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Use of Mental and Behavioral Health Services

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

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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 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 Use of Mental and Behavioral Health Services, and highlights data collected between August 2023 and June 2024; more than 1,000 stakeholders participated in surveys, interviews, and/or focus groups. Comparisons are made to previous years of data from this Evaluation when appropriate.

The services of interest to the Evaluation include:

- 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.

Identifying Youth Mental & Behavioral Health Needs

The West Virginia Department of Human Services (DoHS) has been actively encouraging the use of valid assessments to measure youth functioning and need. These tools can be used to identify appropriate services and settings in which services should be delivered (e.g., in the community versus in RMHT or other out-of-home placements).

The importance of early detection and intervention was mentioned by all stakeholders; by increasing the use of standardized evaluations and assessments, it will be possible to compare youth needs and functioning across the system.

DoHS is supporting the use of the Child and Adolescent Functional Assessment Scale (CAFAS), which helps determine intensity of service need based on the child's functioning, and the Child and Adolescent Needs and Strengths (CANS) tool to identify youth service needs.

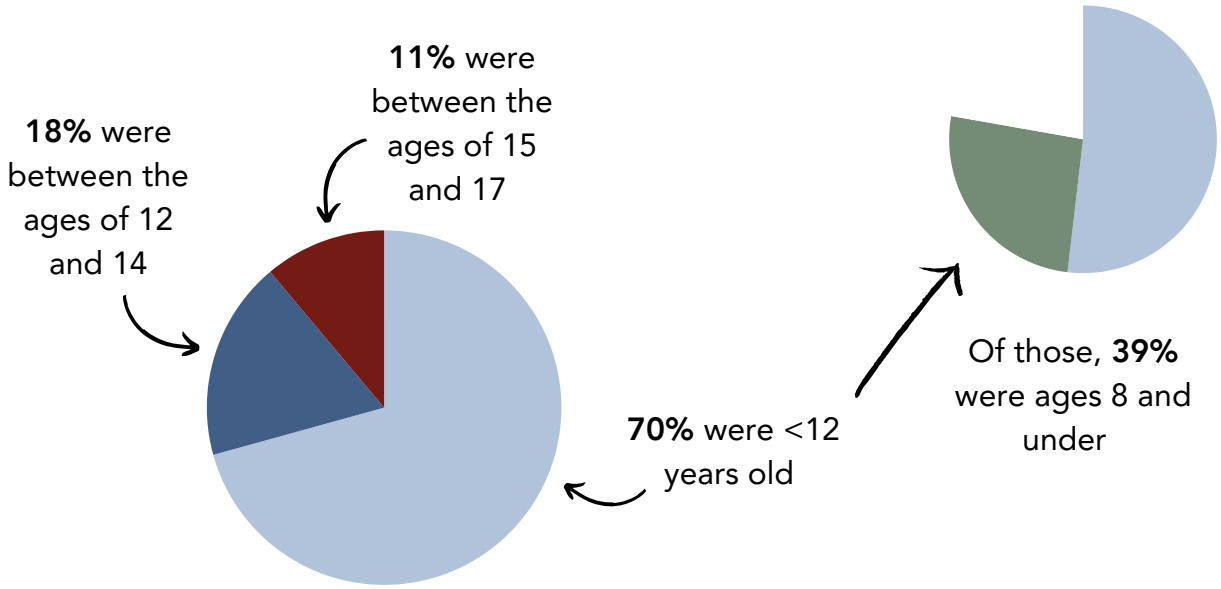
THINGS TO CONSIDER:

Judges and providers frequently experienced long wait times for psychological evaluations to be completed, which they attributed to a lack of professionals who are qualified to administer them. Long wait times were also attributed to a perceived overuse of the CSED Waiver, which stakeholders believe has created additional backlog and strain on the availability and capacity of providers who are able to conduct psychological evaluations.

Youth Diagnosis

Providers, judges, system-level stakeholders, and caregivers consistently mentioned the importance of mental and behavioral health diagnoses to gain access to needed services and resources across years of the Evaluation. This topic was added to the most recent survey administered to community-based caregivers.

