Evaluation Report: Year 2

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

WEST VIRGINIA Department of Health & Human Resources

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Executive Summary

The West Virginia Department of Health and Human Resources (WV DHHR) Children's In-Home and Community-Based Services Improvement Evaluation Project utilizes a multi-year mixed methods approach to measure the impact of recent changes made to the mental and behavioral health system on different stakeholders, including youth 21 years of age or younger who are at-risk of placement in or who are currently receiving residential mental health treatment (RMHT), their caregivers, service providers across the continuum of care, as well as system-level stakeholders such as judges and DHHR staff. This project published two Baseline reports in 2022, one focused on providers, organizations, and system-level stakeholders, and one focused on youth in RMHT and their caregivers. This report is a continuation of that work in that it contains Year 2 data and comparisons to Baseline for organizations, facilities, providers, and youth in RMHT as well as their caregivers. System-level stakeholders are being interviewed and asked to participate in focus groups again this year, and those findings will be included in the 2024 report. A separate report containing Baseline data for youth who are at-risk of placement in RMHT (and their caregivers) will be published in the fall of 2023.

This report includes primary data collected in Year 2 with surveys and interviews, as well as secondary analyses of administrative data. Specific data collection activities and analyses were as follows:

Youth- and Family-Level

- Administration of two statewide surveys: the Youth Survey to all West Virginia (WV) youth 21 years of age or younger in RMHT and the Caregiver Survey to their parents or legal guardians.
- Interviews conducted with nine caregiver-youth pairs as well as one youth who is a ward of the State, as part of the case series design.

Community- and Provider-Level

- Administration of two statewide surveys: the Organization and Facility Survey to all administrators of the youth mental and behavioral health services of interest, and the Provider Survey to all mental and behavioral health providers and other professionals who interact with youth with mental and behavioral health needs, such as social workers, juvenile justice partners, and law enforcement.

System-Level

- Analysis of statewide hospital discharge data for diagnoses related to serious emotional disorders for youth 21 years of age or younger.

The expectation is that the expansion of in-home and community-based services will lead to less reliance on and use of RMHT for youth with mental or behavioral health needs. Key findings from the data collection activities and analyses are outlined below.

1.1 Summary of Key Findings and Recommendations

WV DHHR continues to expand on policies, procedures, and infrastructure to reduce reliance on and use of RMHT when it is clinically feasible to deliver mental and behavioral health services to youth in their homes and communities. Providers, organizations, and facilities reported improvements to workforce capacity, and caregivers and their youth in RMHT are noticing the differences. That said, stakeholders want more—organizations and facilities reported challenges with service coverage and continue to experience difficulties hiring and retaining providers with advanced training and experience, caregivers and youth need more community-based services with higher levels of intensity, and opportunities exist to further engage stakeholders in discharge planning and transitioning youth out of RMHT. Recommendations included in this report focus on actionable strategies to address these and other types of feedback received from different stakeholders to help identify additional ways to continue the great work being done to improve the health and wellbeing of WV youth.

1.1.1 Caregivers and Youth

There are fewer youth in RMHT than in previous years, and overall, the average length of stay in RMHT has gone down. However, youth who completed the Year 2 survey reported slightly longer stays in RMHT than at Baseline. At the time of Year 2 data collection approximately a third of youth were in RMHT between 7 and 12 months, and approximately a quarter for 13 months or more, meaning these youth (and their respective caregivers) might have had little recent exposure to community-based mental and behavioral health services. Therefore, it is understandable that some decreases in awareness and usage were observed in Year 2. Less than half of caregivers and their youth in RMHT in Year 2 had heard of the community-based services included in this Evaluation, with even fewer reporting that youth received them in the last 12 months. Caregivers and youth reported the highest awareness and use of Wraparound and Behavioral Support Services (including Positive Behavior Support) in Year 2, and both felt that these services helped delay youth's placement in RMHT.

Caregivers at Baseline and in Year 2 reported that they have the knowledge necessary to access community-based mental and behavioral health services. Youth at Baseline neither agreed nor disagreed. Importantly, youth in RMHT in Year 2 knew how to access the Children's Crisis and Referral Line (CCRL) and Wraparound, which are arguably two of the most important services that can connect youth and families with immediate, intermediate, and long-term supports.

Caregivers and their youth in RMHT in Year 2 reported an increase in the value of community-based services over time. Even though youth functioning was similar at Baseline and in Year 2, caregivers and youth noticed benefits as a result of receiving mental and behavioral health services, including better school attendance and fewer encounters with police compared to Baseline.

Caregivers value community-based mental and behavioral health services but continued to express the need for more. Several caregivers reported in the surveys and during interviews that RMHT is the "right place" for many of their youth because they are not able to access needed

services in their communities. Caregivers indicated that continued expansion of community-based mental and behavioral health services, especially at higher levels of intensity, should help transition their youth out of RMHT and prevent readmissions in the future. In this sense, community-based mental and behavioral health services were viewed as mechanisms that help sustain the benefits youth gained from RMHT.

Fewer caregivers and youth called the police or went to hospitals to access mental and behavioral health services compared to Baseline; more caregivers and youth are turning to social services and other supports. Youth in RMHT in Year 2 also agreed that they would be able to get mental and behavioral health services outside of a hospital setting if they are needed again in the future, but their caregivers neither agreed nor disagreed.

Caregivers and their youth in RMHT in Year 2 reported improvements in engagement and satisfaction with mental and behavioral health services compared to Baseline. Determinants of caregiver and youth engagement and satisfaction include the need for consistent and high-quality communication with the care team, especially when it comes to treatment and discharge planning, and being able to find services that are right for youth in terms of being individualized and at the right level of intensity. Other facilitators included regularly scheduled treatments and appointments, and access to people who can help advocate for youth, help caregivers stay informed, and help connect youth with needed services. Staff turnover at provider agencies and DHHR, and changes in service availability also emerged as barriers to caregiver and youth treatment engagement. Overall, though, caregivers and youth continued to feel engaged and respected by providers, and there was a considerable increase in youth satisfaction with services compared to Baseline.

1.1.2 Providers

Providers are aligned with DHHR policies and priorities for promoting the use of community-based mental and behavioral health services to delay or reduce the need for RMHT for WV youth. Providers were more aware of and exchanged more referrals with community-based mental and behavioral health services than at Baseline. Providers also had greater capacity to provide mental and behavioral health interventions than last year. However, providers continued to express concerns about having adequate mental and behavioral health services in their counties and regions. Much like caregivers, providers at Baseline and in Year 2 indicated that the need for more community-based services and the clinical needs of youth are among the top contributors to out-of-home placements. When asked about barriers to maximizing their referral networks for youth referred to RMHT, providers reported at Baseline and Year 2 that the top three barriers are: lack of qualified providers in their networks or areas, lack of resources, and lack of information about resources available in the community.

Providers continued to be committed to delivering quality care to WV youth. Providers agreed at Baseline and in Year 2 that they deliver evidence-based practices and indicated that they have the knowledge and skills needed to function in their current roles. At the same time, providers continued to express interest in additional trainings. For example, approximately two thirds of providers reported interest in trainings on the National Wraparound Initiative, and in crisis

response and stabilization, at Baseline and in Year 2. Law enforcement officers and other stakeholders associated with juvenile justice also expressed interest in trainings on how to respond to crisis situations involving youth with mental and behavioral health needs. Lastly, providers recognized that turnover effects the quality of care delivered to WV youth. Providers reported intentions to stay in their current roles and organizations for the foreseeable future. Several providers went so far as to write-in "Appalachian" when asked their race and ethnicity, demonstrating their strong ties to the communities in which they deliver services.

1.1.3 Organizations and Facilities

All mental and behavioral health services included in this Evaluation are available statewide; however, organizations and facilities (hereafter referred to as organizations) continued to report challenges with workforce and capacity. There was a considerable drop in the percentage of organizations that had the capacity to serve all of the youth being referred to them compared to Baseline, and several indicated that it was due to lack of workforce, as well as not offering the services that youth needed.

Service accessibility continued to be a major theme in Year 2. More organizations had waitlists compared to Baseline, and few had other nearby providers to whom they could refer youth. Yet, 65-77% of referrals were exchanged with other organizations in their region; 21-25% exchanged referrals with organizations outside of their regions, and 10-13% with out-of-state organizations, many of which were residential mental health treatment facilities (RMHTFs). Overall, though, fewer organizations exchanged referrals with other stakeholders in Year 2 than at Baseline. It could be that more organizations are referring caregivers and youth to the Assessment Pathway rather than to other provider organizations. Year 3 data collection will further explore referral processes and practices.

Geography plays a role in service accessibility in WV. All services reported some difficulty with providing coverage to all of the counties in their regions. The services that reported the greatest difficulties with coverage included the Children with Serious Emotional Disorders (CSED) Waiver Wraparound, Assertive Community Treatment, and RMHT. Regions 4 and 6 (as defined by the Bureau for Behavioral Health) had the greatest percentage of organizations that reported difficulties. Most of the barriers to providing service coverage were related to staffing, rurality and/or distance to services in some of the larger counties, as well as the need for more psychiatric services.

More organizations had staff with the necessary training and skills in Year 2 than they did at Baseline, but they still need more. Approximately half of the organizations had difficulty hiring and retaining staff in Year 2. Organizations had difficulty hiring and/or retaining therapists, social workers, people with training and/or experience that would qualify for certifications, and people who can work nights and weekends. Strategies for maximizing workforce capacity include joint staffing and supervision, offering fringe benefits such as hybrid work schedules, and the use of conferencing technology to facilitate communication and service delivery.

1.1.4 Additional Key Findings and Recommendations

One additional theme that emerged at Baseline and in Year 2 was the need to ensure that youth have safe and stable home environments. Some youths were removed from their homes or were unable to return to home after RMHT due to unstable or unsafe home environments, for example if their caregivers were using substances. In these situations, system-level stakeholders at Baseline and Year 2 providers recommended individual and family therapy for caregivers and/or other members of the household, in addition to the services needed by youth.

Additional recommendations are offered at the end of each section of the main report. Most of the recommendations were related to one or more of the following topics:

- Continue to expand in-home and community-based mental and behavioral health services at varying levels of intensity.
- Continue to expand the mental and behavioral health system workforce.
- Continued outreach activities focused on awareness of community-based mental and behavioral health services among providers, caregivers, and youth.
- Continue to identify service-specific needs within and across counties and regions.
- Continue to identify stakeholders who can help caregivers and youth navigate the mental and behavioral health system.

1.2 Concluding Summary

When taken together, findings from this Evaluation indicate that mental and behavioral health services are working. There are some youths in RMHT who might be ready to be transitioned back into their homes and communities, and the mental and behavioral health system is making significant improvements to provide services to help with these transitions.

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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
BBH	Bureau of Behavioral Health
BMS	WV Bureau for Medical Services
BSS	Behavioral Support Services
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Assessment of Needs and Strengths
CCRL	Children's Crisis and Referral Line
CMCRS	Children's Mobile Crisis Response and Stabilization
CPS	Child Protective Services
CSED	Children with Serious Emotional Disorders
DO	Doctor of Osteopathic Medicine
ED	Emergency Department
EPSDT	Early and Periodic Screening Diagnostic and Treatment
FAST	Functional Assessment Screening Tool
LPN	Licensed Practical Nurse
MD	Doctor of Medicine
NP	Nurse Practitioner
NWI	National Wraparound Initiative
PA	Physician Assistant
PBS	Positive Behavior Support
PECFAS	Preschool and Early Childhood Functional Scale
PRTF	Psychiatric Residential Treatment Facilities
RN	Registered Nurse
RMHT	Residential Mental Health Treatment
RMHTF	Residential Mental Health Treatment Facility
SOC	System of Care
WV	West Virginia

WV DHHR	West Virginia Department of Health and Human Resources
WVU	West Virginia University

2 Introduction

2.1 Project Overview

The West Virginia Department of Health and Human Resources (WV DHHR) is implementing the Children's In-Home and Community-Based Services Improvement Project to expand and improve services for youth with mental and behavioral health needs. The work to expand in-home and community-based services is focused on the continuum of care within the mental and behavioral health system, with particular emphasis placed on:

- Children's Mobile Crisis Response and Stabilization (CMCRS)
- Children with Serious Emotional Disorders (CSED) Waiver Mobile Response
- CSED Waiver Wraparound
- West Virginia Children's Mental Health Wraparound (WV CMHW)
- Behavioral Support Services (including Positive Behavior Support) which is referred to in this report as Behavioral Support Services (including PBS). This service was referred to as Positive Behavior Support (PBS) at Baseline.
- Assertive Community Treatment (ACT)
- Residential mental health treatment (RMHT)
- Children's Crisis and Referral Line (CCRL; 844-HELP4WV)

The following workgroups were convened to help identify and prioritize specific areas for mental and behavioral health service expansion:

- Executive Steering Committee
- Workgroup Leads
- Pathway to Children's Mental Health Services Workgroup
- Home and Community Based Services Workgroup
- Quality Assurance and Performance Improvement Workgroup
- Outreach and Education to Stakeholders Workgroup
- Workforce Workgroup
- R3 (Reducing Reliance on Residential Services): Model of Care Workgroup
- R3 (Reducing Reliance on Residential Services): Stakeholders Workgroup

2.2 Systems Improvements: Highlights from 2022-2023

With the support of workgroups and partners across the State, DHHR has achieved numerous accomplishments since 2019. Progress has been significant, despite overcoming many adversities associated with responding to a pandemic during the same period of time. The most recent highlights of these accomplishments are as follows.

- Approaches for facilitating access to services:
    - Removed CSED Waiver income limitations to increase eligibility for services.
    - Continued the phased rollout of the Assessment Pathway that helps streamline access to services.
    - Continued the phased rollout of the Qualified Independent Assessment work that started in late 2022. This process helps identify youth needs and provide recommendations for the appropriate level of care in the least restrictive environment using functional assessment scores.
- Approaches for identifying areas of WV with the greatest need:
    - Prioritized provider outreach and support using county-level data to identify areas with few referrals to in-home and community-based mental and behavioral health services and high referral rates to RMHT.
- Approaches for increasing awareness of services:
    - Distributed wallet cards to healthcare providers to give to families at well-child visits. The wallet cards contain information about how to recognize when youth have mental and/or behavioral health needs, and how to contact the Children's Crisis and Referral Line (844-HELP4WV).
    - Implemented the Outreach and Education tracker.
    - Updated the Kids Thrive website. Changes included a separate page for the Resource Rundown as well as additions to the "How Do I" section that contains resources for families.
    - Implemented the Resource Rundown to help improve caregivers' awareness and understanding of available programs and services. The Resource Rundown sessions are weekly, interactive, and held virtually.
- Approaches for expanding services and continuous quality assurance monitoring:
    - Provided ongoing training in Wraparound, including trainings for Wraparound facilitators.
    - Implemented the Performance Improvement Project Team that meets weekly to discuss continuous quality improvement efforts and monitor fidelity to the National Wraparound Initiative.
    - Ongoing certification in Behavioral Support Services (including PBS). Twenty-nine new providers were certified by Concord University in 2022, and additional trainings are planned for 2023.
- Approaches for expanding discharge planning and transitions out of RMHT:
    - Ongoing identification of places that can support continued improvements among youth who just transferred out of RMHT. For example, DHHR has been working to

expand the number of foster homes in WV, especially those willing to take older youth. In 2023 a transitional living model of care will also be implemented, including DHHR's release of an Announcement of Funding Availability for Transitional Living for Vulnerable Youth in Residential Programs for those 17-21 who are in the custody of the Bureau for Social Services.

    - Developed procedures for implementing a monthly reauthorization process for youth in RMHT, including a review of plans for discharge.

- Screening:
    - Updated policies in collaboration with the Bureau for Social Services and Probation Services to incorporate screening of pre-adjudicatory youth when a youth does not currently have a DHHR worker assigned to them and/or when a youth might be a danger to themselves or others. This new policy went into effect November 1, 2022. Quarterly reviews of the screening and referral data will start in early 2023 to assess county-level data and engage chief probation officers in the quality assurance process.
    - Implemented methods for improving data quality and providing technical assistance for screening entities such as Youth Services, Child Protective Services (CPS), HealthCheck, Probation Services, and the Bureau of Juvenile Services.
    - Conducted additional training on electronic referral processes among providers who use HealthCheck and/or the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) tool.

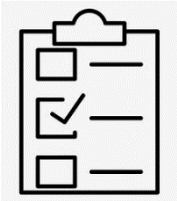
2.2.1 Evaluation Background

WV DHHR engaged West Virginia University Health Affairs Institute in 2020 to conduct an outcomes-focused evaluation of the State's expansion of in-home and community-based mental and behavioral health services for youth 21 years of age or younger (hereafter referred to as the Evaluation). The expansion work was conceptualized as an overall initiative with workgroups driving the service-related components. During the planning phase of the Evaluation (4/15/2020 – 1/15/2021), an Evaluation Plan was developed to provide the overarching Evaluation framework, including evaluation questions that are being assessed at three levels:

- ***Youth- and Family-level:*** an examination of youth with mental and behavioral health needs who are 21 years of age or younger, and their caregivers (i.e., parents and/or legal guardians).
- ***Community- and Provider-level:*** an examination of organizations, providers, and other partners who deliver the continuum of services available as part of the mental and behavioral health system.
- ***System-level:*** an examination of statewide trends and collaborations among system-level stakeholders.

The second phase of the Evaluation (5/1/2021 – 7/31/2022) focused on Baseline data collection. Baseline findings were presented in the System and Community-Level Evaluation Report dated March 31, 2022 (revised June 15, 2022) and the Youth and Family-Level Evaluation Report dated July 29, 2022 (revised September 15, 2022).

The Evaluation is currently in the third phase of work (8/1/2022 - 7/31/2023), which is centered on Year 2 data collection. Evaluation activities for this current report include mixed methods data collection using:



Surveys

Case Series Interviews

Secondary Data Analysis

The quantitative work for this report included updating, administering, and analyzing data from four surveys:

- The Caregiver Survey
  - For methods and development of the Caregiver Survey, see Appendix A.
  - For analytics used to prepare the data tables, see Appendix B.
  - For a list of data tables created for the Caregiver Survey, see Appendix C.
- The Youth Survey
  - For methods and development of the Youth Survey, see Appendix A.
  - For analytics used to prepare the data tables, see Appendix B.
  - For a list of data tables created for the Youth Survey, see Appendix D.
- The Provider Survey
  - For methods and development of the Provider Survey, see Appendix A.
  - For analytics used to prepare the data tables, see Appendix B.
  - For a list of data tables created for the Youth Survey, see Appendix E.
- The Organization and Facility Survey
  - For methods and development of the Organization and Facility Survey, see Appendix A.
  - For analytics used to prepare the data tables, see Appendix B.
  - For a list of data tables created for the Youth Survey, see Appendix F.

Youth were eligible for the Year 2 survey if they were in RMHT on July 1, 2022, and were 21 years of age or younger on this date. Data analyses are currently underway for surveys and case series data collected from youth who are at risk of placement in RMHT; findings from these data collection activities will be presented in a report that will be submitted in October 2023. For this report, the Caregiver Survey was administered to parents and legal guardians of youth in RMHT on July 1, 2022, the Organization and Facility Survey captured perspectives of organizational leaders and administrators of the services of interest, and the Provider Survey captured perspectives of mental and behavioral health service providers, healthcare providers, and other stakeholders who regularly interact with youth with mental and behavioral health needs, such as probation officers and guardians ad litem. Secondary analyses were also conducted on existing administrative data in an effort aimed at data triangulation. Secondary data were from the National Syndromic Surveillance database. The qualitative data included in this report were primarily derived from the case series design, which includes three rounds of interviews with pairs of youth in RMHT and their caregivers. Responses to open-ended survey items were also qualitatively analyzed for this report.

As with any survey methodology, there is a potential for social desirability bias—the tendency for participants to answer questions in ways that will be seen favorably. It is possible that participants may not have felt comfortable sharing negative experiences, especially during one-on-one interviews. However, the findings reported here contain rich, detailed descriptions of a wide range of diverse experiences from youth and caregivers, as well as providers and organizational administrators, indicating that participants were generally forthcoming and shared information honestly.

Additionally, participants that agreed to take part in this Evaluation may be different in some ways from the target population of all youth and caregivers accessing mental and behavioral health services in WV. While care was undertaken to capture representative samples, individuals who participate in research or evaluation studies are typically more likely to identify as female and have higher income and more education. In turn, they may report better mental or behavioral health functioning or achieve greater access to services than those not represented in the data. Additional limitations and mitigation strategies can be found in Appendix B.

The next sections provide overviews of the different levels of assessment, including brief descriptions of data collection methods, analyses, and descriptive findings. Following that, the synthesized quantitative and qualitative findings for the evaluation questions are presented by topic. Finally, the appendices contain detailed information about evaluation questions and indicators, data collection methods and analytics, and profiles that were generated for case series participants.

2.3 Youth- and Family-Level Overview

The purpose of the youth- and family-level assessment is to capture youth and caregivers' awareness of mental and behavioral health services in WV, engagement and participation in services and treatment planning, and youth functioning. Caregiver and youth perspectives were

captured with two statewide surveys and paired caregiver-youth interviews, which are described in more detail below.

2.3.1 Caregiver Survey

The Caregiver Survey was developed to collect information from biological parents, foster parents, kinship care providers, or other types of legal guardians. For the purposes of this report, caregivers were eligible to take this year's survey if one or more of their youths ages 0-21 were in RMHT in WV or other states on July 1, 2022. Participants were contacted using computer-assisted telephone interviewing software and given the option to participate online or via phone. Data were collected between November 4, 2022, and January 13, 2023. There were 180 completed surveys, resulting in an overall response rate of 41.5%.

The Year 2 Caregiver Survey captured caregiver perspectives with a combination of Likert-type scales, multiple choice questions, and open-ended text responses. The Year 2 Caregiver Survey included five distinct scales that measure functioning, service experiences, and treatment outcomes:

- The Caregiver-Youth Functioning Scale that measures caregivers' perceptions of their youth's functioning in daily, social, school, and family life.
- The Caregiver-Access and Satisfaction Scale that measures caregivers' ability to access services and their satisfaction with those services.
- The Caregiver-Social Support Systems Scale that measures caregivers' access and comfort with someone that they can talk to and crisis support.
- The Caregiver-Treatment Participation Scale that measures caregivers' involvement and participation in their child's treatment.
- The Caregiver-Engagement and Respect Scale that measures caregivers' perceptions of experiences with staff and providers specifically related to cultural competence, respect, and communication.

