, I could reach out to her [for] de- escalation...So during the worst part of things, she was our biggest help.*

CASE SERIES

Use of Juvenile Justice Services

Caregivers and youth involved in juvenile justice viewed the courts as an important access point for mental and behavioral health services. Several caregivers discussed legal interventions, such as filing incorrigibility, State custody, and/or criminal charges that ultimately helped increase their awareness of and access to mental and behavioral health services and resources. Referrals from juvenile justice partners and mandated participation were especially helpful for youth with higher intensity and/or more complex needs. Caregivers and youth valued the structure, supervision, and authority afforded by probation and other court services and supports, which helped promote youth well-being and response to treatment in and outside of their homes.

THINGS TO CONSIDER:

Probation officers often filled the role of system navigators and care coordinators/case workers for those involved with juvenile justice. Caregivers and youth reported positive experiences in the surveys and Case Series Interviews. It will be important that DoHS continues outreach to probation officers and other juvenile justice partners, to build and maintain relationships, understand how court policies and practices affect the delivery of youth mental and behavioral health services, and whether/how policies and practice for mental and behavioral health affect the courts. It is also worth exploring whether probation officers have the training and skills that other case workers, care coordinators, or other providers might have.

Structured Recreational Activities

Structured recreational activities helped keep youth in their homes and communities, and helped sustain improvements after youth transitioned from out-of-home placements. Goal-oriented services and activities, including alternative school environments, technical and vocational training, ROTC or other pre-military programs, peer mentoring, and day and overnight camps were mentioned specifically. Caregivers and youth want support to integrate both informal recreational activities and formal mental and behavioral health services during planning and delivery of their care.

CASE SERIES

Caregiver and Youth Engagement and Satisfaction

Case series participants reported greater inclusion, involvement, and engagement over time, but still desired more. Caregivers and youth reported the highest levels of engagement with Wraparound (including CSED Waiver Wraparound and Safe at Home), and RMHT.

Barriers to engagement included lack of capacity and turnover among members of the care team, which led to discontinuities in care, a lack of decision-making autonomy and participation in service planning and delivery, and lower levels of caregiver and youth engagement. Caregivers and youth found it beneficial to build lasting relationships with providers and DoHS staff, whom they often referred to as "friends," "advocates," and/or "cheerleaders." Caregivers especially appreciated when providers or other members of the care team were able to take on the role of a "third parent," by helping identify youth needs, and by providing resources and supports to help promote youth well-being at home (including respite services).

Out-of-home placements sometimes prevented caregiver engagement and involvement. This was sometimes due to youth's preferences for limited caregiver inclusion. That said, the primary barrier was distance (i.e., placements far away from their homes and communities), which made it difficult for caregivers to remain engaged. In such cases, telehealth technology was particularly valued by caregivers and youth.

Facilitators of caregiver and youth engagement included:

- Having a say in treatment planning and decision-making discussions, especially when they perceived that their voices were valued by the care team.
- Rapport, empathy, and trust were also highly valued (see more below).
- Regular and consistent communication with and proactive updates from providers, DoHS staff, and other members of the care team.
- Access to system navigators, as described above.
- Timely responses by providers, DoHS staff, or other system navigators when youth had escalating needs.
- Access to mental and behavioral health services that were tailored to youth needs, including perceiving that providers and services were a "good fit."
- Agency and self-advocacy that was built over time and through exposure to the mental and behavioral health system, positive experiences with providers and other members of the care team, and reductions in mental and behavioral health stigma.

CASE SERIES

Engagement with Providers

Engagement was highest when providers were able to demonstrate empathy, compassion, and an in-depth understanding of youth and family needs and experiences. Caregivers and youth expressed the need and desire to build and maintain ongoing (i.e., long-term) relationships with providers. Strong rapport with providers increased caregiver and youth confidence that they could address youth's complex needs. When there is **not continuity of care**, caregivers and youth experienced:

- Re-traumatization (e.g., having to repeatedly recount difficult experiences and/or ways that they were not able to access needed youth services).
- Lack of trust and buy-in that sometimes led to a "fight or flight" mentality among youth.