According to caregivers: **60%** of community-based youth have received a mental or behavioral health diagnosis. Most mental and behavioral health diagnoses were made when youth were 11 years of age or younger.



*0% were between the ages of 18 and 21

Caregivers reported that youth diagnoses included:

- Attention Deficit Hyperactivity Disorder (ADHD), which was by far the most frequently mentioned
- Anxiety Disorders
- Post-Traumatic Stress Disorder (PTSD)
- Depressive Disorders
- Oppositional Defiant Disorder (ODD)
- Autism Spectrum Disorder
- Bipolar Disorder

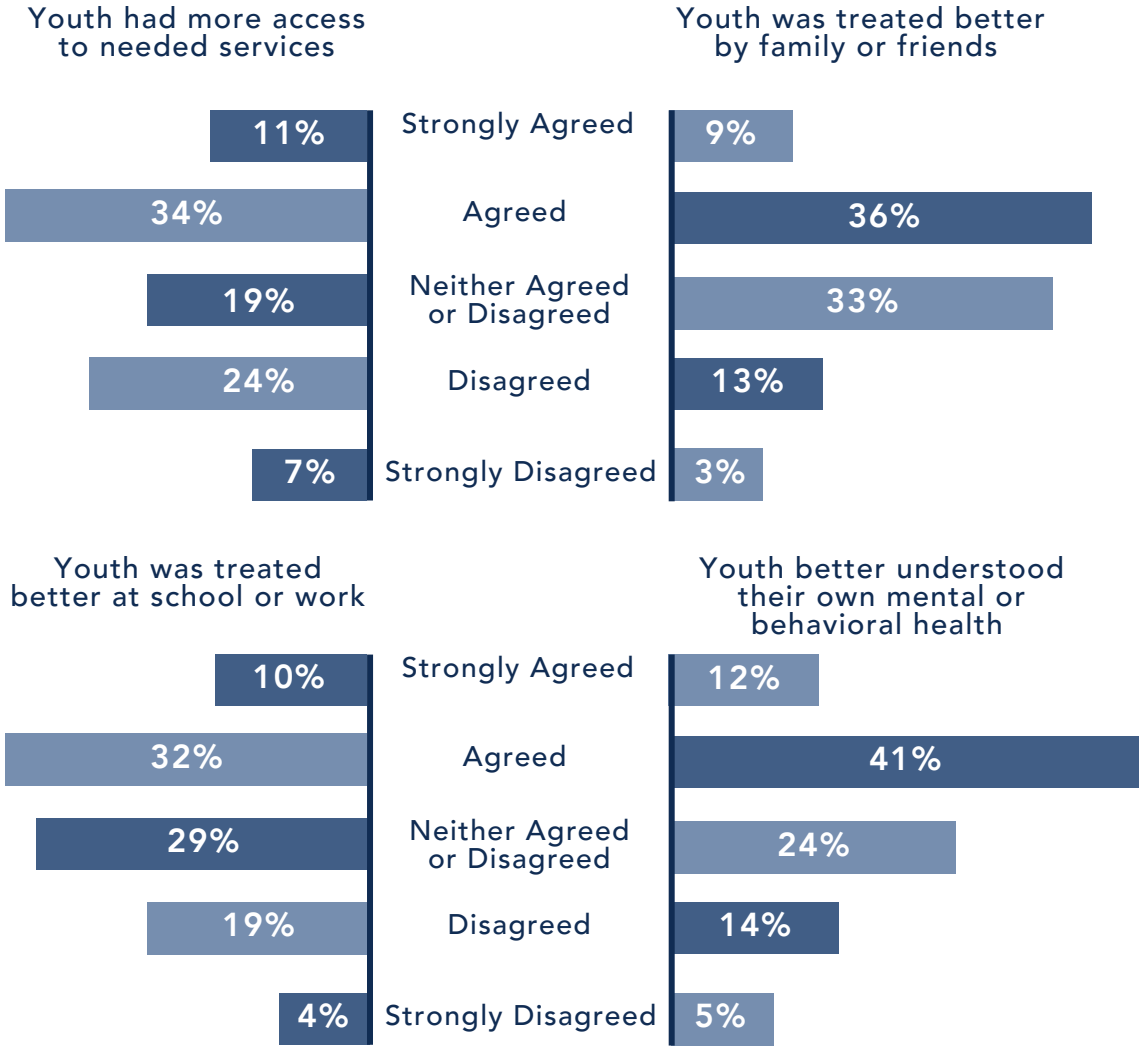
Approximately one half of youth who received RMHT and more than one third of community-based youth had teachers, doctors, or other trusted adults recognize that they had mental and behavioral health needs and suggested the county or State intervene to help them.