The Year 2 Caregiver Survey was updated to include two additional services: CSED Waiver Mobile Response was added in with Children's Mobile Crisis Response and Stabilization, and CSED Waiver Wraparound was added to WV Children's Mental Health Wraparound to represent "Wraparound" in general. The Caregiver Survey did not ask about CSED Waiver Mobile Response or CSED Waiver Wraparound separately because Baseline data indicated that caregivers and youth do not always identify with the names of services but are generally aware of the types of services that youth receive. There was also the concern that similarities to the other services might cause confusion, and that caregivers might not know the exact funding mechanism behind these services. Therefore, findings from the Year 2 Caregiver Survey are written up as applicable to "Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response" and "Wraparound."

A detailed explanation of the data collection methods for the Caregiver Survey can be found in Appendix A.

2.3.2 Caregiver Survey Respondent Descriptive Findings

The Year 2 sample of 174 caregivers included 143 individuals who identified as female (82%) and 27 individuals who identified as male (16%; 1% preferred not to answer, 2% were missing). The majority of respondents identified as "White" (89%, n=154) and non-Hispanic (93%, n=162). In addition, 11 respondents (6%) described their race as African American/Black and two respondents (1%) described their race as American Indian or Alaska Native (1% other, 4% preferred not to answer, 2% were missing). There was variation in employment status; the greatest percentage (55%) indicated that they were employed/self-employed, 14% reported that they were unable to work, and 10% were retired. Respondents were employed in a variety of professions, with the highest number of respondents employed in healthcare/social care (22%). Most respondents (79%) had a combined household income below $75,000.

Caregivers in the Year 2 sample represented 180 youth who were in RMHT on July 1, 2022. Caregivers reported that most of their youth in RMHT (79%) were between 12-17 years old. Caregivers reported that their youth's stay in RMHT at the time of data collection ranged from 1-13 or more months. Many youths (42%) had received RMHT prior to their most recent enrollment, and 13% had been in RMHT four or more times.

2.3.3 Youth Survey

The purpose of the Year 2 Youth Survey was to collect information from youths 21 years of age or younger. For the purposes of this report, in order to be eligible to take the survey youth had to be in RMHT in WV or other states on July 1st, 2022. Data were collected via teleconference calls and in-person at RMHTFs between November 2, 2022, and February 17, 2023. Caregiver consent to contact youth between the ages of 12-17 was obtained as part of the Caregiver Survey if needed; the Bureau of Social Services provided blanket consent to contact youth between the ages of 12-17 who were considered to be wards of the State. Youth between the ages of 18-21 were able to provide their own consent to participate in the survey as adults. There were 156 completed surveys, for an overall response rate of 24.1%.

The Youth Survey captured youth experiences with a combination of Likert-type scales, multiple choice questions, and open-ended text responses. At Baseline, three distinct scales were developed to measure functioning, satisfaction, and engagement. The Social Support Systems Scale was added to the Year 2 Youth Survey. The four scales in the Year 2 survey were:

- The Youth Functioning Scale that measures youth's perceptions of their functioning in daily, social, school, and family life.
- The Youth-Access and Satisfaction Scale that measures youth's ability to access services and their satisfaction with those services.
- The Youth-Engagement and Respect Scale that measures youth's perceptions of experiences with staff and providers specifically related to cultural competence, respect, and communication.

- The Youth-Social Support Systems Scale that measures youths' access and comfort with someone that they can talk to and crisis support.

The Year 2 Youth Survey was updated to include two additional services: CSED Waiver Mobile Response was added in with Children's Mobile Crisis Response and Stabilization, and CSED Waiver Wraparound was added to WV Children's Mental Health Wraparound to represent "Wraparound" in general. The Youth Survey did not ask about CSED Waiver Mobile Response or CSED Waiver Wraparound separately because Baseline data indicated that caregivers and youth do not always identify with the names of services but are generally aware of the types of services that youth receive. There was also the concern that similarities to the other services might cause confusion, and that caregivers might not know the exact funding mechanism behind these services. Therefore, findings from the Year 2 Youth Survey are written up as applicable to "Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response" and "Wraparound."

A more detailed description of the data collection methods for the Youth Survey can be found in Appendix A.

2.3.4 Youth Survey Respondent Descriptive Findings

The sample of 156 youths in RMHT included 101 respondents (65%) who reported they were assigned male at birth and 52 respondents (33%) reported that they were assigned female at birth (1% preferred not to answer, 1% were missing). Less than forty percent of respondents (37%, n=58) were wards of the State. A majority of the respondents (82%) identified as White. Other races reported by respondents included African American/Black (15%), Native American/Alaska Native (4%), other (4%), Asian American/Asian (3%), and Native Hawaiian/other Pacific Islander (1%). In addition, 19 respondents (12%) identified as Hispanic, Latino/a, or of Spanish origin. Most respondents (63%, n=99) were between 15-17 years old. There were 27 respondents (17%) between the ages of 12-14 and 30 respondents (19%) that were between 18-21 years old. At the time of Year 2 data collection youth reported that they had been in RMHT anywhere from 1-13 or more months, with the highest percentage of respondents (42%) staying in RMHT between 7-12 months. In addition to their most recent stay in RMHT, 33% of youth reported that they had been in RMHT one other time, 21% reported two additional times, 15% reported three additional times, and 26% had been in RMHT four or more times. Of the youth who completed the survey, 125 (80%) were in an RMHTF within WV; 31 (20%) were in RMHTFs outside of WV.

2.3.5 Case Series Youth and Caregiver Interviews

Case series interviews provide an in-depth understanding of youth and family experiences with mental and behavioral health services over time. Semi-structured qualitative interviews were conducted with youth in RMHT and their caregivers at Baseline; follow-up interviews take place every six months for the duration of the Evaluation. Case series participants were recruited purposefully from the surveys to represent different parts of WV. Results from the first round of case series interviews were presented in the Youth and Family-Level Evaluation Report dated July 29, 2022 (revised September 15, 2022).

The current report details the findings from the second and third rounds of case series interviews. The second round of interviews was conducted with 15 participants (eight caregivers, seven youth), including: eight caregivers who identified and were assigned female at birth (100%), all of whom (100%) selected "White" when asked to indicate their race. Their reported relationship to their paired youth included: one biological mother (13%), three adoptive mothers (38%), two biological grandmothers (25%), and two biological grandmothers/adoptive mothers (25%). Three caregivers (38%) reported that they were employed at the time of Year 2 data collection, two (25%) were retired, and three (38%) were unemployed and unable to work. Four caregivers (50%) reported an annual household income above $75,000, and four (50%) below $75,000. There were seven youths interviewed as part of Round 2 case series interviews, five of whom (71%) identified and were assigned male at birth; two were assigned female at birth (28.6%), one of whom identified as male. One youth was between 12-14 years of age, five (71%) were between 15-17 years old, and one was 18 years of age or older. Five youth (71%) identified as "White", one as both white and Native American/Alaskan Native (14%), and one selected "I don't know" (14%). Three youths (43%) were placed in a WV RMHTF, two (29%) in out-of-state RMHTFs, and two (29%) at their caregivers' WV home residences.

The third round of case series interviews included 10 participants: seven caregivers and three youth. Six of the seven caregivers participating in Round 3 interviews identified as and were assigned female at birth (86%) and one identified and assigned male at birth (14%); all identified as White race alone (100%). Their reported relationship to their paired youth included: one biological mother (14.3%), two adoptive mothers (29%), two biological grandmothers (29%), and two biological grandparents/adoptive parents (28.6%). Two caregivers (29%) reported that they were currently employed, two (29%) were retired, and three (43%) were unemployed and/or unable to work. Three caregivers (43%) reported an annual household income above $75,000, and four (57%) below $75,000. There were three youth who participated in Round 3 interviews, two of whom identified as and were assigned male at birth (67%), and one of whom was assigned female at birth and identified as male (33%). One youth was between the ages of 12-14 years old, and two (67%) were between the ages of 15-17 years old. One youth identified as "White", one as both white and Native American/Alaskan Native (33%), and one selected "I don't know" (33%). One was placed in a WV RMHTF (33%), and the other two at out-of-state RMHTF (67%). Please refer to Appendix G for more detailed information.

2.4 Provider- and Community-Level Overview

The purpose of the provider- and community-level assessment is to evaluate:

- Workforce and service capacity among organizations that provide youth mental and behavioral health services.
- Processes and procedures for mental and behavioral health screenings and referrals.
- Coordination and integration of mental and behavioral health services with other stakeholders, such as law enforcement officers, court judges, attorneys, parole officers, and social services case workers, among others working within the continuum of youth mental and behavioral health services in WV.

Provider- and community-level perspectives were collected in Year 2 with two statewide surveys which are described below in more detail.

2.4.1 Provider Survey

The purpose of the Provider Survey was to collect information from individuals who deliver care to youth with mental and behavioral health needs in WV, as well as law enforcement officers and other members of the legal and juvenile justice system. Data was collected by web and phone between November 9th, 2022, and March 7, 2023. There were 1,141 providers who completed surveys for an overall response rate of 16.1%.

The Provider Survey began with a screening question to confirm whether the respondent had interacted with a youth who was experiencing a mental health crisis or had mental health difficulties in the last 12 months. The remainder of the survey contained over 250 items divided into modules that were specific to different types of providers (see more below). Demographic questions, such as age, gender identity, and race/ethnicity were asked of all respondents at the end of the survey, except for law enforcement officers who were not asked to provide demographic information, but instead were asked about their jurisdictions.

The Baseline Provider Survey asked about CSED Waiver services in general. During Baseline data collection, the Assessment Pathway started its phased rollout, and greater emphasis was being placed on two CSED Waiver services in particular: Mobile Response and Wraparound. Therefore, the Year 2 Provider Survey was updated to replace “CSED Waiver” with the two respective services of interest: “CSED Waiver Mobile Response” and “CSED Waiver Wraparound.”

A more detailed explanation of the data collection methods for the Provider Survey is included in Appendix A.

2.4.2 Provider Survey Respondent Descriptive Findings

Provider Survey respondents represented a diverse range of professional roles, including Licensed Social Worker, School Counselor, Case Manager/Case Worker, Counselor, Attorney, Probation Officer, Registered Nurse/Licensed Practical Nurse, Psychologist, Family/General/Internal Medicine Practitioner, Pediatrician/Primary Care Physician/Physician Assistant/Nurse Practitioner, Behavioral Analyst, BJS Treatment Staff, and Psychiatrist. Provider type was self-selected by the respondent, and results may underrepresent certain provider types due to similarities between categories. For example, few survey respondents identified their professional role as Residential Direct Care Staff or Residential Facility Social Workers; this could be due to respondents choosing to identify themselves as a “licensed social worker,” particularly if these individuals split their time in RMHTFs.

With respect to geographic coverage, Provider Survey respondents indicated that they deliver services in all six regions as defined by the Bureau for Behavioral Health (BBH):

- Region 1: 167 providers (17%) and 20 law enforcement officers (12%)
- Region 2: 199 providers (21%) and 38 law enforcement officers (22%)

- Region 3: 188 providers (19%) and 19 law enforcement officers (11%)
- Region 4: 314 providers (32%) and 38 law enforcement officers (22%)
- Region 5: 317 providers (33%) and 45 law enforcement officers (26%)
- Region 6: 105 providers (11%) and 27 law enforcement officers (16%)

Region was missing for 105 providers (11%). See Appendix B for information about how the Region variable was created and assigned to providers.

As previously mentioned, the Provider Survey contained modules that were asked of certain providers depending on the role that they selected at the outset of the survey and the services that they said they offered. The following provides a breakdown of the number and types of providers who responded to each of the modules included in the Year 2 Provider Survey:

- Healthcare Provider Module (n=162)
    - The Healthcare Provider Module was completed by behavior analysts, registered/licensed nurses, nurse practitioners (NPs) or physician assistants (PAs), doctors of medicine (MDs) and doctors of osteopathic medicine (DOs), family medicine practitioners, general medicine practitioners, internal medicine practitioners, psychiatrists, psychologists, RMHT direct care staff, and RMHTF social workers.
    - Some evaluation questions asked for comparisons of mental and behavioral health service providers and "traditional" healthcare providers. When applicable, the "traditional" healthcare providers (referred to in this report as healthcare providers) included registered/licensed nurses, NPs and PAs, MDs and DOs, and family medicine, general medicine, and internal medicine practitioners (n=110).
- Social Service Module (n=714)
    - The Social Services Module was completed by "case managers, caseworkers, and other social service providers," counselors, licensed social workers, school counselors, and educators.
- Probation Officer Module (n=42)
    - The Probation Officer Module was completed by any respondent who selected this as the provider type that best described their current role.
- Attorney and Guardian ad Litem Module (n=50)
    - The Attorney and Guardian ad Litem Module was completed by any person who selected that they were an attorney or designated guardian ad litem for youth.

There were several service-specific modules included in the Provider Survey as well.

- BSS Module (n=40)

        - The BSS Module was nested within the Healthcare Provider and the Social Services Modules and was completed by the 38 providers who indicated at the outset of the survey that they provide Behavioral Support Services (including PBS).
- Wraparound Module (n=332)
    - The Wraparound Module was nested within the Healthcare Provider Module and the Social Services Module and was completed by the 317 providers who indicated at the outset of the survey that they provide CSED Waiver Wraparound or WV Children's Mental Health Wraparound.
- ACT Module (n=40)
    - The ACT Module was nested within the Healthcare Provider Module and the Social Services Module and was completed by the 39 providers who indicated at the outset of the survey that they provide Assertive Community Treatment

2.4.3 Organization and Facility Survey

The purpose of the Organization and Facility Survey was to collect administration, workforce, and referral information from the organizations and facilities that provide behavioral and mental health services to WV youth. Data was collected during a 14-week period starting on November 16, 2022. It is worth noting that the sampling strategy was adjusted in Year 2 to reduce possible redundancies in responses by organizational leaders and administrators from central offices and satellite locations, which reduced the overall sampling frame from 146 organizations at Baseline to 81 in Year 2. There were 56 surveys completed in Year 2, for an overall response rate of 76%.

For the purposes of this report, the term "Organization" will be used to refer to any individual professional responding to the Organization and Facility Survey with information that encompasses an entire service entity. This includes community mental health centers, hospital units, and residential mental health treatment facilities. "Organization" is the term this report will use to discuss the respondents of the Organization and Facility Survey.

Many organizations offer more than one service of interest to this Evaluation. Another change made to the Year 2 survey is that service-specific modules were created to capture potential differences for each mental and behavioral health service offered by each organization. Service-specific survey items asked about the county/counties in which services are offered, what resources are provided as part of the service, staffing and training, and service-specific referrals and coordination.

The Baseline Organization and Facility Survey asked about CSED Waiver services in general. As mentioned, the Assessment Pathway started its phased rollout during Baseline data collection, and greater emphasis was being placed on two CSED Waiver services in particular: Mobile Response and Wraparound. Therefore, as was done with the Provider Survey, the Year 2 Organization and Facility Survey was updated to replace "CSED Waiver" with the two respective services of interest: "CSED Waiver Mobile Response" and "CSED Waiver Wraparound."

Additional details about the collection methods for the Organization and Facility Survey are can be found in Appendix A.

2.4.4 Organization and Facility Respondent Descriptive Findings

Survey respondents indicated that 19 organizations (21%) offered Assertive Community Treatment in Year 2, 25 (27%) offered Children's Mobile Crisis Response and Stabilization, 26 (29%) offered CSED Waiver Mobile Response, 61 (67%) offered Behavioral Support Services (including PBS), 42 (46%) offered RMHT, 14 (15%) offered WV Children's Mental Health Wraparound, and 44 (48%) offered CSED Waiver Wraparound. Survey respondents also indicated that they provide services across all six BBH regions: Region 1 (n=21), Region 2 (n=31), Region 3 (n=26), Region 4 (n=47), Region 5 (n=37), and Region 6 (n=33).

2.5 System-Level Overview

The purpose of the system-level assessment is to capture interactions between youth-serving stakeholders across the WV mental and behavioral health system and provide insights into their collaborative processes and outcomes. For this report, system-level analyses focused on data from the National Syndromic Surveillance Program (NSSP), described in greater detail below.

2.5.1 Secondary Analysis of National Syndromic Surveillance Data

Data from the NSSP was used to assess trends in the utilization of emergency departments by youth 21 years of age or younger to access mental and behavioral health services since the beginning of the in-home and community-based service expansion work. Emergency department visits for mental and behavioral health services were isolated by ICD-10 codes reflecting a mental and/or behavioral health diagnosis. The complete analytic methods used to examine the syndromic data can be found in Appendix B.

The next sections contain findings to address evaluation questions that were grouped by the following topic areas: awareness of services; reducing unnecessary youth placements in RMHT; access to services; workforce capacity, system-level alignment; experiences with services and discharge planning; youth and family status. Each section begins with a list of evaluation questions being addressed, and a summary of findings from that section.

3 Evaluation Results: Awareness of Mental and Behavioral Health Services

3.1 Finding: Overall, provider awareness of mental and behavioral health services increased over time

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has awareness of mental health services for children changed (families, mental health providers, medical providers, DOE staff, courts, police)?
- How has awareness of MH services for children changed among (families, MH providers, medical providers, partner organizations)?
- How has awareness of mental health services for children changed among mental health providers and medical providers?
- How has awareness of mental health services and supports among child-serving mental health professionals changed, including ACT eligibility? (e.g., primary care physicians, juvenile judges and probation, emergency room staff, foster care parents)

Indicators that were identified for each evaluation question are included for reference in Appendix H.

3.1.1 Summary

DHHR continued to reach out to providers to increase their awareness of and to promote referrals to community-based mental and behavioral health services. Data suggest those efforts are working, although provider awareness varied by service and provider type. In Year 2 providers were most aware of the Children's Crisis and Referral Line, Behavioral Support Services (including PBS), WV Children's Mental Health Wraparound, and Children's Mobile Crisis Response and Stabilization. Providers were least aware of Assertive Community Treatment. **The greatest change since Baseline included a 19% increase in provider awareness of the Children's Crisis and Referral Line, a 15% increase in awareness of Children's Mobile Crisis Response and Stabilization, and a 12% increase in awareness of Behavioral Support Services (including PBS).** Similar to Baseline, RMHT social workers and case managers, case workers, and other social service providers were among those most aware of community-based mental and behavioral health services, and healthcare providers were among those least aware. **In general, more providers were aware of high quality mental and behavioral health services that can meet the diverse need of youth than they were at Baseline, and more providers were aware of others who work across the mental and behavioral health system to provide a continuum of care.**

3.1.2 Provider Awareness by Service

The 2023 DHHR Semi-Annual Report described major efforts to provide training and technical assistance to providers to increase awareness of the continuum of community-based services available within the mental and behavioral health system, improve data quality, and help standardize and streamline screenings and assessments. Data suggest those efforts are working, although awareness varies by service and provider type. Service-specific findings were as follows:

3.1.2.1 Children's Mobile Crisis Response and Stabilization

A greater percentage of providers were aware of CMCRS in Year 2 than at Baseline.

- 51% of providers were aware of Children's Mobile Crisis Response and Stabilization at Baseline compared to 66% of providers in Year 2, representing a 15% increase in awareness.
- At Baseline RMHT social workers were the most aware of Children's Mobile Crisis Response and Stabilization (100%) and registered/licensed nurses, attorneys and guardians ad litem, and law enforcement officers were the least aware (0%, 10%, and 11%, respectively).
- In Year 2, the greatest percentage of providers who were aware of Children's Mobile Crisis Response and Stabilization included the single internal medicine practitioner (100%) and case managers, case workers or other social service providers (90%). General medicine and family medicine practitioners were least aware of Children's Mobile Crisis Response and Stabilization in Year 2 (0% and 9% respectively; Appendix E, Services & Programs, Table 3.2).

Targeted efforts have also been made to increase awareness of youth crisis services among law enforcement officers. For example, the 2023 DHHR Semi-Annual Report documented efforts to increase law enforcement officers' awareness and utilization of the Children's Crisis and Referral Line, Children's Mobile Crisis Response and Stabilization, and CSED Waiver Mobile Response services. By working with law enforcement, DHHR is helping to connect families to services right away, and in doing so to help keep youth out of the juvenile justice system when possible. These efforts are likely related to the **7% increase in law enforcement officers' awareness of Children's Mobile Crisis Response and Stabilization and the 5% increase in awareness of how to access Children's Mobile Crisis Response and Stabilization teams compared to Baseline**.

- A greater percentage of law enforcement officers were aware of the Children's Mobile Crisis Response and Stabilization teams in their areas or networks in Year 2 (18%) compared to Baseline (11%; Appendix E, LEOs, Table 12.2).
- Of the law enforcement officers who were aware of Children's Mobile Crisis Response and Stabilization services, 79% at Baseline and 84% in Year 2 were aware of how to access the team their areas or networks. However, few law enforcement officers worked directly with Children's Mobile Crisis Response and Stabilization teams in the 12 months when asked at Baseline and in Year 2 (Appendix E, LEOs, Table 12.2).

Although some improvements have been made compared to Baseline, overall awareness of community-based youth crisis services remains low among law enforcement officers. Law enforcement officers reported that they have received several trainings on how to work with youth in crisis situations, focusing on such topics as autism, emotional intelligence, EMT basic mental health classes, Handle with Care/CPS, and Certified Crisis Negotiation. Nevertheless, many law enforcement officers expressed interest in additional training focused on responding to crisis situations involving youth with mental and behavioral health needs (see Section 4.6 below for more information).

3.1.2.2 Children with Serious Emotional Disorders Waiver Mobile Response (CSED) Waiver Mobile Response

The Baseline Provider Survey captured "CSED Waiver" services in general; the Year 2 Provider Survey asked about specific CSED Waiver services, including CSED Waiver Mobile Response. A similar percentage of providers were aware of CSED Waiver Mobile Response in Year 2 as they were of the Children's Mobile Crisis Response and Stabilization and CSED Waiver services at Baseline.

- At Baseline 51% of providers were aware of Children's Mobile Crisis Response and Stabilization and 51% were aware of the CSED Waiver services. Similarly, 52% of providers were aware of CSED Waiver Mobile Response in Year 2.
- The greatest percentage of providers who were aware of the CSED Waiver services and Children's Mobile Crisis Response and Stabilization at Baseline were RMHT social workers and behavior analysts; among the least aware were psychiatrists and healthcare providers.
- In Year 2, the greatest percentage of providers who were aware of CSED Waiver Mobile Response were case managers, case workers or other social service providers (91%) and family medicine, general medicine, and internal medicine practitioners were least aware (0% respectively; Appendix E, Services & Programs, Table 3.2).