For example, one caregiver recalled during an interview that:

> *Her therapist changed every 3 or 4 months...[Youth]'s takeaway was, 'well, why do I even bother? Because you know, I get to know this one, and then somebody else comes in, and then we have to start all over again.'*

Trust and rapport were facilitated by regular contact with the same providers (and other members of the care team) who expressed an appreciation and understanding of youth needs, including local challenges that families were facing.

While continuity of care was valued and led to better outcomes, some Case Series participants felt that changing providers allowed youth to have a much needed "fresh start."

Engagement with DoHS Staff

Caregivers and youth reported increasingly positive experiences with DoHS caseworkers and staff over time. High levels of satisfaction were attributable to regular, consistent, proactive communication, which was a major theme throughout the Case Series Interviews. Youth engagement was also heavily influenced by perceptions that DoHS staff understood their specific needs and advocated for different ways to meet those needs.

Satisfaction with Mental and Behavioral Health Services

Caregivers and youth expressed greater satisfaction with the system, and with mental and behavioral health services, over time. Many of the same factors that affected their awareness of, access to, and engagement with mental and behavioral health services, contributed to their overall satisfaction.

As mentioned, many Case Series participants were generally satisfied with RMHT and other out-of-home placements because they felt like it was the "right place" to meet youth needs. However, caregivers of older youth with more complex needs reported some dissatisfaction (as well as uncertainty and some skepticism) when their youth cycled through multiple out-of-home placements, and experienced difficulties when youth lacked timely access to transition services (see more on page 11).

CASE SERIES

Youth Functioning

All Case Series participants observed improvements in youth's functioning over time. However, experiences were mixed regarding long-term sustainability of benefits gained in response to mental and behavioral health treatments (both in and outside of the home).

Caregivers and youth reported positive experiences with probation and other court-mandated services. Otherwise, caregivers emphasized the importance of youth choice in receiving and/or participating in mental and behavioral health services, and some youth did in fact choose to discontinue all services between rounds of Case Series Interviews. In some instances, caregivers reported that youth were doing well and were "spreading their wings." A few caregivers felt that youth would benefit from ongoing and/or additional mental and behavioral health services and supports, but felt that they had less of a say in the care of older youth who were nearing adulthood.

Therapy, mental and behavioral health medication, and RMHT were reported to have the greatest impact on youth functioning. Observable improvements and treatment benefits included emotional regulation and behavioral stability at home, and in their schools and communities. Many caregivers and youth mentioned better anger management, less aggression, and improved communication, listening, and coping skills. Youth also mentioned and appreciated:

- Having a greater understanding of their mental and behavioral health needs. For older youth this included a better understanding and ability to articulate the consequences of their actions and legal ramifications as they neared adulthood.
- Learning about "responsibility," "boundaries," and ways to avoid "bad influences."
- Having tools that gave them greater confidence in handling daily stressors.

When services "worked," they improved caregiver-youth relationships, and promoted positivity, optimism, and perceived progress toward better overall health and well-being. Transitional services were specifically identified as contributing to youth functioning after an out-of-home placement. Access to step down services, including structured and goal- or skill-oriented services and supports, also helped prevent "relapses" and/or readmissions to RMHT, detention centers, or other out-of-home placements. When these transitional services were delayed or perceived as not available, caregivers reported feelings of apprehension, and even despair.

For youth with mental and behavioral health issues, as with all youth, well-being is a process. Caregivers and youth shared:

> *We know how to work through problems. [Youth's] doing better, you know she talks about everything, and she's not, you know, as emotional...[She's] stable and safe, and feeling that she can talk and express herself the way she wants to.*

> *But right now, I [youth] think I'm at a peace of mind where I'm safe and that's all that matters right now.*

> *Things have been pretty stable here at home... His behavior has been great. And so yeah, there's been a lot of improvement… He's done really good…[He's] balanced, he's wonderful.*

Improved well-being was attributed to a variety of factors, including:

SERVICES

"We did have all the services that I felt that we needed to help him [be] successful when he came home, [including] Safe at Home, his social worker, and probation officer…We wanted everything to work, [so] we did whatever they asked us to do, and [workers] were always there to help us do those things."