More data are needed to understand potential changes and experiences with diagnoses over time.

THINGS TO CONSIDER:

The high number of ADHD diagnoses is notable and may be worth further exploration. Stakeholders were in agreement that without diagnoses, access to services might be limited.

Several follow-up survey items asked caregivers about changes to youth experiences after they received mental and behavioral health diagnoses. Since receiving a mental or behavioral health diagnosis:



Mental and Behavioral Health Medication

Across years of the Evaluation, caregivers consistently mentioned the importance and need for medication and medication management. This topic was added to the most recent survey administered to community-based caregivers.

Approximately one half of community-based youth take medication to help with their mental and behavioral health needs, according to their caregivers in 2023. More youth ages 12 to 21 (55%) take medication than youth under the age of 12 (45%).

- Most caregivers agreed that youth take their mental and behavioral health medication as prescribed.
- Most caregivers believed that the medication seems to be working.

OVERALL

47% of community-based youth take medication to help with their mental and behavioral health needs.

AMONG THOSE:

84% of community-based caregivers agreed that medication works for their youth.

As noted above, half of community-based youth were not taking mental or behavioral health medication.

- The primary reason why youth were not on mental or behavioral health medications is because they were not recommended.
- Caregivers felt like mental and behavioral health medications might help as many as 10% of community-based youth who currently do not have prescriptions for them.

In previous years, caregivers and youth indicated that it can be hard to find the right medication and expressed some issues with dosage and side effects. Finding a qualified provider to manage medication can be challenging, especially when those providers are not part of the regular care team and/or have limited time to build rapport with youth and families.

As mentioned in the Barriers and Engagement report (July 2024), some caregivers had difficulties with insurance coverage for mental and behavioral health prescriptions.

Use of Mental and Behavioral Health Services

One of the main goals of this Evaluation is to consider whether, when, and how community-based services can help keep youth in their homes and communities by delaying or avoiding the need for out-of-home placements such as RMHT when it is clinically feasible to do so. An important caveat is that some youth need RMHT, which all stakeholders mentioned throughout the Evaluation (see the Out-of-Home Placements section below for more information).

As detailed in the Service Awareness report (July 2024), it can be challenging to capture youth's use of community-based mental and behavioral health services from self-reports in surveys and interviews because:

- Caregivers and youth tend to be able to report service locations and the mental and behavioral health interventions that youth received but are less likely to know or remember the specific names of services. For example, they are able to recall that youth went to Prestera for therapy and medication management but might not know that the services were delivered as part of Assertive Community Treatment.

- Caregivers and youth will use phrases interchangeably like "CSED Waiver" or "Safe at Home" to refer to any Wraparound services. Similarly, they will use "Mobile Crisis" to refer to Children's Mobile Crisis Response and Stabilization and CSED Waiver Mobile Response. Therefore, it was not always possible to tease out differences between similar services (e.g., between CSED Wavier Wraparound and WV Children's Mental Health Wraparound) from the caregiver and youth data. To help overcome these challenges, the surveys and interview materials included service names and descriptions, with "Wraparound" as an overarching category for CSED Wavier Wraparound, WV Children's Mental Health Wraparound, and Safe at Home, and "Mobile Response" as an overarching category for CSED Waiver Mobile Response or Children's Mobile Crisis Response and Stabilization.

THINGS TO CONSIDER:

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.

Use of Community-Based Mental and Behavioral Health Services

Providers and system-level stakeholders recognize that DoHS prioritizes in-home and community-based mental and behavioral health services over the use of RMHT or other out-of-home placements. However, overall use of the community-based mental and behavioral health services of interest to this Evaluation was low, according to caregiver and youth survey data. Recall and awareness of service names likely influenced these findings (as noted above).