There are several stakeholders, including the Bureau for Behavioral Health (BBH), Bureau for Medical Services (BMS), and The University of Maryland Institute for Innovation and Implementation, who are identifying and considering implementation of national standards across Children's Mobile Crisis Response and Stabilization and CSED Waiver Mobile Response. Related trainings will help further increase provider awareness.

3.1.2.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

The Baseline Provider Survey did not separate out the different services under the CSED Waiver; the Year 2 survey asked about specific CSED Waiver services, including CSED Waiver Wraparound. A greater percentage of providers were aware of CSED Waiver Wraparound in Year 2 than they were of CSED Waiver services at Baseline. A smaller percentage of providers were aware of CSED Waiver Wraparound in Year 2 than they were of WV Children's Mental Health Wraparound at Baseline or in Year 2.

- At Baseline 67% of providers were aware of WV Children's Mental Health Wraparound and 51% were aware of CSED Waiver services in general. More than half of providers (58%) were aware of CSED Waiver Wraparound in Year 2.
- Behavior analysts and licensed social workers were among some of those most aware of WV Children's Mental Health Wraparound and CSED Waiver services at Baseline, and healthcare providers were among some of those least aware.
- The greatest percentage of providers aware of CSED Waiver Wraparound in Year 2 were RMHT social workers (100%) and case managers, case workers or other social service

providers (95%). Family medicine, general medicine, and internal medicine practitioners were least aware (0% respectively; Appendix E, Services & Programs, Table 3.2).

3.1.2.4 WV Children's Mental Health Wraparound

A similar percentage of providers were aware of WV Children's Mental Health Wraparound at Baseline and Year 2.

- 67% of providers were aware of WV Children's Mental Health Wraparound at Baseline and 69% were aware in Year 2.
- At Baseline, RMHT direct care staff and RMHT social workers were the most aware (100%) and registered/licensed nurses, NPs and PAs, and medical doctors were the least aware (0%, 0% and 8%, respectively).
- In Year 2 the greatest percentage of providers who were aware of WV Children's Mental Health Wraparound were psychiatrists and RMHT social workers (100% respectively), and general medicine and internal medicine practitioners were least aware (0% respectively; Appendix E, Services & Programs, Table 3.2).

3.1.2.5 Behavioral Support Services (including Positive Behavior Support; PBS)

A greater percentage of providers were aware of Behavioral Support Services (including PBS) in Year 2 than they were of PBS at Baseline.

- 61% of providers were aware of PBS at Baseline compared to 73% who said they were aware of Behavioral Support Services (including PBS in Year 2.
- At Baseline, RMHT direct care staff, RMHT social workers, and behavioral analysts were the most aware (100%, respectively) and registered/licensed nurses, MDs/DOs and psychiatrists were the least aware (0%, 8% and 11%, respectively).
- In Year 2 the greatest percentage of providers who were aware of Behavioral Support Services (including PBS) were RMHT social workers (100%), and the one internal medicine practitioner was not aware, and pediatricians/primary care physicians were also among the providers who were least aware (15%; Appendix E, Services & Programs, Table 3.2).

3.1.2.6 Assertive Community Treatment

A similar percentage of providers were aware of Assertive Community Treatment at Baseline and in Year 2.

- 17% of providers were aware of Assertive Community Treatment at Baseline, and 21% were aware of Assertive Community Treatment in Year 2.
- At Baseline RMHT social workers were most aware and registered/licensed nurses, NPs and PAs, and RMHT direct care staff were the least aware.
- In Year 2 the greatest percentage of providers who were aware of Assertive Community Treatment were educators (56%) and RMHT direct care staff, NPs and PAs, and general

medicine and internal medicine practitioners were least aware (0% respectively; Appendix E, Services & Programs, Table 3.2).

One point to consider is that Assertive Community Treatment is still a relatively small service that is still in development. The target population for Assertive Community Treatment is 18 years of age or older. At the time of Year 2 data collection, many Assertive Community Treatment service recipients were over the age of 21 and are thus outside of the age range of this Evaluation (0-21). While not expected to directly impact most youth under 21, work is underway to expand Assertive Community Treatment over the next few years so that it is available at all WV community-based health centers. Progress will continue to be documented in this Evaluation.

3.1.2.7 Children's Crisis and Referral Line (CCRL)

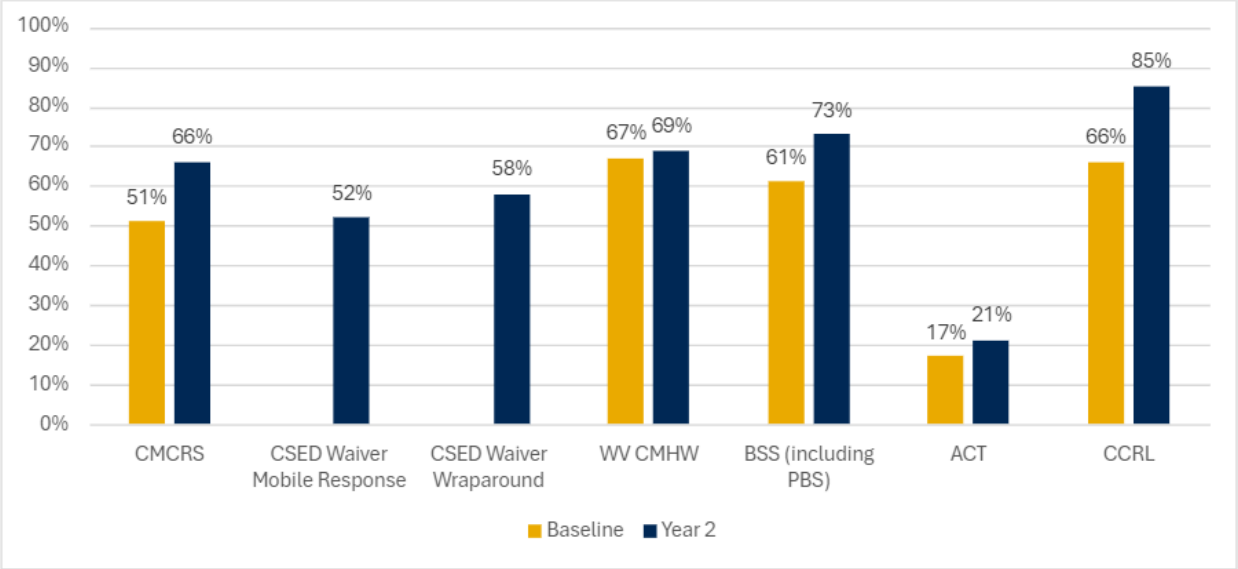
A greater percentage of providers were aware of the CCRL in Year 2 than they were at Baseline.

- 66% of providers were aware of the CCRL at Baseline compared to 85% in Year 2.
- At Baseline RMHT social workers were the most aware (100%) and registered/licensed nurses and RMHT direct care staff were the least aware (0%).
- In Year 2, in addition to the one internal medicine practitioner (100%), the greatest percentage of providers who were aware of the CCRL were RMHT social workers (100%), case managers, case workers or other social service providers (94%) and school counselors (91%); family medicine practitioners were least aware (18%; Appendix E, Services & Programs, Table 3.2).

DHHR has been working to raise awareness of the CCRL, in part because it is a primary means of entry to the Assessment Pathway and to the mental and behavioral health system. Outreach efforts included press releases, meetings with stakeholders, events, billboards, social media posts, summit presentations, wallet cards for providers, and training and education for mental and behavioral health and healthcare providers. Subsequently, an increase in calls to the CCRL has also been observed, as reported in the 2023 DHHR Semi-Annual Report.

To summarize, Year 2 providers were most aware of CCRL, Behavioral Support Services (including PBS), WV Children's Mental Health Wraparound, and Children's Mobile Crisis Response and Stabilization; providers continued to be least aware of Assertive Community Treatment. Figure 1 displays provider awareness by service and year. One caveat to note for Figure 1 is that CSED Waiver Mobile Response and CSED Waiver Wraparound were added to the Year 2 surveys, which is why no Baseline data are available. The Baseline survey asked about CSED Waiver services in general; the Year 2 surveys ask about CSED Waiver Mobile Response and CSED Waiver Wraparound specifically.

Figure 1: Aggregate Provider Awareness by Service and Year



Taken together, the greatest percentage of Year 2 providers were aware of some of the most important community-based services representing different ends of the continuum of community-based mental and behavioral healthcare, in that the CCRL and CMCRS are intended to provide immediate, albeit relatively short-term support such as responding to youth in crises and/or providing information about services, whereas WV Children's Mental Health Wraparound is intended to be a bridge from interim to longer-term supports such as Behavioral Support Services (including PBS).

3.1.3 Provider awareness of high-quality services across the care continuum

Providers differed in their awareness of high-quality mental and behavioral services, in their awareness of a diversity of youth mental and behavioral health services, and in their perceptions that youth service providers are aware of other stakeholders who represent the continuum of youth mental and behavioral health services, with some improvements reported in Year 2. Compared to Baseline, more provider types are moving toward the middle and/or positive end of the survey scales when asked about their awareness of a diversity of high-quality services that represent the continuum of services across the mental and behavioral health system.

More provider types were aware of high-quality mental and behavioral services in Year 2 than at Baseline.

- At Baseline, registered/licensed nurses, RMHT direct care staff, and attorneys and guardians ad litem somewhat disagreed that they were aware of high-quality mental or behavioral health services for youth in their areas, whereas behavior analysts and RMHT social workers agreed, and the remainder of providers neither agreed nor disagreed. These findings did not vary by region.

- In Year 2, family medicine practitioners and attorneys and guardians ad litem somewhat disagreed that they were aware of high-quality mental and behavioral health services for youth in their areas, the one internal medicine practitioner and RMHT social workers somewhat agreed, and the remaining provider types neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.3; Appendix E, Attorneys & GALs, Table 11.1). These findings did not vary by region.

More providers were aware of mental and behavioral services that can meet the diverse needs of youth in WV in Year 2 than at Baseline.

- At Baseline, social service providers and probation officers somewhat agreed that they were aware of services that can meet the diverse needs of youth; court judges, and attorneys and guardians ad litem somewhat disagreed; other providers neither agreed nor disagreed.
- In Year 2, RMHT social workers, the one internal medicine practitioner, social service providers, and probation officers somewhat agreed that they were aware of services that can meet the diverse needs of youth; family medicine practitioners and attorneys/guardians ad litem somewhat disagreed, and the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.3; Appendix E, Social Services & Probation, Table 13.1; Appendix E, Attorneys & GALs, Table 11.1). Juvenile court judge perspectives will be captured again in Year 3.

There was varied agreement about awareness of a continuum of youth-serving mental and behavioral health providers. Providers were asked to respond to a survey item that stated, “I find that service providers are generally aware of other service providers to support a continuum of mental and behavioral healthcare for youth and caregivers." There were fewer provider types that disagreed in Year 2 than there were at Baseline.

- Providers somewhat disagreed at Baseline that service providers are generally aware of other service providers who represent the continuum of youth mental and behavioral health services except for behavioral analysts, and attorneys and guardians ad litem who neither agreed nor disagreed.
- RMHT social workers somewhat agreed, behavioral analysts, registered/licensed nurses, RMHT direct care staff, and attorneys and guardians ad litem neither agreed nor disagreed, and the remaining provider types somewhat disagreed that service providers are generally aware of other service providers who represent a continuum of youth mental and behavioral health services (Appendix E, Referral Policies, Table 8.3; Appendix E, Attorneys & GALs, Table 11.1).

When taken together, it appears that provider outreach and education is working. For example, DHHR has an initiative to distribute wallet cards to healthcare providers. The wallet cards contain information on how to identify youth mental and behavioral health needs and how to access crisis services. Healthcare providers were still among those least aware of community-based mental and behavioral health services in Year 2; however, healthcare providers were generally more

aware of the CCRL than any other community-based mental and behavioral health service. Based on the progress since Baseline, recommendations are included below.

3.1.4 Recommendations

Recommendation: Continue provider outreach, education, and technical support to enhance provider awareness of community-based mental and behavioral health services, especially among healthcare providers.

Recommendation: Consider whether marketing strategies such as branding and standardized service descriptions can increase provider awareness.

Recommendation: Continue to provide training and support to increase law enforcement officers' awareness of and collaborations with community-based mental and behavioral health services.

3.2 Finding: Awareness plays a critical role in youth access to and utilization of mental and behavioral health services.

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has awareness of mental health services for children changed (families, mental health providers, medical providers, DOE staff, courts, police)?
- How has awareness of wraparound services among West Virginians whose children are receiving mental health services changed?
- How has awareness among West Virginians related to availability of mobile crisis services/the mobile crisis hotline changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

3.2.1 Summary

Youth in RMHT were generally more aware of the community-based mental and behavioral health services than their caregivers, at Baseline and in Year 2, whereas caregivers felt more knowledgeable about how to start and use services. That said, findings varied by service. Similar to Baseline, caregivers of youth in RMHT in Year 2 were most aware of Wraparound and least aware of Assertive Community Treatment. Youth in RMHT in Year 2 were most aware of Behavioral Support Services (including PBS) and were also least aware of Assertive Community Treatment. **Caregivers agreed that they had the knowledge to start and use all of the services being evaluated. Youth in RMHT in Year 2 agreed that they had the knowledge to start and use Children's Crisis and Referral Line and Wraparound**, but neither agreed nor disagreed for other services. As mentioned, the Children's Crisis and Referral Line and Wraparound are arguably some of the most important community-based mental and behavioral health services representing different aspects of the mental and behavioral health system. The

Children's Crisis and Referral Line is intended to be an entry point for families, which includes connecting them with immediate but often short-term services, whereas Wraparound represents a bridge from interim to longer-term services; both services are able to connect youth and their families to additional services and supports as needed.

Caregivers and their youth in RMHT continued to report improvements in their understanding of how to access mental and behavioral health services over the last 12 months. Approximately two-thirds of caregivers and half of the youth who reported an increased understanding of how to access services in Year 2 indicated that this knowledge increased their likelihood of using mental and behavioral health services if they are needed again in the future. Most of the caregivers and their youth in RMHT in Year 2 became aware of mental and behavioral health services during encounters with juvenile justice, at school, from DHHR, from their close social network, and from providers. **Teachers, doctors, or other trusted adults in youth lives are also becoming an increasingly important resource to help caregivers recognize if their youth have mental and behavioral health needs**.

Findings from Round 1 and Round 2 interviews with caregivers involved in the case series indicate that most were uncertain and unaware of which services were available to sustainably benefit their youths' unique needs, and/or they did not know where to begin looking for services. However, during Round 3 interviews, **small but important improvements in awareness of available services were reported among youth who had recently returned home from RMHT**.

The greatest changes since Baseline included a 14% decrease in caregivers' awareness of Wraparound and a 7% decrease in youth awareness for Children's Mobile Crisis Response and Stabilization. As reported in greater detail below (see Section 4.5) approximately a third of youth in the Year 2 sample were in RMHT between 7-12 months, and approximately a quarter for 13 months or more, meaning these youth (and their respective caregivers) might have had little recent exposure to community-based mental and behavioral health services, which might explain the observed decreases in awareness compared to Baseline. **Caregivers who were aware of community-based mental and behavioral health services included in this Evaluation agreed that they knew how to start and use them, and little variation was observed over time**. Youth neither agreed nor disagreed that they knew how to start and use the services at Baseline, but as mentioned above, **youth in RMHT in Year 2 agreed that they know how to access the Children's Crisis and Referral Line and Wraparound**.

3.2.2 Caregiver and Youth's General Awareness of Services

DHHR prioritizes outreach to youth and families. The 2023 DHHR Semi-Annual Report described several outreach efforts, including the "Resource Rundown," which are weekly interactive sessions to provide information, answer caregivers' questions, and increase awareness of services and supports. The need for outreach was evident in the survey data: several stakeholders agreed that there is room for improvement in caregivers' awareness of mental and behavioral health services. When asked to indicate their levels of agreement on scales anchored by 1 (Disagree) and 5 (Agree), providers somewhat disagreed at Baseline and in Year 2 that families/caregivers are aware of community-based mental and behavioral health services

available in WV to meet their youth's needs (1.8 respectively; Appendix E, Referral Policies, Table 8.3). Similarly, caregivers neither agreed nor disagreed that they knew which types of mental and behavioral health services were available to help their youth or to provide family support (Appendix C, Crisis Support and Access, Table 2.2). However, when asked at the outset of the survey to name any mental and behavioral health services they had heard of or that were offered to their youth in RMHT in Year 2, caregivers reported that they had heard of a variety of interventions and services including counseling, therapy, medication management/psychiatrist/ PCPs, residential programs, waiver programs, DHHR, crisis services, in-home services, Safe at Home, school-based services, Wraparound, juvenile services (e.g., drug court, youth reporting center), Youth Health, Youth Services, hospital-based services, and many also listed specific facilities and providers. When asked the same question, youth in RMHT in Year 2 mentioned medical care, shelters, detention centers, placements (in- and out-of-state), group homes, therapy, hotlines, phone apps, DHHR, CPS, Safe at Home, and services at school. Yet less than half of caregivers or youth in RMHT indicated that they had heard of any of the community-based mental and behavioral health services included in this Evaluation when they were listed later in the survey.

Many case series participants were uncertain or unaware of appropriate mental and behavioral health services; however, **there were some improvements in awareness of services among caregivers of youth who had returned home from residential treatment in Round 3**. In Round 1, participants frequently did not mention community-based programs or services by name. Overall, perceived service awareness and confidence in service availability were low for youths returning home from RMHT. Caregivers during Round 2 interviews stated, "I'm not familiar with all the services. I don't know what's there. . . I get frustrated too easy, because I don't understand, and I don't know how to cope" (Caregiver, Grandmother) and "The services aren't there. Yeah, there's no services. . . I know that the boy needs help. What kind of help he needs, I don't know because I don't know what's fully available. I know what help he has gotten hasn't helped" (Caregiver, Grandmother). However, during Round 3, some youths were more familiar with services available to them upon discharge and one caregiver stated that she felt more confident finding resources for youth due to her "excellent" DHHR case worker.

3.2.3 Caregiver and Youth Awareness by Service

The following are service-specific findings about caregiver and youth awareness of the services included in this Evaluation. The surveys ask if caregivers and their youth in RMHT had heard of each of the services included in this Evaluation, and if yes, whether they had the knowledge to start and use those services.

3.2.3.1 Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response

Approximately a quarter of caregivers and their youth in RMHT in Year 2 were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response. Little variation in awareness of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response was observed among caregivers and awareness slightly decreased among youth in RMHT in Year 2 compared to Baseline. Caregivers felt that they had the knowledge needed to

start and use Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response at Baseline and in Year 2, but their youth in RMHT neither agreed nor disagreed.

Awareness:

- 27% of caregivers of youth in RMHT at Baseline were aware of Children's Mobile Crisis Response and Stabilization compared to 26% of caregivers who were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.1).
- 32% of youth in RMHT at Baseline were aware of Children's Mobile Crisis Response and Stabilization compared to 25% who were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response in Year 2 (Appendix D, Demographics & Awareness, Table 1.3.1).

Knowledge of how to start and use the service:

Caregivers and youth were asked to rate their level of agreement on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of survey items. **Caregivers agreed that they had the knowledge to start and use Children's Mobile Crisis Response and Stabilization**, whereas their youth in RMHT neither agreed nor disagreed, and little noteworthy variation was observed over time.

- Caregivers of youth in RMHT agreed at Baseline (3.8) and in Year 2 (3.6) that they had the necessary knowledge to start and use Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response (Appendix C, Future Service Needs, Table 7.1).
- Youth in RMHT at Baseline (2.6) and in Year 2 (3.5) neither agreed nor disagreed that they had the necessary knowledge to start and use Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response (Appendix D, Future Service Needs, Table 6.1).

Awareness of Children's Mobile Crisis Response and Stabilization was limited among youth and caregivers across all rounds of the case series interviews. See Appendix G for more information.

3.2.3.2 Wraparound

The Year 2 Caregiver and Youth Surveys ask about "Wraparound" in general but list "CSED Waiver Wraparound" and "West Virginia Children's Mental Health Wraparound" and "Safe at Home" in the service description in case they might be more familiar with one in particular. **More caregivers were aware of Wraparound than any other service included in this Evaluation in Year 2.** However**,** awareness of Wraparound decreased for caregivers between Baseline and Year 2; little variation was observed among their youth in RMHT. This is one of the few exceptions where caregivers reported more awareness of a community-based mental and behavioral health service than their youth. **Caregivers felt that they had the knowledge needed to start and use Wraparound at Baseline and in Year 2, and their youth in RMHT in Year 2 agreed**.

Awareness:

- 52% of caregivers of youth in RMHT were aware of Wraparound at Baseline compared to 38% in Year 2, representing a 14% decrease in awareness (Appendix C, Demographics & Awareness, Table 1.3.1).
- 25% of youth in RMHT at Baseline and 25% of youth in RMHT in Year 2 were aware of Wraparound (Appendix D, Demographics & Awareness, Table 1.3.1).

Knowledge of how to start and use service:

Caregivers and youth were asked to rate their level of agreement on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of survey items. **Caregivers agreed at Baseline and in Year 2 that they had the knowledge to start and use Wraparound; youth in Year 2 also agreed**.

- Caregivers of youth in RMHT agreed at Baseline (3.7) and in Year 2 (3.6) that they had the necessary knowledge to start and use Wraparound (Appendix C, Future Service Needs, Table 7.1).
- Youth in RMHT at Baseline neither agreed nor disagreed (2.6) that they had the necessary knowledge to start and use Wraparound, whereas youth in RMHT in Year 2 agreed (3.6) to having said knowledge (Appendix D, Future Service Needs, Table 6.1).

During the data collection period, DHHR was actively working to update policies to encourage the use of Wraparound to help transition youth out of RMHT and back into their homes and communities. The survey data indicated that caregivers and youth in RMHT were aware of and know how to start and use Wraparound. As reported below, an improved understanding of how to access services increases caregiver and youth intentions to use services in the future. Together these data suggest that caregivers and their youth in RMHT should respond positively to having Wraparound as a central part of discharge planning.