INCREASED CAREGIVER KNOWLEDGE

"[She needed services] because of the environments and the situations I had put her in, and that was my fault, you know… As long as you know, we know to seek for help for any time we have a problem, and that we communicate…"

IMPROVED CAREGIVER-YOUTH RELATIONSHIP

"I used to not tell [my caregivers] anything, [but] now I pretty much tell them everything….It makes me feel better like somebody's actually listening…. Since I've been home, I have a good relationship with them... I feel like my parents understand me more [and] better than like what they had in the past."

Overall, youth in the Case Series thrived when they had access to safe, stable, nurturing environments, and families thrived when they had the resources and support to help them. As one caregiver summarized, it was a "perfect storm that they got her on the right medications [and] proper therapy. We learned to parent different. She matured... [She's] just happy now, you know, and living life. It seems like that block that was missing has now been found."

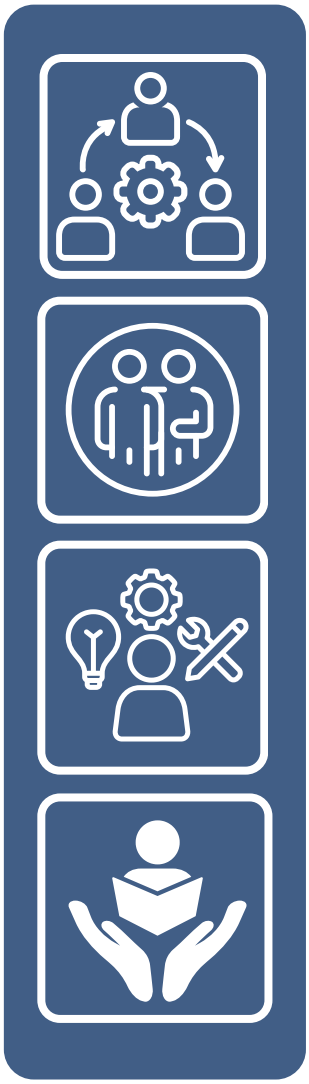
CASE SERIES

Conclusion and Things to Consider

Case Series Interviews provided a platform for caregivers and youth to share rich and in-depth details about their experiences over time. Findings suggest there is positive momentum, as well as opportunities for further improvement.

Many things to consider that were mentioned in other reports are also relevant here. The Case Series findings echoed the experiences reported by stakeholders in other data collection tools from this Evaluation (e.g., surveys, focus groups), and provided insights into specific aspects of the mental and behavioral health system. These are organized by report for easy reference.

Barriers and Engagement



DoHS might explore ways to help align caregiver and provider expectations about communication and response times. Additionally, it might be helpful to provide contact information for designated care coordinators (e.g., case workers, Wraparound Facilitators) so that caregivers have someone they can turn to when they are unable to reach providers or staff directly.

It is possible that caregivers and youth underestimate the time it takes to process referrals, make eligibility determinations, and find available providers who offer needed services. Examining opportunities to streamline administrative processes related to psychological assessments and referrals is recommended. Increased awareness and use of the CCRL (844-HELP4WV) can help ensure timely access to services, in that families and youth can be connected to immediate services online or over the phone, in-person within a few hours (via CMCRS and/or CSED Waiver Mobile Response), and to interim services such as CMHW within a few days while referrals and eligibility determinations for longer term services are being made.

Providers and system-level stakeholders recommended the implementation of a statewide centralized platform to help process and facilitate referrals, which might help fill reported communication gaps in treatment, planning, and discharges from services. A platform of this nature could expand the number of providers and staff who have access to information that could help caregivers navigate the mental and behavioral health system. Perhaps caregivers could be granted access to the system as well. While providing a platform to track and manage referrals has been successfully used in other communities and states, it is worth noting that it can be challenging to implement another system without additional staffing capacity and buy-in.