Caregivers and youth consistently reported the greatest use of Wraparound and Behavioral Support Services (including Positive Behavior Support), although some findings varied across stakeholders and settings:

Wraparound:

- More community-based youth received Wraparound than youth in RMHT, as expected.
- 40% of community-based youth received Wraparound in 2023, according to their caregivers. Approximately 25% of youth received Wraparound in previous years, according to caregivers and youth across RMHT and community settings.

Behavioral Support Services (including PBS):

- Caregivers reported greater use of Behavioral Support Services (including PBS) than youth, and use was greater among youth in RMHT than community-based youth.

Use of Assertive Community Treatment (ACT) was low, and this finding was consistent across caregivers and youth, and across RMHT and community settings. This was somewhat expected, though, given that ACT is still being implemented, and is intended for youth at the higher age range within the population of interest to this Evaluation, meaning many would not have been eligible.

Use of the CCRL and CMCRS/CSED Waiver Mobile Response was low, and this finding was consistent across caregivers and youth, and across RMHT and community settings.

THINGS TO CONSIDER:

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 that the state's geography ranges from urban to extremely rural, and meeting the goal of arriving within an hour or two can sometimes be too long when youth 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.

Use of RMHT was higher than expected among community-based youth. Approximately one third of community-based youth received RMHT in 2022 (and 16% in 2023, according to caregivers). More information is needed to understand the timing of RMHT among community-based youth (i.e., whether they were identified as "at-risk" prior to or after an out-of-home placement). See page 12 for more information about RMHT and other out-of-home placements.

Use of 'Other' Community-Based Services and Resources

Caregivers were able to write-in 'other' community-based mental and behavioral health services and resources that youth received beyond the services of interest to the Evaluation. Those included:

- Counseling, therapy, and/or behavioral health services
- Medication management
- Juvenile justice-related services (e.g., court-mandated participation, probation)
- Assessments, evaluations, and earlier intervention
- Step-down services to transition youth back into their communities after out-of-home placements
- Hospital-based services, including acute psychiatric care
- Waiver services (including IDD and CSED)

While findings were consistent over time, caregivers and youth reports differed in several noteworthy ways:

- Caregivers mentioned a broader array of mental and behavioral health interventions, whereas youth tended to mention various types of therapy (e.g., trauma therapy, animal therapy) and peer mentorship.
- More youth mentioned support for independent living than caregivers.

Services that were perceived as needed but not available are outlined in the Barriers and Engagement report (July 2024). Many of the same themes emerged.

Use of Crisis Services

Youth experiencing mental or behavioral health crises need immediate care. Crisis services, such as the CCRL (844-HELP4WV), in partnership with CMCRS and CSED Waiver Mobile Response, connect youth and families to immediate services over the phone, online, and in-person (in their homes or other community settings). The goal is to reduce the rates by which youth and families call the police or go to a hospital emergency room for mental and behavioral health services.

Called the police

More caregivers called the police during a mental or behavioral health emergency than youth, and reports were considerably higher among caregivers of youth in RMHT. Findings were consistent over time.

>30% of caregivers of youth in RMHT called the police during a mental or behavioral health emergency.

<20% of youth in RMHT called the police during a mental and behavioral health emergency.

<10% of community-based caregivers or youth called the police during a mental or behavioral health emergency.

Law enforcement officers somewhat agreed that they are prepared and have the training necessary to respond to a mental or behavioral health emergency involving youth, but expressed the desire for more, especially with regard to de-escalation training.

Only 21% of law enforcement officers were aware of CMCRS or CSED Waiver Mobile Response in 2023. More than 80% of law enforcement officers who were aware of CMCRS and CSED Waiver Mobile Response knew how to access those teams, but less than 25% utilize these services, and less than 20% used 844-HELP4WV in 2023.

THINGS TO CONSIDER:

Targeted outreach might support law enforcement during calls involving youth and families experiencing mental and behavioral health crises.

Perhaps the wallet card initiative, which has been popular among healthcare providers, might also be effective with law enforcement officers. See the Workforce, Capacity, and Resources and the Collaboration and Referrals reports (July 2024) for additional details.