Some participants in the case series referred to Wraparound services as “Safe at Home,” In fact, three caregivers noted receiving “Safe at Home” services while a fourth caregiver (in Round 3) mentioned anticipating using Safe at Home after discharge. This caregiver mentioned being pleased that a potential service was in place but expressed skepticism about its effectiveness due to prior negative service experiences. When asked about awareness of Wraparound during Round 2, one youth said, "Actually, I don't know if I received Wraparound. I just heard my grandma—she always talked about something about—Wraparound this, Wraparound that. So, I thought I received it...” After asking the interviewer what Wraparound entailed and receiving an answer, he responded, “I thought that was Safe at Home...I had Safe at Home" (Youth). This exchange suggests that during Round 2, some families may have been more familiar with the name “Safe at Home” to describe Wraparound services.

During Round 3 interviews, a youth-caregiver pair and another caregiver anticipated using CSED services at RMHTF discharge, but neither appeared to understand what the service entails. One youth believed CSED was like an “in-home therapy program” and his caregiver stated, “They were going to try to set up something called CSED, or something. I don't really understand. I don't know anything about it. I think it's just more in-home services for family therapy. But nothing has

transpired" (Caregiver, Grandmother). The other caregiver that discussed CSED added, "But see, I don't know what CSED is. Nobody has, I mean, I know it's a service. . . it's not clear for me. I feel like I need a little more detail..." (Caregiver, Biological Mother).

3.2.3.3 Behavioral Support Services (including Positive Behavior Support; PBS)

More youth in RMHT in Year 2 were aware of Behavioral Support Services (including PBS) than any other service. Caregivers reported similar levels of awareness as youth in RMHT in Year 2. Little variation in knowledge of how to access Behavioral Support Services (including Positive Behavior Support) was observed over time; caregivers felt that they had the knowledge needed to start and use Behavioral Support Services (including PBS), but their youth in RMHT neither agreed nor disagreed.

Awareness:

Awareness of Behavioral Support Services (including PBS) increased for caregivers in Year 2 compared to Baseline. Little change was observed among youth in RMHT, who reported similar levels of awareness as their caregivers in Year 2.

- 21% of caregivers of youth in RMHT were aware of PBS at Baseline compared to 41% who said they were aware of Behavioral Support Services (including PBS) in Year 2, representing a 20% increase in awareness (Appendix C, Demographics & Awareness, Table 1.3.1).
- 44% of youth in RMHT at Baseline were aware of PBS compared to 42% who were aware of Behavioral Support Services (including PBS) in Year 2 (Appendix D, Demographics & Awareness, Table 1.3.1).

Knowledge of how to start and use the service:

Caregivers and youth were asked to rate their level of agreement on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of survey items. Caregivers agreed and their youth in RMHT neither agreed nor disagreed that they had the knowledge to start and use Behavioral Support Services (including PBS), and little variation was observed over time.

- Caregivers of youth in RMHT agreed at Baseline (3.7) and in Year 2 caregivers (3.8) that they had the necessary knowledge to start and use Behavioral Support Services (including PBS; Appendix C, Future Service Needs, Table 7.1).
- Youth in RMHT at Baseline (2.6) and in Year 2 (3.5) neither agreed nor disagreed that they had the necessary knowledge to start and use Behavioral Support Services (including PBS; Appendix D, Future Service Needs, Table 6.1)

There was no discussion of Behavioral Support Services (including PBS) during case series interviews in Rounds 1, 2, or 3, although half of youth participating in the case series self-reported awareness of Behavioral Support Services (including PBS) in their surveys.

3.2.3.4 Assertive Community Treatment

As noted above, Assertive Community Treatment is a relatively small service, and the target population for Assertive Community Treatment (18+) is at the high end of the youth included in this Evaluation (ages 0 to 21). Therefore, awareness is expected to be somewhat lower than the other community-based services. Awareness slightly decreased for caregivers and their youth in RMHT compared to Baseline. Little variation in self-reported knowledge of how to access Assertive Community Treatment was observed over time; caregivers felt that they had the knowledge needed to start and use Assertive Community Treatment, but their youth in RMHT neither agreed nor disagreed.

Awareness:

- 16% of caregivers of youth in RMHT were aware of Assertive Community Treatment at Baseline compared to 11% in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.1).
- 24% of youth in RMHT at Baseline were aware of Assertive Community Treatment compared to 20% in Year 2 (Appendix D, Demographics and Service Awareness, Table 1.3.1).

Knowledge of how to start and use the service:

Caregivers and youth were asked to rate their level of agreement on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of survey items. There was little variation in self-reported knowledge of how to access Assertive Community Treatment over time.

- Caregivers of youth in RMHT agreed at Baseline (3.7) and in Year 2 (3.9) that they had the necessary knowledge to start and use Assertive Community Treatment (Appendix C, Future Service Needs, Table 7.1).
- Youth in RMHT at Baseline (2.7) and in Year 2 (3.3) neither agreed nor disagreed that they had the necessary knowledge to start and use Assertive Community Treatment (Appendix D, Future Service Needs, Table 6.1).

There was no discussion of Assertive Community Treatment during case series interviews in Rounds 1, 2, or 3. As mentioned, it is expected that knowledge and awareness is lower for Assertive Community Treatment than other services due to the difference in age range of target populations. There are efforts to continue to expand Assertive Community Treatment over the next few years, so that it is available at all WV community-based health centers, which will increase availability for older youth and young adults who are transitioning out of RMHT and would be eligible for this service.

3.2.3.5 Residential Mental Health Treatment (RMHT)

This report includes data for youth in RMHT and their caregivers; however, Baseline data indicated that caregivers and youth were more likely to identify where youth received services (e.g., Chestnut Ridge) but they did not always know the services or interventions that youth

received (e.g., “residential mental health treatment”). In Year 2, increases in awareness were observed for both groups, but youth remained more aware of RMHT than their caregivers.

Awareness:

- 67% of caregivers had “heard of” RMHT at Baseline compared to 76% in Year 2, representing a 9% increase in awareness (Appendix C, Demographics & Awareness, Table 1.3.1).
- 87% of youth had “heard of” RMHT at Baseline compared to 94% in Year 2, representing a 7% increase (Appendix D, Demographics & Awareness, Table 1.3.1).

While awareness of RMHT increased, there are still some gaps that are likely related to the nomenclature—not all caregivers identify with the terminology of “residential treatment.”

3.2.3.6 Children’s Crisis and Referral Line (CCRL)

Caregivers and youth in RMHT reported little variation in their awareness of the CCRL compared to Baseline. Approximately a quarter of caregivers and a third of their youth in RMHT are aware of the CCRL. Caregivers felt that they had the knowledge needed to start and use the CCRL at Baseline and in Year 2, and their youth in RMHT in Year 2 agreed.

Awareness:

- 24% of caregivers of youth in RMHT were aware of the CCRL at Baseline compared to 25% in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.1).
- 35% of youth in RMHT at Baseline were aware of the CCRL compared to 32% in Year 2 (Appendix D, Demographics & Awareness, Table 1.3.1).

During case series interviews, participants who expressed a lack of awareness of services and/or social support were offered resources. There were at least two instances during Round 2 and another two in Round 3 where caregivers were offered information about 844-HELP4WV.

Knowledge of how to start and use the service:

Youth reported improvements in their knowledge of how to start and use services compared to Baseline. When asked to rate their level of agreement on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), caregivers and their youth in RMHT reported the following:

- Caregivers of youth in RMHT agreed Baseline (4.0) and in Year 2 (3.8) that they had the necessary knowledge to start and use the CCRL (Appendix C, Future Service Needs, Table 7.1).
- Youth in RMHT at Baseline neither agreed nor disagreed (2.8) that they had the necessary knowledge to start and use the CCRL, whereas youth in RMHT in Year 2 agreed (3.7) with having said knowledge (Appendix D, Future Service Needs, Table 6.1).

3.2.4 Caregiver and Youth Understanding of How to Access Services

Awareness varied over time and somewhat differently for caregivers and their youth across different services. The survey also asked caregivers whether caregivers felt like their understanding of how to start and use services changed over the last 12 months, and this was added to the Year 2 Youth Survey. **Approximately half of the caregivers and 59% of their youth in RMHT in Year 2 reported improved understanding of how to access services over the last 12 months. Two thirds of caregivers and approximately half of youth who reported an increased understanding of how to access mental and behavioral health services in Year 2 indicated that this knowledge increased their likelihood of using mental and behavioral services if they are needed again in the future.**

Improved understanding:

- 47% of caregivers of youth in RMHT at Baseline reported improved understanding of how to access mental and behavioral health services over the 12 months, compared to 42% in Year 2 (Appendix C, Crisis Support and Access, Table 2.3).
- 59% of youth in RMHT in Year 2 reported an improved understanding of how to access mental and behavioral health services over the last 12 months (Appendix D, Experiences with Mental Health, Table 2.6).

No change:

- 46% of caregivers of youth in RMHT at Baseline and 44% in Year 2 reported no change in their understanding of how to access services (Appendix C, Crisis Support and Access, Table 2.3).
- 34% of youth in RMHT in Year 2 reported no change in their understanding of how to access mental and behavioral health services over the last 12 months (Appendix D, Experiences with Mental Health, Table 2.6).

Less understanding:

- 11% of caregivers of youth in RMHT at Baseline and 6% in Year 2 reported that their understanding of how to access services got worse over the last 12 months (Appendix C, Crisis Support and Access, Table 2.3).
- 3% of youth in RMHT in Year 2 reported that their understanding of how to access services got worse over the next 12 months (Appendix D, Experiences with Mental Health, Table 2.6).

Caregivers and youth who reported that their understanding of how to access services improved over the last 12 months received a follow-up question about likelihood of using services again in the future**. Caregivers of 55% of youth in RMHT at Baseline and caregivers of 67% of youth in RMHT in Year 2 reported that their improved understanding of how to access services increased their likelihood of using services if their youth needed them again in the future** (Appendix C, Crisis Support and Access, Table 2.3). **Similarly, of the youth in RMHT in Year 2 who had improved understanding of how to access services, 54% reported an increased**

likelihood of using services again if they are needed in the future (Appendix D, Experiences with Mental Health, Table 2.6).

3.2.5 How Caregivers and Youth Heard About Services

Teachers, doctors, or other trusted adults who are in youth lives are becoming an increasingly important resource for accessing services, especially when it comes to recognizing that youth have mental and/or behavioral health needs. Specifically:

- Caregivers of 33% of youth in RMHT at Baseline and caregivers of 59% of youth in RMHT in Year 2 had a teacher, doctor, or other trusted adult in their youth's life recognize that the youth needed help (Appendix C, Crisis Support and Access, Table 2.1).
- Caregivers of 34% of youth in RMHT at Baseline and caregivers of 39% of youth in RMHT in Year 2 had a teacher, doctor, or trusted adult in their youth's life request that the county/State intervene to help them (Appendix C, Crisis Support and Access, Table 2.1).

To help inform future outreach to families, the Year 2 surveys also asked caregivers and youth how they found out about mental and behavioral health services (Appendix C, Demographics & Awareness, Table 1.5; Appendix D, Demographics & Awareness, Table 1.5). Table 1 displays the percentage of caregivers and youth who heard about services from the sources listed in the Year 2 surveys.

Table 1: Sources by Which Caregivers and Youth Heard About Mental and Behavioral Health Services

Information Source	Caregivers (n=174)	Youth (n=156)
Referred by a doctor	20%	13%
Radio	0%	2%
Television	0%	3%
Internet	6%	5%
CCRL (844-HELP4WV)	0%	0%
A friend	5%	4%
From their youth	0%	-
From their caregiver	-	19%
Do not remember	13%	13%
Other	64%	43%

The greatest percentage of caregivers and their youth in RMHT found out about services from sources "other" than what was listed in the surveys. Caregivers and youth wrote in responses that included the judicial system (such as court, probation officers), school (e.g., teachers, school officials), system-level stakeholders (e.g., DHHR, CPS, caseworkers), social networks (e.g., friends and family), and providers. Caregivers also mentioned that they heard about services as part of their personal experiences. Youth also wrote in foster care. When asked what information would be useful to enable them to start and use services, write-in responses from caregivers suggest that greater awareness of the different services (such as relevant contact information or details on the specific programs offered) and increased responsiveness from the services (such as responding to phone calls in a timely manner) would be beneficial. Youth were not certain and reported primarily wanting more information on services in general either through internet searches or knowledgeable individuals.

3.2.6 Recommendations

Recommendation: Consider targeted outreach for the Children's Crisis and Referral Line and Wraparound to help ensure that families are aware of support mechanisms that can connect them with short- intermediate- and longer-term mental and behavioral health services, especially those intended to help transition youth out of RMHT and back into their homes and communities. Some marketing took place in 2022, although the timing of data collection was likely too early to detect changes.

Recommendation: Consider how the three Wraparound programs (CSED Waiver Wraparound, BBH's WV Children's Mental Health Wraparound, and the Bureau for Social Services' Safe at Home) are marketed. The Baseline report noted several instances where providers and caregivers knew "Safe at Home" but did not always associate it with "Wraparound." Consistent branding might help increase awareness.

Recommendation: Increased understanding of how to access services increases the likelihood of using services again if they are needed in the future, demonstrating the importance of outreach and promotion efforts targeting caregivers and youth. Given that caregivers and youth often hear about services from stakeholders in the mental and behavioral health system (e.g., juvenile justice, CPS, providers), consider initiatives targeting providers, such as the wallet card initiative among healthcare providers, as a route to increase caregiver and youth awareness of mental and behavioral health services.

Recommendation: Consider how to market specific interventions that youth and/or caregivers might get separately, and other interventions that might provide resources to the entire family. At Baseline and in Year 2 stakeholders from across the mental and behavioral health system indicated that youth and their caregivers and/or other members of their households might benefit from mental and behavioral health services. Youth and family access to high-quality services before, during, and after RMHT helps ensure that families have the support they need, and that youth have safe environments to return to.

4 Evaluation Results: Reducing Unnecessary Placement in RMHT

Finding: Many providers are aware of policies and procedures for promoting the use of in-home and community-based mental and behavioral health services to reduce reliance on RMHT

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has the philosophy toward the use of community-based services changed among youth/caregivers, providers, and partner organizations (understanding the continuum of services)?
- How has the philosophy toward community-based services (including residential) changed among residential mental health treatment facility staff? (understanding the continuum of services)
- How has the philosophy toward community-based services (including residential) changed among stakeholders? (understanding the continuum of services)
- How engaged are stakeholders with DHHR bureaus and mental health programs?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

4.1.1 Summary

Many providers reported awareness that DHHR prioritizes in-home and community-based services and felt that their organizational policies and procedures are in alignment. Providers seem willing to utilize community-based mental and behavioral health services to avoid unnecessary out-of-home placements, but reported several important factors that affect these placements, including a lack of community-based services, lack of parental capacity, unstable or unsafe home environments, and the need for supports to help ensure that necessary follow ups for courses of treatment are taking place. Providers also indicated that RMHT is sometimes necessary, due to clinical necessity and/or when youth have unique needs that cannot be met in other service settings. Participants in the case series agreed with providers' reported philosophy toward RMHT.

4.1.2 Provider Perspectives on Policies for Supporting Youth with Mental and Behavioral Health Needs

The Provider Survey asks about awareness of DHHR policies and procedures for supporting youth with mental and behavioral health needs. A series of survey items asked providers to indicate their levels of agreement on scales that ranged from 1 (Disagree) to 5 (Agree), and findings were as follows:

Mental and behavioral health and healthcare providers somewhat agreed that DHHR prioritizes in-home and community-based care over out-of-home placement when youth might be better served at home.

- Mental and behavioral health and healthcare providers at Baseline (3.6) and in Year 2 (3.6) somewhat agreed statewide, but level of agreement varied by provider type.
    - At Baseline, behavior analysts, MDs/DOs, psychiatrists, and psychologists somewhat agreed, licensed/registered nurses neither agreed nor disagreed, RMHT direct care staff and RMHT social workers somewhat disagreed, and the registered/licensed nurse disagreed.
    - In Year 2 family medicine practitioners, psychiatrists, and RMHT direct care staff neither agreed nor disagreed; the remaining mental and behavioral health and healthcare providers somewhat agreed (Appendix E, Referral Policies, Table 8.1.2).

Social service providers and probation officers somewhat agreed that DHHR prioritizes in-home and community-based services over out-of-home placements when youth might be better served at home.

- The statewide average level of agreement at Baseline was 3.9 and in Year 2 it was 3.8; however, level of agreement varies by provider type.

- At Baseline all social service providers and probation officers somewhat agreed.
- In Year 2, case managers, case workers, and other social service providers, licensed social workers, and probation officers somewhat agreed; counselors, school counselors, and educators neither agreed nor disagreed (Appendix E, Social Services & Probation, Table 13.1).

DHHR's prioritization of in-home and community-based care is evident in their policies and procedures, and providers somewhat agree that these policies and procedures help them support this mission. Specifically, providers at Baseline and in Year 2 somewhat agreed that policies and procedures for coordinating care with DHHR partner agencies promote in-home and community-based care over out-of-home placements when youth could be better served at home, although level of agreement varied by provider type.

- Mental and behavioral health and healthcare providers somewhat agreed that policies and procedures for coordinating care with DHHR partner agencies promote in-home and community-based care over out-of-home placements when youth could be better served at home, and little variation in the means were observed over time: the statewide average level of agreement was 3.6 at Baseline and 3.6 in Year 2 respectively.
    - At Baseline behavior analysts, NPs and PAs, MDs/DOs, psychiatrists, and psychologists somewhat agreed, whereas registered/licensed nurses disagreed, RMHT direct care staff somewhat disagreed, and RMHT social workers neither agreed nor disagreed.
    - In Year 2, behavior analysts, NPs and PAs, psychologists, and RMHT direct care staff somewhat agreed, whereas the remaining provider types neither agreed nor disagreed, indicating change toward the middle and positive ends of the scale (i.e., no providers disagreed; Appendix E, Referral Policies, Table 8.1.2).

DHHR is also working to increase awareness of their priorities, policies, and procedures among stakeholders associated with the juvenile justice system. Survey data indicated that there is some room for improvement with regard to the clarity and dissemination of policies and procedures for juvenile justice partners who interact with youth with mental and behavioral health needs.

- 21% of law enforcement officers indicated in the Year 2 survey that they received protocols for responding to calls involving youth experiencing an acute mental health crisis (Appendix E, LEOs, Table 12.3).
- Attorneys/guardians ad litem neither agreed nor disagreed (2.4) at Baseline and in Year 2 (2.8) that the protocols for working with youth with mental and behavioral health needs are clear (Appendix E, Attorneys & GALs, Table 11.1).
- Probation officers, on the other hand, neither agreed nor disagreed at Baseline (3.5) but somewhat agreed in Year 2 (3.7) that there are clear protocols for interacting with youth with mental and behavioral health needs (Appendix E, Social Services & Probation, Table 13.1).

Most community-based provider organizations have policies that align with DHHR priorities. For example, most providers disagreed that organizational policies contribute to out-of-home placements.

- Mental and behavioral health and healthcare providers somewhat disagreed that their organization's policies or regulations contribute to out-of-home placements when the youth would be better served at home. The statewide average level of agreement was 2.0 at Baseline and in Year 2 the average level of agreement was 2.3.
    - At Baseline MDs/DOs neither agreed nor disagreed and the remaining provider types disagreed.
    - In Year 2 psychiatrists and RMHT social workers disagreed, behavior analysts, NPs and PAs, the internal medicine practitioner, psychologists, and RMHT direct care staff somewhat disagreed, and the remaining provider types neither agreed nor disagreed (Appendix E, Out-of-Home Placements, Table 9.1).
- Providers somewhat agreed at Baseline (4.5) and in Year 2 (4.4) that their organization encourages collaboration with other youth-serving organizations, and little variation was observed among provider types over time (Appendix E, Social Services & Probation, Table 13.1).

Given the role of Medicaid and the CSED Waiver in facilitating access to mental and behavioral health services, it was expected that providers would have some awareness of BMS's policies for delivering services to youth with mental and behavioral health needs. Survey data indicated that mental and behavioral health and healthcare providers varied in their awareness of BMS's policies at Baseline and in Year 2.

- Mental and behavioral health and healthcare providers neither agreed nor disagreed that they were aware of BMS's policies for delivering mental and behavioral health services to youth, and little variation was observed over time. The statewide average level of agreement at Baseline was 3.2 and the statewide average level of agreement in Year 2 was 2.8 but the distribution of responses varied by provider type.
    - At Baseline, behavior analysts and RMHT social workers agreed that they were aware of BMS's policies for delivering mental and behavioral health services to youth, whereas NPs and PAs and psychologists somewhat disagreed, and RMHT direct care staff disagreed; the remaining neither agreed nor disagreed. The providers who were aware of BMS policies somewhat agreed that these policies are understandable (4.1) but neither agreed nor disagreed that BMS policies make it easy to coordinate care (3.5).
    - In Year 2, RMHT social workers agreed and psychiatrists somewhat agreed that they were aware of BMS's policies for delivering mental and behavioral health services to youth. The one internal medicine practitioner disagreed, and registered/licensed nurses, NPs and PAs, and family medicine and general medicine practitioners somewhat disagreed; the remaining providers neither

agreed nor disagreed. The providers who were aware of BMS policies reported similar levels of agreement in Year 2 as they did at Baseline in that they somewhat agreed that these policies are understandable (4.2) but neither agreed nor disagreed that BMS policies make it easy to coordinate care (3.4; Appendix E, Referral Policies, Table 8.1.1).

4.1.3 Providers' Philosophy Toward Referring Youth to Community-Based Services

Providers agree with the philosophy that referring youth to community-based mental and behavioral health services can help supplement or replace RMHT, but felt that more supporting processes, policies, services, and resources are needed. For example, approximately 70% of Year 2 providers who had heard of the mental and behavioral health services of interest indicated that they (the services) need more resources (Appendix E, Services & Programs, Table 3.2.1).

Providers were asked to report on factors that contribute to out-of-home placements when youth might be better served in their homes and communities. Providers agreed at Baseline and in Year 2 that the top four contributors to out-of-home placements were:

- Lack of community-based services
- Lack of parental capacity
- Clinical necessity
- The unique needs of youth that could not be met in other service settings

Providers wrote in additional reasons why youth might be placed out of the home, and two themes emerged when qualitatively analyzed:

- Concerns about the capacity of the system; namely the lack of local providers and limited community resources and services.
- Family considerations, such as caregivers' lack of treatment engagement, unstable/unsafe home environments, and/or caregiver substance use.

Additional reasons included financial issues (e.g., a lack of funding for foster care services) and accountability (e.g., judges not enforcing timelines, lack of CPS case management and follow-through, low youth engagement).