It can take weeks or sometimes months for providers to build rapport with youth, meaning that it can take time for youth to engage in mental and behavioral health services and to respond to treatments. In fact, youth commonly described initial hesitation or resistance to engage in services. Additionally, some changes in response to treatment might not be very "observable," which might lead caregivers to prematurely conclude that services are not working. In fact, focus group participants mentioned that some caregivers have misaligned expectations about how quickly youth will respond to treatment.

It's possible that several factors are contributing to varying perceptions about service availability, including: provider and staff turnover that can lead to discontinuity in care, changes in funding that affect which providers offer mental and behavioral health services and interventions, and the expressed need for more mental and behavioral health services at important turning points such as discharge from RMHT or transition into adulthood (see next section for additional details).

Use of Mental and Behavioral Health Services

In addition to continued marketing to increase awareness of services, DoHS should continue to develop and expand the use of administrative data, such as Medicaid claims data, to help triangulate findings on service utilization.

Caregivers and youth from the Case Series portion of this Evaluation, as well as System-Level Focus Group and Provider Focus Group participants, have reported long wait times for in-home and on-site crisis support services. Service coverage is challenging given the state's geography that ranges from urban to extremely rural communities, but even meeting the goal of arriving within an hour or two can sometimes be too long for many families with youth who are experiencing a mental or behavioral health crisis. As described in greater detail below, some caregivers and youth are still calling the police or going to hospitals in crisis situations.

Data from this Evaluation suggest that many caregivers and youth have had positive experiences with juvenile justice.

- The court was seen as an avenue to file incorrigibility for youth who needed RMHT but were unable to access it.
- Caregivers reported that probation officers were particularly helpful with system navigation and provided assistance with care coordination.
- Judges relied on multidisciplinary teams comprised of stakeholders from across the children's mental health system to ensure that youth receive the services they need in the appropriate setting.
- DoHS's ongoing relationship building with juvenile justice partners should continue to encourage effective collaborations across systems.

There are systems in place to track bed availability for individuals experiencing homelessness. Perhaps there is a way to implement a similar system to streamline ways to check for RMHT beds using a dashboard that makes it easier (and faster) to identify facilities in-state.

Awareness

Awareness is an ongoing need, given changes to the workforce and youth needs. Recommendations for increasing provider, caregiver, and youth awareness can be found at the end of this report.

Strategies to increase awareness of mental and behavioral health services and resources among system-level stakeholders, juvenile justice partners, and providers will indirectly benefit caregivers and youth who rely on these individuals for information. Providers suggested greater DoHS presence at community and school-based events to help increase awareness and build rapport with families. They recommended:

- Continued engagement of stakeholders in family advisory teams and school coalitions to increase positive interactions between DoHS and the families they serve
- Targeted outreach for seniors providing kinship care, including traditional media outreach, and opportunities for word-of-mouth connections via food pantries and/or senior centers.

Lastly, perceived lack of local mental and behavioral health providers emerged in all of the reports (July 2024).

Findings from the Case Series provided additional context to the overall Evaluation results and highlight the importance of caregiver and youth voice and inclusion in systems evaluation. Future evaluation should consider ways to ensure that their perspectives are captured and used to inform data-driven decision making.

Appendix A: Glossary

This page defines the acronyms used and/or other key terms used throughout the report.

Acronym	Definition
ACT	Assertive Community Treatment
CCRL	Children's Crisis and Referral Line (844-HELP4WV)
CMCRS	Children's Mobile Crisis Response and Stabilization
CMHW	WV Children's Mental Health Wraparound
CSED	Children with Serious Emotional Disorders
DoHS	WV Department of Human Services
IDD	Intellectual and Developmental Disabilities
PBS	Positive Behavior Support
RMHT	Residential Mental Health Treatment

Appendix B: Data Collection Overview

This report includes data collected throughout the Evaluation. Reports from previous years can be found on the KidsThrive website: https://kidsthrive.wv.gov/Pages/default.aspx.

The table below provides a description of all data collected as part of this Evaluation. Findings in this report are summarized by year for ease of interpretation. References to specific groups at specific points in time in previous reports (e.g., "youth in RMHT at Baseline"), data collection dates, and number of participants are displayed below.