Police Encounters

Caregivers and youth across RMHT and community settings reported police encounters. Youth in RMHT had more police encounters than community-based youth, which was somewhat expected given that youth in RMHT might have higher intensity needs. Few community-based youth had police encounters in 2023, most of whom were between the ages of 12 and 21, as expected.

Most of the caregivers and youth from across RMHT and community settings said that the frequency of police encounters has remained the same or gone down compared to previous years; less than **10%** of youth had more police encounters than in previous years and this finding was consistent across settings and over time. While a majority of youth did not have police encounters, many of those who did were arrested and/or went to court because of it.

- Approximately **40%** of youth in RMHT who had an encounter with police in the last 12 months were arrested, compared to approximately **30%** of community-based youth.
- More youth in RMHT went to court because of their encounters with police than community-based youth.

THINGS TO CONSIDER:

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 rely on multidisciplinary teams comprised of stakeholders from across the children's mental and behavioral health system to ensure that youth receive the services they need in the appropriate setting. See page 17 for additional details.

DoHS's ongoing relationship building with juvenile justice partners should continue to encourage effective collaborations across systems.

Visited a Hospital Emergency Department for Mental and Behavioral Health Services

Percentages of caregivers and youth who reported visiting a hospital emergency department (ED) to access mental and behavioral health services for youth were as follows:

2021
- **20%** of caregivers of youth in RMHT
- **28%** of youth in RMHT

2022
- **22%** of caregivers of youth in RMHT
- **14%** of youth in RMHT
- **13%** of community-based caregivers
- **14%** of community-based youth

2023
- **11%** of community-based caregivers

Over time, most caregivers and youth agreed that they would be able to access mental and behavioral health services outside of a hospital ED if youth needed services again in the future, with the exception of caregivers of youth in RMHT in 2022 who neither agreed nor disagreed.

Out-of-Home Placements

All stakeholders recognize the importance of using in-home and community-based services to avoid unnecessary out-of-home placements for youth with mental and behavioral health needs.

Spotlight on Policy

The surveys ask stakeholders whether they think the State prioritizes and supports in-home and community-based services over out-of-home placements when youth might be better served at home.

Providers from across the children's mental and behavioral health system somewhat agreed that DHHR prioritized in-home and community-based services over RMHT when youth would be better served at home. Little variation was observed over time. Probation officers, as well as case workers and case managers, tended to have higher levels of agreement than other provider types.

Note: Findings reference "DHHR" because the data were collected prior to the reorganization into DoHS.

Policy changes have occurred throughout this Evaluation; therefore, it was somewhat expected that awareness of and attitudes about policies would change over time. Findings from mental health, behavioral health, and healthcare providers are reflective of this.

Approximately half of mental health, behavioral health, and healthcare providers had at least some familiarity with the WV Bureau for Medical Services (BMS) policies for delivering mental and behavioral health services in 2023, which is 15% higher than the previous year.

Providers who were aware of BMS policies somewhat agreed that the policies are understandable, and neither agreed nor disagreed that the policies make it easy to coordinate care.

THINGS TO CONSIDER:

Opportunities exist to increase awareness of BMS policies and procedures. The State should continue to prioritize relationship-building and engagement with providers. While it may take time to see changes in the data, providers are recognizing efforts made by DoHS (e.g., monthly provider meetings, lunch and learns, the KidsThrive website).

Factors that Contribute to Residential Mental Health Treatment or Other Out-of-Home Placements

The top factors that contribute to out-of-home placements were consistent across years of the Evaluation: lack of community-based services, clinical necessity and unique youth needs, provider-caregiver misalignment, and home environment.

Lack of community-based services

Need for specialized services:

- Nearly all stakeholders reported the need for more specialized and intensive services in the community, especially for co-occurring disorders involving autism and IDD, suicidality, sexual behaviors, and violent behaviors which also contribute to out-of-state placements.
- Stakeholders continue to express the need for more crisis services, especially those that help avoid hospitalizations that can lead to short- and long-term placements.
- Youth explicitly mentioned the need and desire for specialized types of therapy (e.g., trauma-related therapy, animal therapy).
- Alternative out-of-home placements outside of RMHT and step-down services that can help youth transition back into their homes and communities after RMHT.