Case series participants report similar perspectives and experiences as providers and felt that the philosophy around community-based mental and behavioral health services did not appear to change over time. Many caregivers agreed that RMHT was the right fit for their youth given the intensity of their needs, even knowing the difficulties inherent to residential placement, such as difficulties with communication, engagement, and physical distance. However, caregivers also reported that the benefits of RMHT are sometimes only temporary when there are few community-based mental and behavioral health services to provide the structure needed to successfully transition out of RMHT and back into their homes and communities.

4.1.4 Recommendations

Recommendation: Continue to offer provider training and education on State policies and procedures for supporting youth with mental and behavioral health needs. DHHR is actively working with the Bureau of Juvenile Services, Child Protective Services, and probation officers, but opportunities exist to expand support for attorneys and guardians ad litem, and law enforcement officers.

Recommendation: Continue to monitor factors that contribute to unnecessary out-of-home placements. For example, providers reported the same top four contributors to out-of-home placements at Baseline and in Year 2. DHHR is already working toward the top contributor by expanding the availability of diverse community-based mental and behavioral services across the state. The second contributor was lack of parental capacity, which might be addressed with youth- and family-level support. Sections 8.1 and 8.2 also provide additional details about caregiver and youth needs and preferences for engagement and support. The third and fourth contributors to out-of-home placements highlight the importance of determining which youth are eligible for RMHT, when, for how long, and where can they receive the right level of intensity of services, which is discussed in greater detail in Section 4.2 below.

4.2 Finding: DHHR has recommended and implemented screenings and assessments that help ensure that fewer youth are unnecessarily placed in RMHT and that more youth are transitioned back into their homes and community when it was clinically appropriate to do so

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- Did fewer children with serious mental health conditions unnecessarily enter residential mental health treatment facilities or Psychiatric Residential Treatment Facility after May 2019?
- What proportion of children with serious mental health conditions who had been placed in residential mental health treatment facilities or Psychiatric Residential Treatment Facilities by May 14, 2019 were transitioned back to family homes?
- Were fewer children with serious mental health conditions needlessly removed from their family homes since May 2019?
- What proportion of children were appropriately assessed and placed in residential mental health treatment facilities or Psychiatric Residential Treatment Facility?
- How has the acceptance of community-based mental health treatment (for ACT) as an alternative to residential mental health treatment facility placement changed?
- How have the quality and timeliness of mental health assessments/screenings changed

- How routinely are standardized and approved assessments used by Mobile Crisis services?
- What percentage of Medicaid children not presenting with a MH issues, received a MH screening annually?
- How has the quality and timeliness of CANS assessment for the Wraparound program changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

4.2.1 Summary

There are fewer youth in RMHT than in previous years. Routine screenings and assessments help ensure that the right level of care is determined for each youth. DHHR is promoting the use of the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Scale (PECFAS) to determine eligibility for RMHT. The 2023 DHHR Semi-Annual Report indicated that 80% of youth in RMHT with available CAFAS/PECFAS data meet eligibility criteria for this level of support.

The greatest percentage of organizations and providers reported using Child and Adolescent Needs (CANS) assessment, which is a robust tool for matching youth needs with available services and supports. The quality and timeliness of CANS continues to be a priority for DHHR, as can be seen with efforts to train providers to meet certain fidelity standards when using the CANS, and in the ongoing development and expansion of the WV CANS system.

4.2.2 Number of youths in RMHT

The 2023 DHHR Semi-Annual Report indicates that there are fewer youths in RMHT than in previous years. The 2022 DHHR Semi-Annual Report indicated that there were 1,019 youth in RMHT in May 2019. The 2023 DHHR Semi-Annual Report indicated that as of October 1, 2022, there were a total of 757 youth residing in RMHTFs (508 in-state placements, 249 out-of-state placements), representing a reduction of more than 250 youths.

4.2.3 Screenings and Assessments

Screenings and assessments are a key component of the mental and behavioral health system. They provide an indication of the appropriate level and intensity of services for youth based on a range of factors, including youth functioning, needs, and strengths. Many providers reported at Baseline that they feel comfortable conducting screenings and assessments. At Baseline, 83% of providers felt somewhat or very competent at conducting mental health screenings, and 86% felt somewhat or very competent at conducting mental health assessments. This section provides a snapshot of screening and assessment utilization and practices by organizations and providers, including tools recommended by DHHR for use in determining appropriateness of community-based mental and behavioral health services and/or RMHT.

The Child and Adolescent Functional Assessment Scale and the Preschool and Early Childhood Functional Assessment Scale (CAFAS or PECFAS):

DHHR promotes the use of the CAFAS or PECFAS to determine youth functioning and need for RMHT, which largely happens in social service settings. Based on the standardization of the CAFAS or PECFAS as tools for determining youth eligibility for RMHT, additional items were added to this year's surveys that asked organizations and providers about the use of specific screening and assessment tools. **Many RMHTFs and their staff reported using the CAFAS and/or PECFAS**.

- 41% of mental and behavioral health organizations captured in Year 2 reported using the CAFAS or PECFAS (Appendix F, Background, Table 1.5).
- The greatest percentage that used CAFAS or PECFAS were RMHTFs (61%), and the smallest percentage were WV Children's Mental Health Wraparound organizations and facilities (0%; Appendix F, Background, Table 1.5).
- Across all providers in Year 2, 10% reported using the CAFAS or PECFAS. This included social service as well as other provider types, such as healthcare providers and attorneys who would not be likely to use these tools as part of determining functioning and need for RMHT. Overall, the same percentage of mental and behavioral health and healthcare providers reported using CAFAS or PECFAS as did social service providers. The greatest percentage who used CAFAS or PECFAS were RMHT social workers (50%; Appendix E, Services and Programs, Tables 3.1.1 and 3.1.2).

While there is agreement that community-based mental and behavioral health services are prioritized, there is recognition across the system that some youth require intensive out-of-home supports such as RMHT. As reported in Section 4.1, providers and case series participants agreed at Baseline and in Year 2 that youth are often appropriately placed in out-of-home settings due to clinical necessity and the unique needs of youth that could not be met in other service settings. DHHR considers youth who score a 90 or above on the CAFAS or PECFAS as having severe impairments that typically require intensive supports such as RMHT. Youth with CAFAS or PECFAS scores under 90 tend to have less intensive needs that might be met in their homes and communities, if services and supports are available and accessible. For those youth in RMHT with available assessment data, DHHR found that 80% had a CAFAS or PECFAS of 90 or above.

- DHHR's 2023 Semi-Annual Report indicated that as of October 2022, 150 of the 757 youth in RMHT (20%) had a CAFAS or PECFAS under 90, indicating higher functioning and potential readiness for discharge. Importantly, approximately 70% of these youth had a CAFAS or PECFAS scores within the 60-80 range, indicating that some intensive services and supports might still be needed.

Additional analyses using CAFAS or PECFAS scores are anticipated for next year's report.

DHHR is helping to ensure that fewer higher functioning youth enter RMHT and that more higher functioning youth in RMHT return back to their homes and communities when it is clinically safe

to do so. DHHR's commitment to collecting more screening and assessment data and their efforts to update policies requiring early and ongoing assessments will help achieve this goal.

The Child and Adolescent Needs and Strengths (CANS) Assessment:

The CANS assessment is one of the most popular and robust tools for identifying and matching services to youth's specific needs and strengths. The CANS assessment is a main component of the National Wraparound Initiative, which continues to be an integral part of the mental and behavioral health system in WV. In fact, **more organizations and providers reported using the CANS assessments than any other type of assessment included in the Year 2 surveys:**

- 49% of Year 2 organizations reported using the CANS (Appendix F, Background, Table 1.5).
    - The greatest percentage that used CANS were organizations that offered CSED Waiver Mobile Response in Year 2 (71%), and smallest percentage were organizations that offered Assertive Community Treatment in Year 2 (20%; Appendix F, Background, Table 1.5).
- 27% of Year 2 providers use CANS (Appendix E, Services and Programs, Tables 3.1.1 and 3.1.2).
    - A greater percentage of social service providers reported using CANS (30%) than mental and behavioral health and healthcare providers (11%).
    - The greatest percentage of providers who used CANS were RMHT social workers (100%; Appendix E, Services and Programs, Tables 3.1.1 and 3.1.2).

Marshall University is collecting and analyzing data on the quality and timeliness of CANS assessments. Marshall University's 2022 WV Wraparound Fidelity Review provided evidence of the quality and timeliness of CANS for youth receiving WV Children's Mental Health Wraparound, CSED Waiver Wraparound, or as part of Safe at Home. Findings indicated that **most Wraparound facilitators (91%) have been certified in CANS, which helps ensure that certain quality standards are being met**. Therefore, it was expected that a high number of organizations that offer Wraparound would use the CANS assessment. Three of the five organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to the survey. Only one of the three organizations that offered WV Children's Mental Health Wraparound (33%) reported using the CANS assessment. A similar percentage of organizations that offered CSED Waiver Wraparound in Year 2 (27%) also reported using the CANS assessment.

Data from the WV CANS system also indicate that **CANS assessments are being conducted in a timely manner**, in that 84% of newly enrolled youth had a CANS assessment conducted within the last 30 days, according to Marshall University. This includes new enrollments in Wraparound, CSED Waiver services, PBS, school-based programs that are outside of this Evaluation such as Expanded School Mental Health, and some new placements in RMHT. The number and types of providers who report CANS data in the WV CANS system continues to expand, and the quality, timeliness, and change in CANS scores within and across different services in this Evaluation will be included in future reports, as they become available.

Providers across the state use screening and assessment tools other than the CAFAS, PECFAS, or CANS. Data from the Year 2 Organization and Facility Survey and the Year 2 Provider Survey indicated that use of screening and assessment tools varies by service and stakeholder. Utilization of selected tools are reported below (for the full list of tools see Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2; Appendix F, Background, Table 1.5).

HealthCheck / The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Tool:

- 21% of Year 2 healthcare providers use the EPSDT tool.
    - As expected, the greatest percentage who used the EPSDT were MDs/DOs (70%; Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2).

Family Advocacy and Support Tool (FAST):

- 11% of Year 2 organizations reported using the FAST (Appendix F, Background, Table 1.5).
    - Three services reported using FAST, CSED Waiver Wraparound (13%), RMHTFs (11%), and Behavioral Support Services (including PBS, 9%; Appendix F, Background, Table 1.5).
- 11% of Year 2 providers reported using the FAST.
    - A greater percentage of social service providers reported using the FAST (14%) compared to mental and behavioral health and healthcare providers (1%).
    - The greatest percentage who used the FAST tool were case managers, case workers, or other social service providers (24%; Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2).

Ongoing Assessment

- 45% of Year 2 organizations reported using Ongoing Assessments (Appendix F, Background, Table 1.5).
    - The greatest percentage that used Ongoing Assessments in Year 2 were CSED Waiver Mobile Response (57%; Appendix F, Background, Table 1.5).
- 26% of Year 2 providers used Ongoing Assessments.
    - Most of the providers who use Ongoing Assessments are social service providers.
    - The greatest percentage of providers who use Ongoing Assessments were counselors and licensed social workers (43% respectively; Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2).

Youth Service or Child Protective Services (YS/CPS) Screenings

- 17% of providers use YS/CPS screening tools, most of whom are social service providers.
    - In addition to the one internal medicine practitioner (100%), the greatest percentage of providers who use YS/CPS screening tools were case managers,

case workers, or other social service providers (Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2).

Many of the Year 2 organizations (40%) and 23% of Year 2 providers indicated that they use "other" tools not listed above. Organizational leaders and administrators wrote in responses such as trauma screenings, functional assessments, stress assessments, psychological/problem behavioral evaluation tools, life satisfaction/quality assessments, substance use screening, suicidality screenings, and communication and learning assessments. Providers wrote in that "other" tools they use to screen and assess youth capture daily living skills, language and learning skills, trauma and abuse, suicide, anxiety, social emotional development, behavioral assessment, mental health, ADHD, autism, depression, OCD, substance use, and neurological assessment. Social service providers wrote in many of these same tools, in addition to instruments in such areas as personality assessments and screenings.

Taken together, the survey findings indicate that there is room for improvement in the use of validated screening and assessment tools. Of note, 30% of mental and behavioral health and healthcare providers and 29% of social service providers indicated that they do not use validated screening and assessment tools (Appendix E, Services & Programs, Tables 3.1.1 and 3.1.2). There were also a lot of write-ins, leading to the question of whether some of the "other" tools being used by organizations and providers are in addition to those preferred by DHHR or in lieu of them. This topic is being added to focus group guides to see what insights can be discovered qualitatively as part of next year's data collection.

Qualitative data indicate that caregivers are aware that screenings and assessments are being done prior to and during RMHT, but they were not always satisfied with the processes or outcomes. One caregiver interviewed during Round 3 of the case series reported that psychiatrists working at RMHTFs had limited time to see individual youth each week, and they felt that there was not enough time for proper assessment and diagnosis. The caregiver shared, "The psychiatrist at the facilities—they basically see the kids for 10 minutes once a week. Write the scripts and then they're on to the therapist..." (Caregiver, Grandmother/Adoptive Mother). Other caregivers reported that screening information such as risk assessment scores were used to discharge youth, even though their youth were reportedly engaging in behaviors that could harm RMHT staff and that were also self-injurious. This highlights the importance of using validated screening and assessment tools that accurately reflect youth functioning and related needs, and sharing the findings with caregivers along with explanations of how screening and assessment scores are being used to inform decisions about their youth's care.

4.2.4 Recommendations

Recommendation: Continue to provide outreach, training, and support to promote the use of valid screening and assessment tools to determine changes to youth needs.

Recommendation: Continue to encourage providers and staff who work at RMHTFs to use the CAFAS or PECFAS so that comparisons of youth functioning can be made over time. This is particularly important for helping identify the right level of care needed for youth in RMHT or youth at-risk for out-of-home placements, and how their needs change over time.

Recommendation: Explore whether organizations and providers are using the screening and assessment tools promoted by DHHR in addition to the "other" tools that were reported, or in lieu of them.

Recommendation: Identify factors that help promote the use of screenings and assessments.

Finding: Caregivers and youth feel that some community-based services help delay placement in RMHT, and expressed the desire for more "early" interventions toward this end

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How did receiving Wraparound services contribute to children's ability to remain at home?
- How did receiving CMCR services contribute to children's ability to remain at home?

There were no indicators associated with these evaluation questions.

4.3.1 Summary

The greatest percentage of caregivers and youth reported that Wraparound and Behavioral Support Services (including PBS) helped delay youth's placement in RMHT. In fact, there was a 32% increase in percentage of caregivers who reported that Wraparound helped delay RMHT for their youth in Year 2 compared to Baseline.

4.3.2 Service-Specific Findings

DHHR promotes community-based mental and behavioral health services that are designed to help keep youth in their homes and communities when it is clinically feasible to do so. Caregiver and youth perspectives provide additional insight into the role that community-based services played in their experiences. During Baseline and Year 2, for each service that caregivers "heard of," the survey asks whether their youth had received the service within the last 12 months, and if yes, whether caregivers felt that the service helped delay their youth's placement in RMHT. A similar survey item was added to the Year 2 Youth Survey, so that youths in RMHT in Year 2 who had "heard of" services included in this Evaluation were also asked if they received them and if so, whether they helped delay RMHT. **The greatest percentage of caregivers and their youth in RMHT in Year 2 reported that Wraparound and Behavioral Support Services (including PBS) helped delay RMHT**. Usage was low for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response, and for the Children's Crisis and Referral Line in Year 2, likely contributing to the fact that only 17% of caregivers and no youth felt that these services helped delay RMHT. The biggest changes since Baseline included **a 32% increase the percentage of caregivers who said Wraparound delayed RMHT for their youth**, as well as a 26% decrease for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response.

4.3.2.1 Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response

Few youths in RMHT received Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response during the Evaluation time periods, so it is difficult to generalize findings.

- Caregivers reported that 7 of their youth in RMHT at Baseline received Children's Mobile Crisis Response and Stabilization in the previous 12 months, and for 43% it helped delay placement in RMHT.
- Caregivers reported that 6 of their youth in RMHT in Year 2 received Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response during the last 12 months and for one youth (17%) it helped delay placement in RMHT (Appendix C, Demographics & Awareness, Table 1.3.2).
- Neither of the two youths in RMHT in Year 2 who self-reported receiving Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services in the last 12 months indicated that it helped delay placement in RMHT (Appendix D, Demographics & Service Awareness, Table 1.3.2).

4.3.2.2 Wraparound

The greatest percentage of caregivers of youth in RMHT in Year 2 reported that Wraparound helped delay RMHT, and 22% of youth agreed.

- Caregivers reported that 19 of their youth in RMHT at Baseline received Wraparound in the previous 12 months, and for 25% it helped delay placement in RMHT.
- Caregivers reported that 21 of their youth in RMHT in Year 2 received Wraparound during the last 12 months and for 57% it helped delay placement in RMHT (Appendix C, Demographics & Awareness, Table 1.3.2).
- 22% of youth in RMHT in Year 2 who self-reported that they received Wraparound in the last 12 months indicated that it helped delay placement in RMHT (Appendix D, Demographics & Service Awareness, Table 1.3.2).

4.3.2.3 Behavioral Support Services (including Positive Behavior Support; PBS)

Compared to the other community-based mental and behavioral health services, the greatest percentage of youth in RMHT in Year 2 indicated that Behavioral Support Services (including PBS) helped delay RMHT, and many of their caregivers agreed.

- Caregivers reported that 10 of their youth in RMHT at Baseline received PBS in the previous 12 months, and for 33% it helped delay placement in RMHT.
- Caregivers reported that 34 of their youth in RMHT in Year 2 received Behavioral Support Services (including PBS) during the last 12 months and for 41% of those youth it helped delay placement in RMHT (Appendix C, Demographics & Awareness, Table 1.3.2).
- 38% of youth in RMHT in Year 2 who self-reported that they also received Behavioral Support Services (including PBS) in the last 12 months indicated that it helped delay placement in RMHT (Appendix D, Demographics & Service Awareness, Table 1.3.2).

4.3.2.4 Assertive Community Treatment

As previously noted, most youth in the survey sample do not qualify for Assertive Community Treatment services. As expected, few youths in RMHT reported receiving Assertive Community Treatment during the Evaluation time periods, making it difficult to generalize findings.

- Caregivers reported that one youth in RMHT at Baseline and one in RMHT in Year 2 received Assertive Community Treatment in the last 12 months, and neither felt that it helped delay RMHT (Appendix C, Demographics & Awareness, Table 1.3.2).
- Two youth in RMHT in Year 2 received Assertive Community Treatment in the last 12 months, one of whom did not feel like it helped delay RMHT and the other did not know (Appendix D, Demographics & Service Awareness, Table 1.3.2).

4.3.2.5 Children's Crisis and Referral Line (CCRL)

Many youths in RMHT in Year 2 were in facilities for a large portion of the data collection period. As such, it is not surprising that few youths in RMHT contacted the CCRL during the Evaluation time periods, making it difficult to generalize findings.

- Caregivers reported that 2 of their youth in RMHT at Baseline received CCRL services in the previous 12 months. Only one caregiver responded to the question in the Baseline survey that asked about whether the CCRL helped delay placement in RMHT, and that caregiver reported that it did not.
- Caregivers reported that two of their youth in RMHT in Year 2 received CCRL services during the last 12 months and that it did not delay RMHT for either youth (Appendix C, Demographics & Awareness, Table 1.3.2).
- Neither of the two youths in RMHT in Year 2 who self-reported that they also received CCRL services in the last 12 months indicated that it helped delay placement in RMHT (Appendix D, Demographics & Service Awareness, Table 1.3.2).

As mentioned, these survey findings are only reflective of caregivers and youth who had heard of the community-based mental and behavioral health service included in this Evaluation based on the names and descriptions provided in the survey, *and* when the youth received the specified services in the last 12 months. Stated differently, the skip logic built into the survey resulted in a subset of caregiver and youth perspectives on this topic, likely resulting in underreporting of the impact that these community-based services have on the timing and need for RMHT. Similar themes also emerged in the qualitative data. In Round 2 of the case series interviews, there was little awareness among youth and their caregivers about community-based services that could be delivered at the intensity and with the specialization needed to delay RMHT for their youth. At Round 3, caregivers appeared somewhat more aware of potential services and supports that are available outside of RMHT, but they still expressed doubt that those services would be available, offered at appropriate times (e.g., to youth of a certain age), or could meet youths' complex needs. For example, one of the caregivers interviewed in Round 3 reported currently using additional Medicaid Waiver services to secure more intensive treatment and supports, but expressed

frustration that this route to services had not been used earlier when it might have delayed or prevented the need for RMHT:

> It took years to access this Title 19. We didn't hear about it from our social services worker until, I guess, probably the third year of their working with us. So, if that Title 19 had been more widely known and shared, we'd have had help, you know, in-home services might well have prevented two residential placements (Caregiver, Grandfather/Adoptive Parent).

As part of a continued effort to increase awareness and help families navigate the system, DHHR continues to support the implementation of the CCRL and the Assessment Pathway as well as the use of Wraparound as part of discharge planning to help ensure that youth have access to short- intermediate- and long-term services that are helping delay RMHT and/or helping to ease their transitions out of RMHT and back into their homes and communities.

4.3.3 Recommendations

Recommendation: Continue to implement outreach activities focused on the Children's Crisis and Referral Line (CCRL; 844-HELP4WV), which helps connect families to immediate services and resources, including Children's Mobile Crisis Response and Stabilization services, CSED Waiver Mobile Response services, and Wraparound services that can help delay placement in RMHT.

Recommendation: Consider what factors contribute to delaying or avoiding youth placement in RMHT. Both the qualitative and quantitative data indicate areas for improvement that include increasing awareness of services and early intervention.

4.4 Finding: Some caregivers and youth reported an increase in the value of community-based mental and behavioral health services over the last 12 months

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has the philosophy toward community-based services among families changed?

There were no indicators associated with this evaluation question.

4.4.1 Summary

Seventy two percent of caregivers of youth in RMHT in Year 2 reported that the value of community-based mental and behavioral health services increased or remained the same over the last 12 months. Compared to Baseline, there was a 9% increase in the number of caregivers who said the value of community-based mental and behavioral health services improved over the last 12 months; however, there was also a 5% increase in caregivers who said the value had gotten worse.

The Year 2 Youth Survey asked those between the ages of 18-21 about changes in their perceived value of services over the last 12 months. A greater percentage of youth in RMHT in Year 2 reported improvements in the value of community-based mental and behavioral health services compared to caregivers, although an equal number of youths said the value had stayed the same, and for 10% the value was perceived as having gotten worse over the last 12 months. Case series interviewees noted that community-based mental and behavioral health services are valued, but more are needed, especially at varying levels of intensity.