Year [1]	Project Phase	Stakeholder Group	Data Collection Tool	Reference in Previous Reports	Data Collection Dates	Number of Stakeholders
2021	2a	Service Provider Organizations	Organization and Facility Survey	"Baseline"	8/16/2021 – 11/19/2021	102
2021	2a	Service Providers	Provider Survey	"Baseline"	8/16/2021 – 11/19/2021	1,215
2021	2a	Service Providers	Provider Focus Groups	"Baseline"	11/29/2021 – 1/31/2022	71
2021	2a	Service Provider Organization Key Informants	Organization and Facility Key Informant Interviews	"Baseline"	11/3/2021 – 1/13/2022	14
2021	2a	System-Level Stakeholders	System-Level Focus Groups	"Baseline"	10/7/2021 – 11/1/2021	22
2021	2b	Caregivers of Youth in RMHT	Caregiver Survey	"Baseline"	10/28/2021 – 2/17/2022	108
Ongoing [2]	Ongoing [2]	Caregivers of Youth in RMHT	Case Series Interviews	"Rounds 1-5"	2/21/2022 – 4/29/2024	9
2021	2b	Youth in RMHT	Youth Survey	"Baseline"	11/16/2022 – 4/18/2023	115
Ongoing [2]	Ongoing [2]	Youth in RMHT	Case Series Interviews	"Rounds 1-5"	2/17/2022 – 5/3/2024	10
2022	3	Service Provider Oragnizations	Organization and Facility Survey	"Year 2"	11/16/2022 – 3/7/2023	56
2022	3	Service Providers	Provider Survey	"Year 2"	11/9/2022 – 2/28/2023	1,141

Year [1]	Project Phase	Stakeholder Group	Data Collection Tool	Reference in Previous Reports	Data Collection Dates	Number of Stakeholders
2022	3	Caregivers of Youth in RMHT	Caregiver Survey	"Year 2"	11/4/2022 – 1/13/2023	180
2022	3	Youth in RMHT	Youth Survey	"Year 2"	11/2/2022 – 2/17/2023	156
2022	3	Community-Based Caregivers	Caregiver Survey	"Baseline"	12/22/2022 – 3/31/2023	174
Ongoing [2]	Ongoing [2]	Community-Based Caregivers	Case Series Interviews	"Rounds 1-3"	3/14/2023 – 5/1/2024	6
2022	3	Community-Based Youth	Youth Survey	"Baseline"	1/9/2023 – 3/31/2023	51
Ongoing [2]	Ongoing [2]	Community-Based Youth	Case Series Interviews	"Rounds 1-3"	3/13/2023 – 5/1/2024	5
2023	4	System-Level Stakeholders	System-Level Focus Groups	"Phase 4"	12/12/2023 – 1/9/2024	10
2023	4	Service Provider Organizations	Organization and Facility Survey	"Year 3"	8/1/2023 – 11/10/2023	33
2023	4	Service Providers [3]	Provider Survey	"Year 3"	8/28/2023 – 11/30/2023	722
2023	4	Service Providers	Provider Focus Groups	"Phase 4"	3/11/2024 – 3/28/2024	36
2023	4	System-Level Stakeholders	System-Level Focus Groups	"Phase 4"	12/15/2023 – 1/9/2024	10
2023	4	Community-Based Caregivers	Caregiver Survey	"Year 2"	2/21/2024 – 4/26/2024	213
2023	4	Community-Based Youth	Youth Interviews	"Year 2"	6/3/2024 – 6/21/2024	6

Notes: RMHT = residential mental health treatment.
[1] Represents the year used to reference the data in Phase 4 reports.
[2] Case Series participants were recruited from "Baseline" Caregiver Surveys and Youth Surveys. Case Series Interviews were conducted with the same individuals approximately every six months; participants completed up to five interviews over the course of the Evaluation.
[3] Judge interviews were conducted after the Phase 4 Provider Survey was closed for other provider types. Phase 4 judge interviews were conducted between December 2023 and February 2024; of these 722 providers, 20 were judge interviews.