Workforce and capacity:

- Stakeholders, including caregivers and youth, frequently mentioned that issues with workforce capacity and staff turnover seem to be contributing to the lack of community-based services as well.

Clinical necessity and unique youth needs that cannot be met in other service settings

- Stakeholders recognized that some youth need RMHT. Functional assessments are paramount. Work is ongoing to ensure that those who need RMHT have access to it, and that those who do not require that level of intensity can remain in their homes, and/or are transitioned back into their communities.
- **Many caregivers indicated that RMHT was the "right place" for their youth based on the intensity of their needs,** and to a lesser degree, based on what they felt was available and accessible in their communities. Some caregivers advocated for RMHT (e.g., by filing incorrigibility) when they felt that their youth needed that level of care.
- Judges agreed that clinical necessity was a major factor that contributed to their decisions for placement.

Provider-Caregiver Misalignment

- Lack of parental capacity was a response option selected by many providers when asked about factors that contribute to out-of-home placements.
  - Approximately half of mental health, behavioral health, and healthcare providers indicated that caregivers miss appointments and/or do not answer the phone when they call them.
- Caregivers, on the other hand, continued to express the need for more communication and greater involvement in their youth's care. Engagement and decision-making autonomy was also a major contributor to caregivers' satisfaction with their youth's care. It is possible that some of this is associated with response bias, in that the caregivers who completed surveys and interviews might be (or might want to be) more involved and engaged than those who did not participate in this Evaluation.

All stakeholders agree, though, that youth benefit when their caregivers are engaged and involved in treatment decisions and delivery. See the Barriers and Engagement report (July 2024) for more information.

Home Environment

- Judges reported that the safety of youth and other household members often factors into their decisions about whether to remove youth from their homes.
- Many stakeholders reported the need for family-based services among multiple members of the household, specifically for caregiver substance use and mental health.
- Without access to additional services, providers described a "revolving door" situation where youth responded to RMHT but remain at-risk of readmission after discharge because their home environments have not changed.

Factors that Contribute to Out-of-State Placements

Judges requested that members of the multidisciplinary teams exhaust all community options before exploring out-of-home or out-of-state placements. The language judges used included "least restrictive alternatives" and viewed out-of-home and out-of-state placements as "a last resort." However, assessing all community and in-state options on a case-by-case basis can cause delays in treatment, thereby leading to additional hardships on families (see the Juvenile Justice Partners section below for more information and recommendations).

According to judges, in-state facilities are unable to meet the needs of youth who have:

- Low functional assessment scores
- Low IQ
- A history of violent and/or physically aggressive behaviors
- A history of sexually aggressive behaviors
- Co-occurring medical/physical health needs

Judges also expressed difficulties finding placements for female youth.

Protective Factors that Prevent or Delay Out-of-Home Placements

Caregivers and youth were asked whether receiving the community-based services of interest to the Evaluation helped delay or prevent out-of-home placements.

- Caregivers and youth across RMHT and community settings consistently agreed that Wraparound (including CSED Waiver Wraparound, WV Children's Mental Health Wraparound, and Safe at Home) helped keep youth in their homes and communities.
- Behavioral Support Services (including PBS) and Mobile Crisis (including CMCRS and CSED Waiver Mobile Response) also helped delay or avoid out-of-home placements.
- Few community-based youth received CMCRS, CSED Waiver Mobile Response, or CCRL services in 2023, but trends in the data suggest that they also helped delay or avoid out-of-home placements among youth who utilized them, according to their caregivers.

Other protective factors that emerged in the data:

- Many caregivers reported having strong natural support systems, as did youth.
  - Wraparound relies on natural support systems, which might be contributing to its effectiveness in keeping youth in their homes and communities, and may provide important insights into youth well-being that other providers might consider incorporating into service delivery.
- Access to trusted adults who helped identify youth needs, including school-based services and resources.
- Knowledge of how to access services, which increased the likelihood of using mental and behavioral health services if youth needed them again in the future.
- Judges also mentioned that youth day report centers, juvenile drug courts, and family treatment courts help keep youth in their homes and communities.