4.4.2 Caregiver and youth perceptions about the value of services

As reported in Section 4.3, the perceived value of community-based mental and behavioral health services can affect decisions about usage and rates of placement in RMHT for more intensive youth needs. Perceived value of community-based services was captured at Baseline and in Year 2 for caregivers; this was added to the Year 2 Youth Survey for participants ages 18-21. As displayed in Table 2 below**, most caregivers (72%) and youth between the ages of 18 and 21 in RMHT in Year 2 (80%) felt that the value of mental and behavioral health services stayed the same or got better over the last 12 months** (Appendix C, Crisis Support and Access, Table 2.3; Appendix D, Demographics & Service Awareness, Table 2.6). **Youth between the ages of 18-21 in RMHT in Year 2 were more likely than caregivers to report that the value of mental and behavioral health services had gotten better over the last 12 months**; caregivers were somewhat more likely to report that the value had gotten worse. Regarding change **compared to Baseline, there was a 9% increase among caregivers of youth in RMHT who felt that the value of mental and behavioral health services got better in the past year**; however, there was also a 5% increase in caregivers who felt the value had gotten worse. Table 2 displays perceived value of services by caregivers and youth by year.

Table 2: Caregiver and Youth Perceived Value of Community-Based Services by Year

Perceptions over the last 12 months	Caregivers at Baseline	Caregivers at Year 2	Youth (18-21) at Year 2
	n=108	n=153	n=30
The value of mental and behavioral health services has gotten better	21%	30%	40%
The value of mental and behavioral health services stayed the same	59%	42%	40%
The value of mental and behavioral health services has gotten worse	16%	21%	10%

Caregivers and youth interviewed as part of the case series also value community-based mental and behavioral health services; however, they want more of them, especially services with varying/higher levels of intensity. Most participants in the case series interviews described RMHT as the best fit by default (rather than being the ideal treatment) due to lack of accessible

and intensive, community-based options. They recognized that RMHT presents many challenges (e.g., communication and transportation barriers, difficulty engaging, and family separation), but they believed it generally provided the level of treatment and structure their youth needed. Some of the concerns about community-based mental and behavioral health services were at least partly due to such services having failed to engage the youth in the previous months or years, which is described in greater detail in Section 8.1

Taken together, caregivers and youth value community-based mental and behavioral health services, but more services are needed, especially with higher levels of intensity.

4.4.3 Recommendations

Recommendation: Continue to promote activities that expand caregiver and youth awareness of programs and service offerings. For example, user-friendly and interactive formats such as the Resource Rundown allow for caregivers to ask questions and for others to benefit from the answers to those questions.

Recommendation: Continue to promote the inclusion and engagement of caregivers and youth in service planning, delivery, and discharge. Satisfaction with the process and with services is likely tied to their perceived value in services, which in turn affects service use (see Section 8 for more details).

4.5 Finding: Multiple data sources indicate a downward trend in the average length of stay among youth in RMHT

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has length of stay in residential mental health treatment facilities and Psychiatric Residential Treatment Facilities changed since May 2019?
- How has the length of stay for inpatient hospitalizations changed among wraparound participants?
- How has the length of stay for inpatient hospitalizations due to a primary mental health condition changed among ACT participants?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

4.5.1 Summary

Survey data and the 2023 DHHR Semi-Annual Report were used to examine length of stay. While it varied slightly due to differences in the samples and time frames, **there was an overall downward trend in average lengths of stay**. **The greatest percentage of youth in the Year 2 sample stayed in RMHTFs between 4 and 12 months**.

4.5.2 Length of Stay in RMHT in Year 2

The greatest percentage of youth included in the Year 2 sample stayed in RMHTFs between 4 and 12 months. However, exact estimates for length of stay varied slightly from what was included in the 2023 DHHR Semi-Annual Report.

- The percentages for caregivers and youth were calculated using data reported by parents or legal guardians who completed the Year 2 Caregiver Survey (n=153) or from youth in RMHT who completed the Year 2 Youth Survey (n=156). Caregivers were asked to fill out the Year 2 survey if one or more of their youths were in RMHT on July 1st, 2022. Similarly, youth were asked to fill out the Year 2 survey if they were in a RMHTF on July 1st, 2022.
- The DHHR data were derived from their 2023 Semi-Annual Report and reflect all youth who were in RMHT between January 2021 and June 2022.

Even though the time periods and analytic approaches varied slightly by source, there was enough overlap to be able to find that the data converged as evidenced in Table 3.

Table 3: Length of Stay in RMHT in Year 2 by Data Source

Length of Stay	Caregivers at Year 2 (July 2022)	Youth at Year 2 (July 2022)	DHHR In-State (Jan 2021-June 2022)	DHHR Out-of-State (Jan 2021-June 2022)
4 to 12 months (120 – 365 days)	55%	67%	69%	63%

4.5.3 Changes in Length of Stay in RMHT According to Administrative Data

The 2022 DHHR Semi-Annual Report indicated that the rolling average length of stay for youth in RMHT increased between July 2020 to June 2021, from 242 to 270 days (between 8-9 months), with longer stays observed for youth receiving treatment out-of-state. The 2023 DHHR Semi-Annual Report displayed the length of stay data as the percentage of youth that stayed in RMHT at different intervals of time between January 2021 and June 2022. **Data from the 2023 DHHR Semi-Annual Report indicated that 68% of youth stayed in RMHTFs for 6 months or less**, which aligns with the survey findings below. The DHHR 2023 Semi-Annual Report indicated that the greatest percentage of youth (33%) stayed at an in-state RMHTF between 4-6 months.

- Length of stay was slightly longer for out-of-state placements, with 24% staying between 4-6 months, 24% staying between 7-9 months, and 22% staying one year or longer. One explanation is that youth who are placed out-of-state might have higher and/or more complex needs, which can contribute to longer lengths of stay.

4.5.4 Changes in Length of Stay in RMHT According to Caregivers and Youth

A majority of caregivers reported that their youth were in RMHT for less than a year (Appendix C, Demographics & Awareness, Table 1.1; Appendix D, Demographics & Awareness, Table 1.1). As displayed in Table 4 below, caregivers reported that 59% of their youth in RMHT at Baseline and 47% of their youth in RMHT in Year 2 stayed in a facility for six months or less; these findings are similar to the distributions of length of stay reported in the 2023 DHHR Semi-Annual Report. Youth self-reported slightly longer stays in RMHT than caregivers. At Baseline, 45% of youth reported staying in RMHTFs for six months or less, compared to 33% in Year 2. The greatest percentage of caregivers (28%) and youth (42%) reported that length of stay in RMHT in Year 2 was between 7-12 months. Taken together, while overall length of stay has gone down among all youth in RMHT, caregivers and youth who completed surveys reported slightly longer stays among youth in RMHT in Year 2 than at Baseline.

Table 4 provides a breakdown of caregiver- and youth-reported length of stay at Baseline and in Year 2. It is worth noting that the numbers listed under caregivers (n=108 at Baseline and n=180 in Year 2) represent the number of youth whose caregivers completed surveys that year.

Table 4: Caregiver and Youth Reported Length of Stay in RMHT by Year

Length of Stay	Caregivers at Baseline	Youth at Baseline	Caregivers at Year 2	Youth at Year 2
	n=108	n=115	n=180	n=156
1 to 3 months (30 – 90 days)	19%	10%	20%	8%
4 to 6 months (120 – 180 days)	40%	35%	27%	25%
7 to 12 months (210 – 365 days)	26%	33%	28%	42%
13+ months	8%	20%	16%	24%

4.5.5 Length of Stay in Psychiatric Residential Treatment Facilities (PRTFs)

The 2022 DHHR Semi-Annual Report indicated that youth on average stayed in PRTFs for 9.7 months between July 2020 and June 2021. Data were displayed slightly differently in the 2023 DHHR Semi-Annual Report, which indicated that 59% of youth stayed in an in-state PRTF for 6 months or less between January 2021 and June 2022.

4.5.6 Inpatient Hospitalizations

There are evaluation questions and indicators related to lengths of stay for inpatient hospitalizations among youth receiving Wraparound and Assertive Community Treatment. Unfortunately, Medicaid data were not available due to too few claims for these services during the Evaluation time periods thus far. Alternative sources of administration data are being explored and will be included in future reports as they become available. Results from the case control study being developed in collaboration with DHHR to examine predictors of placement in RMHT might also be able to provide some insights into inpatient hospitalizations.

4.5.7 Recommendations

Recommendation: Continue to develop data capturing factors that contribute to length of stay in RMHT or PRT. Some youth have more complex needs, thereby necessitating longer stays in RMHTFs and/or PRTFs. Stakeholders have also mentioned that the lack of high-intensity community-based services needed to transition youth out of these facilities can also contribute to longer lengths of stay (see Section 8 for more details). Another factor is whether there is a safe environment for youth to return to, which is being prioritized by DHHR.

4.6 Finding: DHHR promotes the use of evidence-based care for youth with mental and behavioral health needs

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- Are the community-based programs associated with the initiative meeting their desired outcomes?
- How have standards changed for mental health services?
- How has the capacity of the mental health service system workforce changed?
- How has awareness among professional stakeholders related to eligibility/accessibility of wraparound services changed?
- How has fidelity of PBS service delivery related to standards of practice changed?
- How many ACT teams met all of the model fidelity factors?
- How has the quality and timeliness of CANS screenings for PBS participants changed?
- How have Wraparound providers' knowledge and skills changed?
- How has the knowledge of the NWI model among Wraparound providers changed?
- How has fidelity to the NWI model changed?
- How has ability and knowledge among Wraparound facilitators and mobile crisis team members to independently deliver and incorporate PBS services into their care delivery changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

4.6.1 Summary

DHHR is promoting the use of Children's Crisis and Referral Line and the Assessment Pathway to connect youth with short- intermediate- and long-term services and supports, including evidence-driven community-based mental and behavioral health services to help keep youth in their homes and communities.

Providers are committed to delivering high-quality evidence-driven care, but opportunities exist to expand upon their understanding and use of tools that have been developed based on national models of care. **Stakeholders also showed a vested interest in promoting wellbeing among youth in the juvenile justice system**. Attorneys/guardians ad litem and law enforcement officers expressed the desire for additional trainings focused on best practices for helping youth with mental and behavioral health needs, especially youth in crisis situations.

4.6.2 Methods for Reducing Reliance on Residential Treatment

The ultimate goal of improving the mental and behavioral health system is to reduce unnecessary youth placement in RMHT. In addition to expanding services, enhancing workforce capacity, and facilitating stakeholder collaboration, efforts to achieve this goal include:

- Reductions in the overall census of WV youth in RMHTFs in and out of state, and in length of stay.
- Ensuring that services and supports are available to help transition youth back in their homes and communities. For example, DHHR is updating policies and procedures to require participation in Wraparound or Assertive as part of discharge processes. DHHR is also working closely with care teams to ensure that youth have a safe and supportive environment to return to.
- Updating policies and providing training, education, and support to providers to help standardize and streamline processes that enable youth and family access to services, through the use of the Children's Crisis and Referral Line and the Assessment Pathway in particular.
- Measuring and accounting for different factors that contribute to out-of-home placements.
- Developing procedures for implementing a monthly reauthorization process for youth in RMHT, including a review of plans for discharge.

DHHR continues to monitor and implement changes to improve the standards of care across the mental and behavioral health system. Examples of enhanced quality standards include:

- Use of robust, validated screening and assessment tools. Over the last year, DHHR has been fostering cross-agency collaborations and in doing so has created opportunities to educate and train providers on how to conduct screenings and assessments and use those findings to connect youth with needed services and determine the appropriateness

of RMHT. DHHR has also prioritized the quality and timeliness of assessments to make sure they happen near enrollment in services and then routinely thereafter, for most services the expectation is at 90-day intervals. As reported in Section 4.2 above, the greatest percentage of organizations and providers are using the CANS or the CAFAS/PECFAS, but many are also using "other" screening and assessment tools.

Increased stakeholder awareness of the continuum of mental and behavioral services and streamlined access to services through the Children's Crisis and Referral Line and/or the Assessment Pathways as preferred/standardized methods for identifying and connecting families to the right services for them. To this end, provider awareness increased for several services compared to Baseline, including a 15% increase in awareness of the Children's Crisis and Referral Line.

4.6.3 Use of Evidence-Based Practices

All of the community-based mental and behavioral health services included in this Evaluation are evidence-based. **As expected, providers agree that they deliver evidence-based care, and they recognize that fidelity to an intervention enhances its effectiveness**. Mental and behavioral health and healthcare providers were asked to report their level of agreement on a scale that ranged from 1 (Disagree) to 5 (Agree) and findings were as follows:

- Providers generally agreed at Baseline (4.8) and in Year 2 (4.6) that they deliver evidence-based practices, with some variation observed by provider type at Baseline (Appendix E, Skillset & Training, Table 4.2).
- Providers generally agreed at Baseline (4.7) and in Year 2 (4.6) that delivering an intervention with fidelity enhances its effectiveness (Appendix E, Skillset & Training, Table 4.2).

There are three community-based mental and behavioral health services included in this Evaluation with particularly robust national service models: Wraparound, Positive Behavior Support, and Assertive Community Treatment.

4.6.3.1 Wraparound

The three types of Wraparound services being implemented in WV, CSED Waiver Wraparound, WV Children's Mental Health Wraparound, and Safe at Home are guided by the National Wraparound Initiative, and DHHR is collaborating with Marshall University to monitor fidelity to this national model. A series of survey items revealed opportunities to expand on Wraparound providers' understanding of the National Wraparound Initiative and related tools. Findings indicate that provider understanding of the evidence behind the National Wraparound Initiative changed over time. Providers were asked to indicate their level of agreement on a scale from 1 (Disagree) to 5 (Agree) and reported the following:

- All eight mental and behavioral health providers offering Wraparound services at Baseline agreed that they understood the evidence behind the National Wraparound Initiative model (4.0).

- There were 332 providers who reported that they deliver Wraparound services in Year 2. Overall, the Year 2 providers neither agreed nor disagreed that they understood the evidence behind the National Wraparound Initiative (3.5).
- Most providers neither agreed nor disagreed that they have the necessary skills to implement National Wraparound Initiative model (3.3 at Baseline and in Year 2 respectively).
- Most providers neither agreed nor disagreed at Baseline (3.3) and in Year 2 (3.1) that they use the National Wraparound Initiative tools to monitor delivery on a case-by-case basis (Appendix E, Wraparound & ACT, Table 10.1).

When asked about their interests, the greatest percentage of all mental and behavioral health and healthcare providers at Baseline (67%) and in Year 2 (66%) indicated that they would like more training on the National Wraparound Initiative (Appendix E, Skillset & Training, Table 4.1). Fortunately, there are resources that can meet providers' training interests and needs. In collaboration with DHHR, Marshall University plans on launching a new wave of Wraparound provider trainings in 2023. These Wraparound trainings rely heavily on the National Wraparound Initiative, and subsequent changes in provider understanding might be detectable by the time data are collected for Year 3.

4.6.3.2 Positive Behavior Support (PBS)

Positive Behavior Support (PBS) is a community-based mental and behavioral health service driven by a robust evidence-based national model of care. DHHR is working with West Virginia University's Center for Excellence in Disability and Concord University to certify providers to ensure that PBS is delivered with fidelity to the national model. Findings suggest that opportunities exist to improve the certification process for PBS. Providers who indicated that they offer PBS were asked to report their level of agreement on scales that ranged from 1 (Disagree) to 5 (Agree) for a series of related survey items:

- Providers at Baseline somewhat agreed that the West Virginia University's Center for Excellence in Disability provides adequate training to prepare providers to implement PBS (3.8); Year 2 providers neither agreed nor disagreed (3.2).
- Most providers neither agreed nor disagreed at Baseline (3.5) and in Year 2 (3.5) that their training prepared them to deliver PBS.
- Most providers neither agreed nor disagreed at Baseline (2.8) and in Year 2 (3.1) that the certification requirements for PBS were clear.
- Most providers neither agreed nor disagreed at Baseline (2.6) and in Year 2 (3.5) that the PBS certification requirements improved the quality of PBS service delivery.
- Most providers neither agreed nor disagreed at Baseline (3.0) and in Year 2 (2.9) that the PBS certification requirements are too burdensome (Appendix E, Skillset & Training, Table 4.3).

In Year 2, 62% of providers indicated that PBS is applicable to their jobs. This Evaluation will continue to monitor provider experiences as the PBS certification processes continue to evolve and transition more fully to Concord University.

4.6.3.3 Assertive Community Treatment

Assertive Community Treatment is the third community-based mental and behavioral health service included in this Evaluation that is based on a robust national model of care. BMS ensures that all Assertive Community Treatment teams have met all fidelity criteria prior to making services available to the public. There were only three providers who reported that they offered Assertive Community Treatment at Baseline, and trends in the data indicated that they neither agreed nor disagreed that they understood the evidence behind Assertive Community Treatment or had the necessary skills to implement it. There were 40 providers who indicated that they offered Assertive Community Treatment in Year 2. Using scales that ranged from 1 (Disagree) to 5 (Agree), providers reported the following:

- Most Year 2 providers somewhat agreed (4.1) that they understood the evidence behind Assertive Community Treatment (Appendix E, Wraparound & ACT, Table 10.2).
- Most Year 2 providers somewhat agreed (4.1) that they have the necessary skills to implement Assertive Community Treatment (Appendix E, Wraparound & ACT, Table 10.2).

DHHR plans to expand Assertive Community Treatment over the next few years. Even though few youths in the target population are eligible for this service because they are 17 years of age or younger and Assertive Community Treatment serves those 18+, this Evaluation will continue to monitor providers' understanding and utilization of Assertive Community Treatment tools and principles. More information about screening for Assertive Community Treatment as a part of discharge planning can be found in Section 8.1 below.

4.6.3.4 Additional Opportunities for Quality Improvement

Possible quality improvement and training-related opportunities emerged from the data from stakeholders associated with the juvenile justice system. The survey data revealed a desire for more trainings focused on best practices for helping youth with mental and behavioral health needs. When asked to report their levels of agreement on scales that ranged from 1 (Disagree) to 5 (Agree), attorneys/guardians ad litem and law enforcement officers reported the following:

- Attorneys and guardians ad litem somewhat agreed at Baseline (4.2) and agreed in Year 2 (4.6) that they are prepared to work with youth with mental and behavioral health needs. However, attorneys and guardians ad litem neither agreed nor disagreed at Baseline (2.9) and in Year 2 (3.5) that they have the necessary training to respond to a mental health crisis involving youth (Appendix E, Attorneys & GALs, Table 11.1).
- Law enforcement officers neither agreed nor disagreed at Baseline (3.4) and in Year 2 (3.5) that they have the training necessary to respond to a crisis involving youth with mental and behavioral. Moreover, law enforcement officers agreed at Baseline (4.1) and

in Year 2 (4.2) that they would like more training in this domain (Appendix E, LEOs, Table 12.1).

When taken together, data indicate that there is a growing commitment to evidence-based practices. Some opportunities exist to further expand the delivery of evidence-based care, which led to the recommendations below.

4.6.4 Recommendations

Recommendation: Consider exploring the factors that might contribute to greater satisfaction with and utilization of trainings and certifications for PBS.

Recommendation: Consider whether there are current trainings or programs that can be used as a platform to provide more guidance to juvenile justice partners on assisting youth with mental and behavioral health needs. For example, Handle with Care might have capacity to expand their trauma-informed curriculum for law enforcement officers to some of these related topics.

5 Evaluation Results: Access to Mental and Behavioral Health Services

5.1 Finding: There is at least one provider for every mental and behavioral health service in every region, but many report difficulties covering certain counties

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- Are all planned services available in each region?
- Can WV families with children who need mental health services access those services in their communities?
- Can WV families with children who need mental health crisis services access PBS services within their community?
- How has wraparound service availability changed?
- Can WV families with children who need mental health services access wraparound services in their communities?
- How accessible are mobile crisis services to families?
- How has the availability of PBS services changed?
- How has the availability of Mobile Crisis services changed?
- How has capacity of the MH workforce changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

5.1.1 Summary

The survey captured at least one organization that offers the services included this Evaluation in every region. The only exception was that the organization that offers Children's Mobile Crisis Response and Stabilization in Region 5 did not respond to the Year 2 survey. Otherwise, based on results of the Year 2 Organization and Facility Survey, **all services being evaluated are available statewide**. However, all reported some difficulty providing coverage for all services to all counties in their regions. The organizations that offered CSED Waiver Wraparound, Assertive Community Treatment, and/or RMHT in Year 2 reported some difficulty providing service coverage in every county in WV. The other community-based mental and behavioral health services being evaluated reported difficulties in six or more WV counties. The greatest percentage of organizations and facilities had difficulties providing service coverage in Regions 4 and 6. The main contributors to difficulties with service coverage include a lack of staff, and the size and/or rurality of certain WV counties.

Care coordination, use of screenings and assessments, and direct support services such as therapy and medication management are offered by approximately half of the organizations and providers who responded to the surveys. There was an increase in providers who coordinate care, offer outreach and education, and crisis interventions.

5.1.2 Availability and Coverage by Service

The Year 2 Organization and Facility Survey was revised to capture more precise service-specific data by region and in some cases by county. For example, a series of survey items asked organizations to report the counties in which they deliver services, if there were particular counties that were difficult to provide services to, and if yes, which ones and why. Findings specific to each service were as follows.

5.1.2.1 Children's Mobile Crisis Response and Stabilization

Fewer organizations that offered Children's Mobile Crisis Response and Stabilization responded to the Year 2 survey than at Baseline, and survey data were not available for Region 5 in Year 2. Therefore, the findings below only represent organizations that offered Children's Mobile Crisis Response and Stabilization in Regions 1-4 and Region 6 in Year 2. Among those that responded in Year 2, more than half experienced difficulties providing service coverage, especially in Regions 4 and 6, with the greatest percentage reporting difficulties in Preston County.

- The eight organizations that indicated that they offered Children's Mobile Crisis Response and Stabilization in Year 2 provided services to all counties in all regions with two exceptions (Appendix F, Referrals, Table 4.1). As noted above, data were not available for Region 5 in Year 2, and organizations that did respond to the survey indicated that there was not coverage for Children's Mobile Crisis Response and Stabilization in three counties in Region 2: Hardy, Mineral, or Pendleton counties.