Stakeholder Perspectives on Juvenile Justice

Judges indicated that many of the juvenile cases that they oversee involve youth with mental and behavioral health needs. In such cases, judges are often the ones making important treatment decisions, such as mandating participation in community-based services that can help reduce the rates of out-of-home placements when it is clinically feasible to do so. Judges reported across data collection years that they prioritize in-home and community-based services over RMHT.

While in past years, mental health, behavioral health, and healthcare providers reported that court orders contributed to out-of-home placements when youth might be better served at home, they neither agreed nor disagreed in 2023. This finding suggests that judges may be recommending RMHT or other out-of-home placements less frequently in recent years.

The Provider Survey asked about perceptions that judges prioritize in-home and community-based services. Probation officers consistently agreed that judges prioritize in-home and community-based services; attorneys and social service providers somewhat agreed. Little variation was observed over time.

According to judges, there are a number of factors that they consider when making treatment recommendations (including out-of-home placements):

- Psychological assessments and evaluations
- Youth service history
- Availability of community-based services, which they rely on multidisciplinary teams to help determine (see more below)
- School attendance
- Whether the youth exhibits physically or sexually aggressive behaviors
- Availability of youth and family support systems
- Caregivers' level of engagement and capacity to manage the youth's behavior
- Safety, home environment, and other family dynamics

Cross-system partnerships help keep youth in their homes and communities when it is clinically feasible to do so

Judges indicated that they need timely and complete information in order to prioritize in-home and community-based services over RMHT during case disposition; MDTs are a primary source of this information. **Judges mostly agreed that MDTs prioritize in-home and community-based services over RMHT, and that there are policies in place to help implement MDT recommendations**. Little variation was observed over time.

> Multidisciplinary teams (MDTs) comprised of attorneys, probation officers, school personnel, mental and behavioral health providers, and State case managers, facilitate systems-level collaborations by providing judges with information, updates, and recommendations to help ensure that youth (and their families) receive needed services in the appropriate setting.

Many judges requested that MDTs exhaust all community options before recommending an out-of-home placement, especially when it might result in an out-of-state placement. However, doing so can result in hardships for youth and families. **Psychological evaluations need to be completed before MDTs can check for available resources that youth would be eligible for, which can take weeks or sometimes even months to accomplish.** This can result in delayed hearings and treatment recommendations.

When judges recommend an out-of-home placement, MDTs must work through the bureaucratic process of checking availability within all in-state facilities. **Judges appreciate the need to keep youth close to their communities when possible. However, the process of identifying an available bed at an in-state facility that youth are eligible for can result in youth being left in unsafe home environments, or temporary placements in hotels or detention centers where they are not receiving needed mental and behavioral health services (which can also compound existing issues with truancy and academic achievement)**. Providers were regretful that sometimes "it's not about what's the best fit -- it's just who will take this kid."

THINGS TO CONSIDER:

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.

Attorney Perspectives

Attorneys and guardians ad litem somewhat agreed that they have the information needed to make appropriate recommendations to the court on behalf of the youth they are representing, and that youth's mental and behavioral health needs are appropriately considered in court. However, attorneys reported increasing concerns over years of the Evaluation that the youth they represent are not getting adequate mental health care and expressed the need for clearer policies for supporting youth with mental and behavioral health needs.

Referrals to and Discharges from Residential Mental Health Treatment

Referrals to Residential Mental Health Treatment

Opportunities exist to increase awareness of policies for making and following up with referrals to RMHT. For example, mental health, behavioral health, and healthcare providers neither agreed nor disagreed that their organizations have clearly defined policies and procedures for following up after youth have been referred to RMHT.

THINGS TO CONSIDER:

The percentage of mental health, behavioral health, and healthcare providers who follow-up after they refer youth to RMHT has increased over time. Most providers follow-up within a few weeks of placing a referral; however, these practices might not align with the time it takes to process these referrals, or the wait times reported by many RMHT facilities, which can range from a few weeks to a few months. More information is needed to determine whether there is a gap in policy and practices for following up with referrals to RMHT.

Many of the day-to-day challenges reported by providers also emerged as barriers to maximizing their referral networks to RMHT:

- Lack of qualified providers within their networks or communities.
- Lack of resources such as funding, staff, materials, and space.
- Lack of cooperation among organizations and agencies due to competition for funding and billable services.

A smaller percentage indicated that staff turnover affected their referral networks in 2023 than the previous year.

As mentioned in the Collaboration and Referrals report (July 2024), providers indicated that they would benefit from a centralized system for making and tracking all referrals, but especially those for out-of-home placements.

Discharges from Residential Mental Health Treatment

The State has been working to develop discharge plans for all youth in RMHT. In addition to the need for timely (re)assessments of youth functioning (e.g., to account for changes in functioning, response to treatment), factors that affect discharge planning include:

- Billing and insurance.
  - An increasing number of providers are collaborating with Wraparound and ACT as part of discharge planning but have encountered difficulties with initiating and billing for additional services while youth are still in RMHT.

- The identification of safe home environments for youth to return to.
  - As mentioned, it can be problematic for youth to return home after RMHT if other members of the household have unmet mental, behavioral, or physical health needs. Even though delaying discharge is less than ideal, it can give DoHS time to identify if kinship care is a possibility.

- Lack of available mental and behavioral health services that can continue to support youth outside of RMHT and/or reduce the rates of readmission.
  - Providers, judges, and caregivers expressed concerns about the lack of services that can transition youth back into their homes and communities, as well as the availability of services after youth turn 18. Specific service needs included structured activities, services and resources that can help reintegrate youth into public schools, job and life skills, peer mentorship opportunities, and ongoing therapy and medication management.

DoHS has prioritized kinship care and is working to develop other alternatives (e.g., intensive group homes) for circumstances when youth are unable to return home. That said, more work is needed to support caregivers so that they can regain custody when possible.

Mental health, behavioral health, healthcare, and social service providers, as well as probation officers, indicated that they include caregivers and youth in discharge planning. In recent years, youth across RMHT and community-based settings agreed that they felt included in discharge planning. Some caregivers felt included in discharge planning but still desired more. Caregivers felt especially disconnected and out-of-the-loop when their youth were placed in facilities out-of-state or outside of their communities.

Conclusion

Reported use of mental and behavioral health services likely underestimates actual use because some youth were in RMHT, and therefore might not have had the ability to access community-based services, and some caregivers and youth were more familiar with interventions than the specific names of services. Eligibility also affects use; not all services of interest to the Evaluation are targeted to the entire sample of youth. That said, results provide useful insights into what is working, and ways to help keep youth in their homes and communities when it is clinically feasible to do so.

Bright spots:

- Protective factors, such as schools, teachers, doctors, and other trusted adults, are valuable supports to help identify youth needs and make connections to resources. Opportunities exist to expand upon the inclusion of other services and resources (e.g., structured recreational activities; peer mentoring programs) into youth plans of care.
- Community-based services, particularly Wraparound and Behavioral Support Services (including Positive Behavior Support) help prevent unnecessary out-of-home placements.
- Judges and other decision-makers are aware of and when possible will account for contextual factors (e.g., home environments) that might affect placement when making treatment recommendations.

While some caregivers and youth rely on the police or hospital emergency rooms during crisis situations, exposure to the children's mental and behavioral health system increased their confidence of accessing other community-based resources (e.g., the CCRL).

Efforts to increase awareness and to address barriers to access will also help increase use of mental and behavioral health services. When taken together, the Evaluation captured snapshots of the system across years. Findings suggest there is positive momentum, as well as opportunities for further improvement. Perspectives of stakeholders within the children's mental and behavioral health system, and adjacent systems such as healthcare and juvenile justice, provided valuable insights.

Appendix A: Glossary

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

Acronym	Definition
ACT	Assertive Community Treatment
ADHD	Attention Deficit Hyperactivity Disorder
BMS	Bureau for Medical Services
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Needs and Strengths Assessment
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

Appendix A: Glossary

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

Acronym	Definition
DHHR	The WV Department of Health and Human Resources (now the Department of Human Services)
DoHS	West Virginia Department of Human Services
FRN	Family Resource Network
IDD	Intellectual and Developmental Disabilities
MDT	Multidisciplinary team
ODD	Oppositional Defiance Disorder
PBS	Positive Behavior Support
PTSD	Post-Traumatic Stress Disorder
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.