- 63% of Year 2 organizations that responded to the survey reported difficulties providing service coverage for Children's Mobile Crisis Response and Stabilization (Appendix F, Referrals, Table 4.5). Some difficulty with service coverage was reported for several counties in Regions 4 and 6, with the greatest percentage of organizations (40%) experiencing difficulties providing coverage in Preston County.

When asked to describe their reported challenges with service coverage, many organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 mentioned the rurality of some WV counties, especially in Regions 2, 4, and 6. One organization mentioned that Preston County is difficult to cover in particular, not just because of its rurality but also the size of the county in that providers and families have to drive long distances to get to service locations.

5.1.2.2 Children with Serious Emotional Disorders (CSED) Waiver Mobile Response

Year 2 surveys asked about specific CSED Waiver services, including Mobile Response. The Baseline surveys asked about the CSED Waiver services in general, so the results for Mobile Response specifically could not be disaggregated in the Baseline data. The seven organizations that indicated in the Year 2 survey that they provide CSED Waiver Mobile Response reported statewide service coverage. However, difficulties providing service coverage were reported in Regions 4 and 6, with the greatest percentage indicating difficulties in Doddridge, Preston, and Braxton counties (Appendix F, Referrals, Table 4.1).

- Baseline survey data were not collected for CSED Waiver Mobile Response services specifically, but CSED Waiver services in general were available in all Regions and counties in WV.
- The seven organizations and facilities that offered CSED Waiver Mobile Response services in Year 2 survey provided services to all six regions (Appendix F, Referrals, Table 4.1).
- 86% of Year 2 organizations that responded to the survey reported difficulties providing service coverage for CSED Waiver Mobile Response services. Some difficulty with service coverage was reported for several counties in Regions 4 and 6. The greatest percentage of organizations and facilities had difficulty providing service coverage in Preston County and Braxton County (33% respectively) and Doddridge (20%; Appendix F, Referrals, Table 4.5).

When asked to describe their reported challenges with service coverage, staffing was the most common issue for organizations that provided CSED Waiver Mobile Response in Year 2, in Regions 4, 5, and 6 in particular. Several organizations also mentioned that rurality makes it difficult to provide CSED Waiver Mobile Response to all WV counties.

5.1.2.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

The Year 2 surveys asked about specific CSED Waiver services, including CSED Waiver Wraparound. The Baseline surveys asked about the CSED Waiver services in general; results for CSED Waiver Wraparound specifically could not be disaggregated in the Baseline data. The 15 organizations that indicated in the survey that they provided CSED Waiver Wraparound in Year

2 reported statewide service coverage for all regions and counties. However, some difficulty providing service coverage was reported in every county. Regions 5 and 6 were particularly difficult to cover, in Cabell, Lincoln, Putnam, Wayne, and McDowell counties specifically.

- Baseline survey data were not collected for CSED Waiver Wraparound services specifically, but CSED Waiver services were available in all Regions and counties in WV.
- The 15 organizations that reported offering CSED Waiver Wraparound in the Year 2 survey provided services to every county in all six regions (Appendix F, Referrals, Table 4.1).
- 11 organizations that offered CSED Waiver Wraparound in Year 2 responded to the survey item about difficulties providing survey coverage, eight of which (73%) responded "Yes" to having difficulties. Among those eight organizations, some difficulty with service coverage was reported for all counties, with the greatest percentage of organizations and facilities reporting difficulties in Regions 5 and 6. The greatest percentage of organizations and facilities that offered CSED Waiver Wraparound in Year 2 had difficulties covering Cabell County, Lincoln County, Putnam County, Wayne County, and McDowell County in particular (all 50% respectively; Appendix F, Referrals, Table 4.5).

When asked to describe their reported challenges with service coverage, organizations that offered CSED Waiver Wraparound in Regions 2, 5, and 6 wrote in responses and indicated a lack of service providers and specifically a lack of intensive community-based services such as psychiatric treatment, especially for acute crises. Organizations in Region 5 also reported staffing issues, and in Region 6 they mentioned that the rurality of several counties makes it difficult for families and staff to access mental and behavioral health facilities.

5.1.2.4 WV Children's Mental Health Wraparound

Three of five organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to the survey. The three organizations that indicated in the survey that they offered WV Children's Mental Health Wraparound in Year 2 reported that provide services in every WV region and county. One of these organizations reported difficulties providing service coverage to half of the counties in Region 6.

- The three organizations that offered WV Children's Mental Health Wraparound in Year 2 provided services to all WV regions and counties (Appendix F, Referrals, Table 4.1).
- Two organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to the survey item about difficulties with service coverage, one of which responded "Yes" to encountering difficulties. That organization reported difficulties providing service coverage in approximately half of the counties in Region 6, specifically Fayette, Mercer, Monroe, Raleigh, and Summers counties (Appendix F, Referrals, Table 4.5).

When asked to describe challenges with service coverage, distance and rurality were identified as issues in six of the 11 counties in Region 6.

5.1.2.5 Behavioral Support Services (including Positive Behavior Support; PBS)

Thirty-five organizations indicated that they provide PBS at Baseline and 35 also reported offering Behavioral Support Services (including PBS) in Year 2 (Appendix F, Referrals, Table 4.1). Year 2 organizations that offered Behavioral Support Services (including PBS) provided statewide coverage, including every county and region in WV. However, difficulty providing service coverage was reported in Regions 5 and 6 in Year 2, with the greatest difficulty reported in Webster County.

- Behavioral Support Services (including PBS) is available statewide. There were 35 organizations that offered PBS in all regions and counties at Baseline.
- In Year 2, there were also 35 organizations that reported offering Behavioral Support Services (including PBS) in all regions and counties (Appendix F, Referrals, Table 4.1).
- 35% of organizations that offered Behavioral Support Services (including PBS) in Year 2 reported difficulties providing service coverage. Organizations reported difficulties providing Behavioral Support Services (including PBS) to many of the counties in Regions 5 and 6; the greatest percentage of organizations and facilities (22%) had difficulty providing service coverage in Webster County in Region 6 (Appendix F, Referrals, Table 4.5).

When asked to describe their reported challenges with service coverage, many organizations that offered Behavioral Support Services (including PBS) in Regions 5 and 6 mentioned staffing, including a lack of providers with the necessary skills for helping youth with mental and behavioral health needs. Organizations in Region 6 also frequently noted that distance and rurality in counties such as McDowell, Raleigh, Summers, and Webster make it challenging to provide service coverage. Two organizations, one covering Morgan County in Region 2 mentioned accessibility issues and one covering Taylor County in Region 4 indicated a “lack of opportunities to provide the type of services (vocational) that we offer.”

5.1.2.6 Assertive Community Treatment

Five organizations indicated that they offered Assertive Community Treatment in Year 2. The five organizations and facilities that offered Assertive Community Treatment in Year 2 reported statewide coverage. However, some difficulty with service coverage was also reported in every county in Year 2, especially Preston, Marion, and Taylor counties in Region 4.

- At Baseline there were 15 organizations that offered Assertive Community Treatment services in Regions 1, 3, 5, and 6, but Region 3 was the only region with coverage in all counties.
- In Year 2 there were five organizations that reported providing statewide coverage for Assertive Community Treatment, with at least one entity covering every county (Appendix F, Referrals, Table 4.1).
- Four out of the five organizations that offered Assertive Community Treatment in Year 2 responded to the survey question about difficulties providing service coverage; all four organizations reported difficulties providing service coverage for Assertive Community Treatment in all counties in their regions. In fact, some difficulty providing coverage was

reported in every county. The greatest difficulty with service coverage was reported in Region 4. Specifically, the greatest number of organizations reported difficulties covering Preston County (75%), followed by Marion and Taylor counties (50% respectively; Appendix F, Referrals, Table 4.5).

Accessibility is expected to continue to expand, especially considering that WV community-based health centers will be required to offer Assertive Community Treatment within the next few years. DHHR also noted that the Assertive Community Treatment team covering the Eastern Panhandle that was being established during Baseline data collection is in the final stages of development, with all necessary contracts in place.

When asked to describe their reported challenges with service coverage, organizations that offered Assertive Community Treatment in Year 2 reported staffing issues statewide. Additional write-ins indicated there were few clients that needed Assertive Community Treatment services in Marion County, and Preston and Taylor counties have rural areas that make it difficult for providers and families to access mental and behavioral health facilities.

5.1.2.7 Residential Mental Health Treatment (RMHT)

The Baseline survey captured 20 RMHTFs that covered all of WV. The 18 RMHTFs that responded to the Year 2 survey also provided coverage in every WV region and county. Five RMHTFs responded to the survey item about service coverage difficulties, four of which responded "Yes" to having difficulties. Those four RMHTFs reported difficulties with service coverage in every county, with the greatest percentage occurring in Regions 4 and 6, in Preston, Taylor, and McDowell counties specifically.

- RMHT is available statewide. At Baseline there were 20 RMHTFs that responded to the Organization and Facility Survey that reported providing statewide coverage.
- In Year 2 there were 18 RMHTFs that also provided coverage in all WV regions and counties (Appendix F, Referrals, Table 4.1).
- Four of the five RMHTFs that responded to the survey item (80%) reported difficulties with service coverage. The four RMHTFs reported some difficulties with service coverage in every county. The greatest percentage of service coverage difficulty was reported in Regions 4 and 6, with 50% reporting difficulties covering Preston County, Taylor County, and McDowell County (Appendix F, Referrals, Table 4.5).

When asked to describe their reported challenges with service coverage, organizations and facilities that offered RMHT in Year 2 indicated that they would like to have more communication with DHHR, and that the rurality of Preston and Taylor counties in Region 4 and McDowell County in Region 6 make it challenging for families and staff to get to mental and behavioral health facilities.

5.1.3 Service Coverage by County and Region

The organizations that offered CSED Waiver Wraparound, Assertive Community Treatment, and/or RMHT in Year 2 reported some difficulty providing service coverage in every county in WV.

The other services being evaluated reported difficulties in six or more WV counties. The greatest percentage of organizations had difficulties providing service coverage in Regions 4 and 6. The qualitative analyses indicated that most of the write-ins for challenges with service coverage fell under three categories: staffing; lack of psychiatric services (specifically psychiatric care, and acute crisis care for psychiatric needs); and distance/rurality. The write-in data are displayed in Table 5 by county and BBH region. While there were no write-ins for Regions 1 or 3, several organizations mentioned that staffing was an issue statewide.

Table 5: County-Level Challenges with Service Coverage

BBH Region	County	Challenges			
		Staffing	Lack of psychiatric services	Distance / Rurality	Other
2	Berkeley	X	X		
2	Grant			X	
2	Hampshire			X	
2	Jefferson	X	X		
2	Morgan	X		X	Lack of referrals
4	Barbour			X	
4	Braxton	X		X	
4	Gilmer			X	
4	Lewis	X			
4	Marion				Lack of clients needing services
4	Monongalia	X		X	
4	Preston	X		X	
4	Randolph			X	
4	Taylor	X			Lack of clients needing services
4	Tucker	X			
5	Boone	X			

BBH Region	County	Challenges			
		Staffing	Lack of psychiatric services	Distance / Rurality	Other
5	Cabell	X	X		
5	Kanawha	X	X		
5	Lincoln	X			
5	Putnam	X	X		
5	Wayne	X	X		
6	Greenbrier	X		X	
6	McDowell	X		X	
6	Mercer	X			
6	Mingo	X			
6	Monroe			X	
6	Nicholas			X	
6	Pocahontas	X		X	
6	Raleigh			X	
6	Summers			X	
6	Webster			X	
6	Wyoming			X	

Staffing was the most commonly reported challenge with service coverage, affecting 19 counties, followed by distance and rurality which was reported in 18 counties. The organizations that mentioned lack of psychiatric services described the need for more psychiatric care in general, as well as for youth experiencing crises.

5.1.4 Provider Perceptions of Service Accessibility

Providers at Baseline and in Year 2 indicated the need for more community-based services. Providers were asked to report their level of agreement to a series of questions on scales that ranged from 1 (Disagree) to 5 (Agree). Findings were as follows:

- Providers mostly disagreed at Baseline (1.9) and in Year 2 (1.9) that there were adequate mental and behavioral health services for youth in the areas where they work (Appendix E, Referral Policies, Table 8.3).

Juvenile justice providers surveyed in Year 2 included attorneys and guardians ad litem. At Baseline, attorneys and guardians at litem neither agreed nor disagreed that there were effective mental and behavioral health service providers in their jurisdictions (2.7). Attorneys and guardians ad litem in Year 2 somewhat disagreed (2.2). They also somewhat disagreed that there are high-quality mental health services in their jurisdictions at Baseline (2.0) and in Year 2 (2.0; Appendix E, Attorneys & GALs, Table 11.1). Judges were not included in Year 2 data collection; judge perspectives will be captured again in Year 3 and included in next year's report.

Providers associated with juvenile justice such as attorneys, guardians ad litem and court judges neither agreed nor disagreed at Baseline that provider agencies in their jurisdiction are accessible to youth. Attorneys and guardians ad litem somewhat disagreed in Year 2 (2.5; Appendix E, Attorneys & GAL, Table 11.1). A finding to consider is that providers somewhat agreed at Baseline (4.4) and in Year 2 providers (4.3) that lack of community-based services contribute to out-of-home placements when youth might be better served at home (Appendix E, Out-of-Home Placements, Table 9.1). As described in greater detail below, the need for more community-based mental and behavioral health services that vary in levels of intensity was a theme that also emerged in the data from the case series interviews, and those participants also agreed that this contributes to youth placement in RMHT.

5.1.5 Availability of Mental and Behavioral Health Interventions

A similar percentage of organizations and providers reported that they deliver specific mental and behavioral health interventions, and little variation was observed over time. For example, Table 6 displays responses when organizations were asked to select which mental and behavioral health interventions they provide.

Table 6: Mental and Behavioral Health Interventions Offered by Organizations by Year

Mental and Behavioral Health Interventions	Baseline	Year 2
	n=79	n=52
Case Management and Care Coordination	47%	48%
Supportive Services	33%	31%
Therapy and/or Counseling	21%	19%

In Table 6, supportive services include respite, medication management, and support with independent living (Appendix F, Background, Table 1.4). These services were available at almost

all of the RMHTFs, and many were offered in organizations that provided Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response. Other services mentioned by organizations included 24-hour staffing, nursing services, referrals to inpatient, Stabilization and Treatment Foster Care Parents certification, positive parenting training, Life Space Crisis Intervention, Therapeutic Crisis Intervention, family engagement, trauma-informed therapy, mentoring for behavioral support professionals, futures planning.

A greater percentage of providers reported offering mental and behavioral health interventions compared to Baseline (Appendix E, Capacity & Resources, Table 5.1). Table 7 provides a breakdown of the top mental and behavioral health interventions offered by providers by year. **The greatest changes since Baseline include a 36% increase in treatment planning, 31% increase in care coordination, a 30% increase in outreach and education, and a 23% increase in the delivery of crisis interventions**.

Table 7: Mental and Behavioral Health Interventions Offered by Providers by Year

Mental and Behavioral Health Interventions	Baseline	Year 2
Treatment planning	46%	70%
Medication management	50%	62%
Crisis intervention	38%	61%
Care coordination	26%	57%
Individual therapy	38%	50%
Outreach and education	17%	47%

Providers also indicated that they offer a number of "other" forms of support, including medication administration, referrals, and evaluations.

5.1.6 Perceptions of Service Availability According to the Caregivers in the Case Series

Among case series participants, there were important, positive changes observed with respect to their ability to access needed services within their communities over the three rounds of interviews. In Round 1, most caregivers expressed a great need for in-home and in-school services for their youth, though they felt less certain about what specific community-based services would best help their youth to stay in the home. In general, families noted the importance of family therapy, specifically, as well as consistent and accessible support, in general. They also noted they did not know where to begin looking for services.

Six months later, during Round 2, caregivers reported that two of their youths who were living at home were receiving community-based therapies but required more intensive support than they were currently receiving. Three of the four caregivers with youth living at home felt “at a loss” about which resources and services could help. One caregiver reiterated problems with access to community-based services as a consequence of residing in a border county. They stated:

> The long-standing issue has been up here in the Panhandle, and the way West Virginia Medicaid is structured that an out-of-state provider has to be an adjacent county to West Virginia. Which left all of the experts in the [city in other state] area not eligible to provide service. Because they're not an adjacent county to us. There were some excellent services there that Medicaid wouldn't allow us to access. . . It took years to access this Title 19 (Caregiver, Grandfather/Adoptive Parent)

Additional Medicaid Waiver services helped facilitate in-home care for this family. Six months later, by Round 3, they were able to work with a psychiatric technical team and the youth was able to try a new medication that resulted in significant improvements. Awareness of and access to community-based services also improved for the two other families who previously felt unsure about what services might help their youth. During their third interview, one caregiver discussed that their youth was getting the services that they needed, and another knew where to get services when their youth was ready.

5.1.7 Recommendations

Recommendation: Consider how the State can encourage more people to go into the field, through university partnerships, incentives, and/or internships.

Recommendation: Continue to provide outreach and education to increase caregiver and family awareness of the continuum of mental and behavioral health services that are available for youth.

Recommendation: Explore the impact of Medicaid policy on county-level service accessibility across state lines.

5.2 Finding: Caregivers and youth in RMHT expressed a lot of interest in community-based services

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has the use of community-based mental health services changed?
- How has the use of PBS services changed?
- How has the use of ACT services changed?
- How has the use of wraparound services changed?
- How have family/caregiver knowledge and skills changed to meet youth behaviors and needs?

- How engaged are WV families in children mobile crisis treatment?
- What is the frequency of Mobile Crisis usage and how has this changed over time?
- Can WV families with children who need MH services access those services in their communities?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

5.2.1 Summary

Overall, reported usage of community-based services was low in Year 2, which is somewhat expected given that approximately a third of youths were in RMHTFs for 7-12 months prior to data collection. The greatest percentage of caregivers (nearly half) reported that their youth in RMHT in Year 2 received Behavioral Support Services (including PBS) in the last 12 months. The greatest percentage of youth in RMHT in Year 2 (nearly a quarter) reported receiving Wraproud services in the last 12 months. Both caregivers and youth agreed that few youths in RMHT in Year 2 received Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization, or services from the Children's Crisis and Referral Line in the last 12 months. The greatest changes since Baseline included a decrease in the percentage of caregivers who reported that their youth received Children's Mobile Crisis Response and Stabilization services. Youth also reported decreases in the use of Behavioral Support Services (including PBS), and an increase in the use of Wraparound compared to Baseline. Both caregivers and youth agreed that few were on the waitlist for additional services at Baseline and in Year 2.

Caregivers and youth experienced barriers that impacted utilization of community-based mental and behavioral health services, such as difficulties getting ahold of the people who could connect youth to providers and services, issues with service accessibility, concerns about not being able to find services that are a "good fit" for youth, and difficulties navigating the mental and behavioral health system. Caregivers and youth also reported waitlist times as a barrier to starting and continuing services, even though few reported waiting for services at the time of data collection.

Caregivers are confident that they have the knowledge needed to access services but were unsure if they would be available in the future. Some services and supports that youth needed but were not available included different types of therapy of varying levels of intensity for both youth and their families, as well as the desire for more communication with providers, and early interventions that can help reduce or prevent the need for RMHT.

5.2.2 Caregiver and Youth Reported Usage of Services

Community-based mental and behavioral health services can help keep youth in their homes and communities, delaying or sometimes reducing the need for placement in RMHT. Community-based mental and behavioral health services can also help transition youth out of RMHT if services are available, accessible, have capacity, and offer varying levels of intensity across different interventions. Overall usage of community-based services was low, which might be expected given that approximately a third of the youth in RMHT in Year 2 had been in facilities for

7-12 months prior to data collection, meaning they had little opportunity to use community-based services.

Caregivers and youth who indicated that they had "heard of" the services in this Evaluation were asked several follow up questions about service use. Both caregivers and youth agreed that few youths in RMHT in Year 2 received Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization, or services from the Children's Crisis and Referral Line in the last 12 months.

Caregivers and youth slightly differed in their reports of the most used services.

- The greatest percentage (nearly half) of caregivers reported that their youth in RMHT in Year 2 used Behavioral Support Services (including PBS) in the last 12 months, whereas only 12% of youth in RMHT in Year 2 reported receiving it in the last 12 months.
- **The greatest percentage of youth in RMHT in Year 2 reported receiving Wraparound in the last 12 months (23%);** 31% of their caregivers reported that their youth in RMHTF had received Wraparound during the same time period.

Caregivers and their youth in RMHT at Baseline reported that PBS was the most commonly used community-based service. Other changes over time were as follows:

- There was a 15% decrease in youth's self-reported use of Behavioral Support Services (27% of youth in RMHT at Baseline and 12% of youth in RMHT in Year 2).
- There was a 10% decrease in caregiver reports of youth's use of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services (23% of youth in RMHT in Baseline and 13% of youth in RMHT in Year 2).
- There was a 9% increase in youth's reported use of Wraparound services (14% of youth in RMHT at Baseline and 23% in Year 2).

Caregivers and their youth in RMHT in Year 2 agreed that few were on the waitlist for any community-based services at Baseline and in Year 2.

5.2.2.1 Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response

The surveys asked about the use of Children's Mobile Crisis Response and Stabilization at Baseline and the use of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response in Year 2. Caregivers reported a decrease in the use of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response compared to Baseline, whereas little variation was observed in youth self-reported usage over time.

- Caregivers of 30 youth in RMHT at Baseline were aware of Children's Mobile Crisis Response and Stabilization, and 23% of those youth received Children's Mobile Crisis Response and Stabilization in the previous 12 months.
- Caregivers of 47 youth in RMHT in Year 2 were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response, and caregivers reported

that 13% of those youth received these services in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).

    - Few caregivers (10% at Baseline and 13% in Year 2) were unsure if youth in RMHT had received Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response in the previous 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).

- 37 youth in RMHT at Baseline were aware of Children's Mobile Crisis Response and Stabilization, 8% of whom reported receiving these services in the previous 12 months, 14% were unsure.
- 31 youth in RMHT in Year 2 were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response, 6% of whom reported receiving these services in the last 12 months, 8% were unsure (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Few youths in RMHT were waiting for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services.

- Caregivers reported that two of their youth in RMHT at Baseline (7%) were on the waitlist for Children's Mobile Crisis Response and Stabilization services. Caregivers reported that none of their youth in RMHT in Year 2 were on the waitlist for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services (Appendix C, Demographics & Awareness, Table 1.3.2)
- One youth in RMHT at Baseline and one youth in RMHT in Year 2 reported that they were on the waitlist for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Compared to their caregivers, a greater percentage of youth in RMHT in Year 2 self-reported that they never received and were not waiting for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response.

- Caregivers reported that 51% of their youth in RMHT in Year 2 never received and are not waiting for Children's Mobile Crisis Response and Stabilization services (Appendix C, Demographics & Awareness, Table 1.3.2).
- 79% of youth in RMHT in Year 2 reported that they never received and not waiting to receive Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

5.2.2.2 Wraparound

The surveys asked about the use of Wraparound over the last 12 months. Caregivers reported similar usage among their youth in RMHT at Baseline and Year 2. **Youth in RMHT in Year 2 reported a 9% increase in the use of Wraparound compared to Baseline. In fact, youth identified Wraparound as the most used community-based service in Year 2.**

- Caregivers who were aware of Wraparound at Baseline represented 56 youth in RMHT, 34% of whom had received it in the last 12 months.
    - Caregivers representing 14% of youth in RMHT at Baseline were aware of Wraparound but were unsure if youth had received it.
- Caregivers who were aware of Wraparound in Year 2 represented 68 youth in RMHT, 31% of whom had participated in it the last 12 months.
    - Caregivers representing 16% of youth in RMHT in Year 2 were aware of Wraparound but were not sure if youth had received it in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- 14% of youth in RMHT at Baseline who were aware of Wraparound participated in the previous 12 months, 21% were unsure.
- 23% of youth in RMHT in Year 2 who were aware of Wraparound participated in the last 12 months, 13% were unsure (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Few youths in RMHT were waiting for Wraparound.

- At Baseline caregivers reported that none of their youth in RMHT were on the waitlist for Wraparound, compared to 6 (9%) in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.2).
- At Baseline two youth (7%) were reportedly on the waitlist for Wraparound, compared to 2 youth (5%) who were on the waitlist in Year 2 (Appendix D, Demographics & Service Awareness, Table 1.3.2).
- Caregivers of 22% of youth in RMHT in Year 2 never received and were not waiting for Wraparound services (Appendix C, Demographics & Awareness, Table 1.3.2).
- 41% of youth in RMHT in Year 2 reported that they never received and were not waiting for Wraparound services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

5.2.2.3 Behavioral Support Services (including Positive Behavior Support; PBS)

The surveys ask about use of PBS within the last 12 months of Baseline data collection and of Behavioral Support Services (including PBS) within the last 12 months of Year 2 data collection. Caregivers reported similar usage of PBS among their youth in RMHT at Baseline and use of Behavioral Support Services (including PBS) among their youth in RMHT in Year 2. In fact, caregivers identified Behavioral Support Services (including PBS) as the most used community-based service among their youth in RMHT at Baseline and in Year 2. On the other hand, fewer youth in RMHT in Year 2 reported using Behavioral Support Services (including PBS) compared to Baseline.

- Caregivers who were aware of PBS represented 24 youth in RMHT at Baseline, 42% of whom had received in PBS in the last 12 months.

        - Caregivers representing 4% of youth in RMHT at Baseline were aware of PBS but were unsure if their youth had received it in the last 12 months.
    - Caregivers who were aware of Behavioral Support Services (including PBS) represented 74 youth in RMHT in Year 2, 46% of whom had received Behavioral Support Services (including PBS) in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
        - Caregivers representing 20% of youth in RMHT in Year 2 were aware of Behavioral Support Services (including PBS) but were unsure if their youth had received it in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
    - 27% of youth in RMHT at Baseline who were aware of PBS said they participated in it within the last 12 months, 6% did not know.
    - 12% of youth in RMHT in Year 2 who were aware of Behavioral Support Services (including PBS) said they participated in it within the last 12 months, 17% did not know (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Few youths in RMHT reported being on the waitlist for PBS at Baseline or in Year 2.

- Caregivers reported that none of their youth in RMHT at Baseline were waiting for Positive Behavioral Support Services, compared to three youths (4%) who were waiting for Behavioral Support Services (including PBS) in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.2).
- One youth in RMHT at Baseline said they were on the waitlist for Positive Behavior Support, and one youth in RMHT in Year 2 said they were on the waitlist for Behavioral Support Services (including PBS; Appendix D, Demographics and Service Awareness, Table 1.3.2)

Compared to caregivers, a greater percentage of youth in RMHT in Year 2 reported that they never received and were not waiting for Behavioral Support Services (including PBS).

- 20% of caregivers said their youth in RMHT in Year 2 never received and not waiting to receive Behavioral Support Services (including PBS; Appendix C, Demographics & Awareness, Table 1.3.2).
- 54% of youth in RMHT in Year 2 said they never received it and are not waiting to receive Behavioral Support Services (including PBS; Appendix D, Demographics and Service Awareness, Table 1.3.2).

It is worth noting that the language in the Year 2 survey changed from PBS to Behavioral Support Services (including PBS) to capture the larger range of services associated with this service. However, some caregivers who took the survey over the phone told survey administrators that they typically associate “BSS” with behavior support specialists who provide care to youth in RMHTFs. Some might also mistake this acronym as standing for the Bureau for Social Services. It will be helpful in future years to reduce the use of acronyms when possible and to ensure that caregivers are reminded of the appropriate context around certain questions. This also supports

the continued use of a survey call center to administer surveys to caregivers over the phone, so that emergent findings such as this can be captured.

5.2.2.4 Assertive Community Treatment

The surveys ask about use of Assertive Community Treatment over the last 12 months. Few youths in RMHT received Assertive Community Treatment at Baseline or in Year 2.

- Caregivers who were aware of Assertive Community Treatment at Baseline represented 19 youth in RMHT, 5% of whom had participated in Assertive Community Treatment the previous 12 months.
- Caregivers who were aware of Assertive Community Treatment in Year 2 represented 20 youth in RMHT, 5% of whom had participated in Assertive Community Treatment in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- Caregivers representing 26% of youth in RMHT at Baseline were aware of Assertive Community Treatment but were unsure if their youth had received it in the last 12 months.
- Caregivers representing 35% of youth in RMHT in Year 2 were aware of Assertive Community Treatment but were unsure if their youth had received it in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- 7% of youth in RMHT at Baseline who were aware of Assertive Community Treatment reported that they had participated in it the previous 12 months, 7% were unsure.
- 2 youths in RMHT in Year 2 (6%) who were aware of Assertive Community Treatment reported receiving it in the last 12 months, 3% were unsure (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Few youths in RMHT were on the waitlist for Assertive Community Treatment at Baseline or in Year 2.

- One caregiver reported that one youth in RMHT at Baseline was on the waitlist for Assertive Community Treatment. Caregivers reported that none of their youth in RMHT in Year 2 were waiting for Assertive Community Treatment (Appendix C, Demographics & Awareness, Table 1.3.2).
- One youth (4%) in RMHT at Baseline was on the waitlist for Assertive Community Treatment; no youths in RMHT in Year 2 reported being on the waitlist for Assertive Community Treatment (Appendix D, Demographics & Awareness, Table 1.3.2).

Compared to self-reports of youth in RMHT in Year 2, a greater percentage of caregivers reported that youth had never received and were not waiting for Assertive Community Treatment.

- Caregivers of 55% of youth in RMHT in Year 2 said that their youth never received and was not waiting for Assertive Community Treatment services (Appendix C, Demographics & Awareness, Table 1.3.2).

- 19% of youth in RMHT in Year 2 said that they never received and were not waiting to receive Assertive Community Treatment services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

5.2.2.5 Residential Mental Health Treatment (RMHT)

The Caregiver Survey asks about use of RMHT in the last 12 months, and similar items were added to the Year 2 Youth Survey.

- Caregivers represented 108 youth in RMHT at Baseline, all of whom received RMHT within the last 12 months, according to DHHR records. Caregivers of 72 of these youth reported being aware of RMHT, and that 72% had received RMHT in the last 12 months, indicating that perhaps caregivers were not aware that the services their youth received fell under "residential mental health treatment," even though they felt confident in their answers. Specifically, caregivers representing 1% of youth in RMHT at Baseline reported being aware of RMHT but unsure whether their youth received RMHT in the last 12 months.
- There were 174 caregivers representing 180 youth in RMHT in Year 2. Caregivers representing 76% of youth in RMHT in Year 2 reported being aware of RMHT (Appendix C, Demographics & Awareness, Table 1.3.1), and that 86% of their youth received it in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2). Caregivers representing 4% of youth in RMHT in Year 2 were aware of RMHT but were unsure if their youth received it in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- 95% of youth in RMHT in Year 2 reported receiving RMHT in the last 12 months, and no youth indicated that they were unsure (Appendix D, Demographics and Service Awareness, Table 1.3.2).

There were few youths waiting for additional RMHT at the time of data collection.

- Caregivers at Baseline reported that three youth (4%) who had received RMHT in the last 12 months were on the waitlist for more RMHT, compared to one youth who was waiting for additional RMHT services in Year 2 (Appendix C, Demographics & Awareness, Table 1.3.2).
- One youth in RMHT in Year 2 said they were on the waitlist for additional RMHT services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

As mentioned, data from the case series interviews indicated that many participants felt that RMHT was the best fit for youth, in part because they felt that the right level of intensive community-based services were not available. Many caregivers felt that it was difficult to get placement in RMHT, and that the court/legal system was their only means to facilitate placement. Those with youth still in a RMHT during Rounds 2 and 3 of case series data collection continued to believe residential treatment was the best available option for their youth's mental and behavioral health needs. In sum, caregivers indicated a desire for community-based services for their youth in lieu of, between, and after RMHTF placement; however, they expressed low

confidence in their ability to access the kind of specialized services that could meet youth's complex, ongoing needs outside of residential treatment.

5.2.2.6 Children's Crisis and Referral Line (CCRL)

The surveys ask about use of services from the CCRL over the last 12 months. Usage of CCRL services reported by caregivers and youth was low at Baseline and in Year 2.

- Caregivers who were aware of the CCRL at Baseline represented 28 youth in RMHT, 7% of whom had received CCRL services in the previous 12 months.
- Caregivers who were aware of the CCRL in Year 2 represented 46 youth in RMHT, 4% of whom had received CCRL services in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- Caregivers representing 18% of youth in RMHT at Baseline were aware of the CCRL but were unsure if their youth received CCRL services in the last 12 months.
- Caregivers representing 15% of youth in RMHT in Year 2 were aware of the CCRL but were unsure if their youth received CCRL services in the last 12 months (Appendix C, Demographics & Awareness, Table 1.3.2).
- 3% of youth in RMHT at Baseline who were aware of the CCRL reported receiving CCRL services in the previous 12 months, 13% were unsure.
- 4% of youth in RMHT in Year 2 who were aware of the CCRL reported receiving CCRL services in the last 12 months, 14% were unsure (Appendix D, Demographics and Service Awareness, Table 1.3.2).

Few youths were waiting for CCRL services, as expected.

- Caregivers reported that none of their youth in RMHT at Baseline or in Year 2 were on a waitlist for CCRL services (Appendix C, Demographics & Awareness, Table 1.3.2).
- At Baseline no youth in RMHT were reportedly on the waitlist for CCRL services, compared to 2 youths (4%) who said they were on the waitlist in Year 2 (Appendix D, Demographics & Service Awareness, Table 1.3.2).
- 72% of caregivers said their youth in RMHT in Year 2 never received and are not waiting for CCRL services (Appendix C, Demographics & Awareness, Table 1.3.2).
- 72% of youth in RMHT in Year2 reported never receiving and were not waiting for CCRL services (Appendix D, Demographics and Service Awareness, Table 1.3.2).

5.2.3 Other Services and Supports Reported by Caregivers and Youth

Some caregivers and their youth in RMHT reported using additional services and supports not listed in the surveys.

- Caregivers of 30% of youth in RMHT at Baseline and caregivers of 39% of youth in RMHT in Year 2 reported the that their youth received or were waiting to receive other mental

and behavioral health services not listed above (Appendix C, Demographics & Awareness, Table 1.4).

- 23% of youth in RMHT at Baseline and 16% of youth in RMHT in Year 2 also reportedly received or were waiting to receive other mental and behavioral health services not listed above (Appendix D, Demographics and Service Awareness, Table 1.4).

Caregivers and their youth in RMHT in Year 2 wrote in the following services that youth received:

- Using counseling/therapy/behavioral health services
- Getting help with medication management
- Having youth evaluated
- Youth participation in step-down programs
- Services offered through hospitals or acute psychiatric facilities
- Services associated with waiver or other DHHR programs, juvenile services, Safe at Home, and educational/vocational/independent living services.

Similarly, in Rounds 2 and 3 of the case series, all caregivers and youth described interventions such as individual, group, and family therapy/counseling, psychiatry, and medication. Some also reported interventions focused on substance use (SAG), anger (ART), trauma, depression, anxiety, ADHD/ADD, sexual behaviors, suicidal ideation, mindful goals, and life skills. One caregiver has obtained assistance from parenting coaches.

As evidenced by case series findings and the "other services and supports" written in on the surveys, there is the possibility that caregivers and/or youth are receiving one or more of the mental and behavioral health services asked about, but they do not recognize the specific service names. This may lead to an underreporting of service usage. To mitigate this issue, service descriptions were included in the surveys, but it cannot be ruled out as a factor given the interview data describing these challenges, and variation in awareness of "residential mental health treatment" despite the fact that all have experienced recent youth stays in RMHTFs. However, caregivers and youth continue to be able to name the organizations and facilities from which services were received. Given their enthusiasm to provide feedback in surveys and interviews, there is little evidence that social desirability affected caregiver or youth reports on usage. It is also worth noting that while caregivers and youth have articulated the need for more services and mental and behavioral health interventions, many express uncertainties about how to best meet youth needs, especially outside of RMHT (see more below).

5.2.4 Barriers to Starting Services

There are several barriers that were reported to have affected the start and continued use of mental and behavioral health services. A similar number of caregivers (approximately half) reported challenges starting services at Baseline and in Year 2. There was a 12% increase in the number of youths in RMHT in Year 2 who reported challenges starting services compared to

Baseline. A greater percentage of caregivers reported barriers to starting services than their youth in RMHT at Baseline and in Year 2.

Caregivers and youth in RMHT were asked to indicate whether they encountered barriers to starting services. If caregivers or youth said "Yes" to experiencing barriers to starting services, they were asked to select which ones from a prepopulated list, with the option to write-in additional barriers. Then participants were asked to indicate which was the "biggest barrier" to starting services.

- Caregivers representing half of the youth in RMHT at Baseline (50%) and caregivers representing 54% of youth in RMHT in Year 2 reported barriers when starting youth mental and behavioral services (Appendix C, Starting Service Barrier, Table 4.1).
- 22% of youth in RMHT at Baseline reported challenges starting services; however, there was little consensus about particular barriers encountered when starting or continuing services. In contrast, 34% of youth in RMHT in Year 2 encountered challenges starting services and trends emerged in barriers they reported (Appendix D, Starting Service Barriers, Table 4.1).

Table 8 below provides a comparison of the percentage of caregivers and youth who experienced barriers to starting services at Baseline and in Year 2. To summarize:

- Caregivers reported difficulties contacting the people responsible for initiating services.
    - For 17% of caregivers this was the biggest barrier encountered when starting services (at Baseline and in Year 2 respectively; Appendix C, Starting Service Barrier, Tables 4.1 and 4.3).
    - The greatest percentage of youth in RMHT in Year 2 (47%) reported this as a barrier to starting services as well (Appendix D, Starting Service Barriers, Table 4.1).
    - As reported in Section 3.2, when asked what additional information is needed to help start and use mental and behavioral health services, **caregivers wrote in that it would be helpful to have contact information for specific people who can help facilitate access to youth services**.
- Caregivers also reported difficulties starting services because the selected services were not available in their area.
    - At Baseline, caregivers reported that lack of available services affected 46% of youth.
    - Caregivers of 37% of youth in RMHT in Year 2 also reported this as a barrier to starting services (Appendix C, Starting Service Barrier, Table 4.1).
- Caregivers also cited long wait times as a barrier to starting services.
    - Caregivers of 41% of youth in RMHT at Baseline and caregivers of 46% of youth in RMHT in Year 2 reported that there was a long wait time between when services

were selected and when the youth was able to start services (Appendix C, Starting Service Barrier, Table 4.1).

- 45% of youth in RMHT in Year 2 who also reported this as a barrier to starting services (Appendix D, Starting Service Barriers, Table 4.1).

The number of caregivers included in Table 8 (n=54 at Baseline and n=78 in Year 2) represents the number of caregivers who responded "Yes" to experiencing barriers to starting mental and behavioral health services for their youth in RMHT. Similarly, the number of youths in Table 8 (n=4 at Baseline and n=49 in Year 2) represents the number of youths in RMHT who self-reported barriers to starting services. Percentages in the table are based off the total number of caregivers and youth who indicated barriers were experienced (at the top of each respective column).

Table 8: Barriers Encountered by Caregivers and Youth When Starting Services by Year

Barriers to Starting Services	Caregivers at Baseline	Caregivers at Year 2	Youth at Baseline	Youth at Year 2
	n=54	n=78	n=4	n=49
The people you needed to contact to start services were unavailable, unresponsive, or too busy.	48%	58%	25%	47%
The system was too complicated.	28%	47%	25%	20%
You didn't understand what you needed to do.	39%	37%	50%	27%
Meetings where things were decided about your child's care were at times that you could not make.	11%	17%	25%	20%
Meetings where things were decided about your child's care were at a location that you could not get to.	13%	18%	25%	20%
Meetings where things were decided about your child's care used technology that you do not have or know how to use.	11%	8%	-	12%

Barriers to Starting Services	Caregivers at Baseline	Caregivers at Year 2	Youth at Baseline	Youth at Year 2
	n=54	n=78	n=4	n=49
None of the programs chosen for your child were a good fit for your child and/or your family.	28%	19%	50%	29%
You couldn't afford the services needed.	7%	8%	25%	10%
There was a long waiting time between when a program was chosen for your child and when your child was able to start the program.	41%	46%	50%	45%
The services that were chosen for your child weren't available in your area.	46%	37%	50%	33%
The services that were chosen for your child weren't available at times when you could join.	15%	22%	25%	20%
The services that were chosen for your child were for a different age group.	7%	14%	50%	12%
You did not have a way to get to and from the services that were chosen for your child.	15%	12%	-	8%
You decided your child didn't need services.	-	1%	-	20%
Other (please specify).	11%	36%	25%	27%

There were a number of "other" challenges encountered by families when starting services. The write-ins were qualitatively analyzed and two of the barriers most commonly cited by caregivers were a lack of communication/involvement in decision making and issues surrounding service availability (Appendix C, Starting Service Barriers, Tables 4.2 and 4.6).

- In terms of communication and decision making, caregivers reported that providers are sometimes unresponsive to the needs of their youth, uncommunicative with families, and generally lacked follow-through.

- A range of barriers were also reported by caregivers with respect to service availability; such barriers included long wait times, insurance related issues, inconvenient hours that conflicted with caregiver schedules, a lack of local providers, and issues associated with eligibility criteria (e.g., a youth was too young/old to qualify for a potentially beneficial service).

Youth identified family-related barriers to starting services; this emerged as a major theme among the youth write-ins (Appendix D, Starting Service Barriers, Table 4.2). Examples include:

- The family did not want the youth to receive services
- Guardian/parent had concerns that the youth might be taken by Child Protective Services (CPS)
- Other issues were going on in the family, such as hospitalizations, drug use, and/or issues with siblings that made it difficult for youth to start services.

Youth also mentioned lack of engagement, including youth's lack of interest in receiving mental and behavioral health services, difficulty disclosing information about their needs and experiences, the desire to run away, not being accepted into services, waitlists, and lack of communication from multidisciplinary teams.

5.2.5 Barriers to Continuing Services

Caregivers and youth also experienced barriers to continuing services. More caregivers and youth experienced barriers to continuing services in Year 2 than at Baseline. A greater percentage of caregivers reported barriers than their youth in RMHT at Baseline and in Year 2.

Caregivers and youth in RMHT were asked to indicate whether they encountered barriers to continuing services. If caregivers or youth said “Yes” to experiencing barriers to continuing services, they were asked to select which ones from a prepopulated list, with the option to write-in additional barriers. Then participants were asked to indicate which was the “biggest barrier” to continuing services.

- Caregivers representing 24% of the youth in RMHT at Baseline and caregivers representing 41% of youth in Year 2 reported barriers to continuing mental and behavioral health services for their youth (Appendix C, Continuing Service Barriers, Table 5.1).
- 17% of youth in RMHT at Baseline and 24% of youth in RMHT in Year 2 also reported barriers to continuing services (Appendix D, Continuing Service Barriers, Table 5.1).

Table 9 below provides a comparison of the percentage of caregivers and youth who experienced barriers to continuing services at Baseline and in Year 2. To summarize, in addition to challenges reaching people to connect them to services and long wait times, barriers to continuing services that were selected by the greatest percentage of caregivers and youth were as follows:

- The services are not producing observable benefits to youth.
    - Caregivers representing more than half of their youths in RMHT at Baseline (58%) reported challenges continuing mental and behavioral health services because

they felt like the services “did not seem to be working,” and for 23% this was the biggest barrier to continuing services.

    - Caregivers representing 38% of youth in RMHT in Year 2 also experienced this barrier (Appendix C, Continuing Service Barriers, Table 5.1), and for 15% it was the biggest barrier to continuing services (Appendix C, Continuing Service Barriers, Table 5.3). The greatest percentage of youth in RMHT in Year 2 (40%) also reported this as a barrier to continuing services (Appendix D, Continuing Service Barriers, Table 5.1).

- Another barrier to continuing mental and behavioral health services was that caregivers and youth did not always feel that the selected services were a good fit.
    - Caregivers representing 23% of youth in RMHT at Baseline and caregivers representing 26% of youth in RMHT in Year 2 indicated that none of the chosen services for their youth were a good fit for their youth and/or families (Appendix C, Continuing Service Barriers, Table 5.1).
    - This barrier to continuing services was also reported by 34% of youth in RMHT in Year 2 (Appendix D, Continuing Service Barriers, Table 5.1).
- Caregivers representing 23% of youth in RMHT at Baseline and 33% in RMHT in Year 2 felt like the system was too complicated, making it difficult to continue services (Appendix C, Continuing Service Barriers, Table 5.1).

The number of caregivers included in Table 9 (n=26 at Baseline and n=58 in Year 2) represents the number of caregivers who responded “Yes” to experiencing barriers to continuing mental and behavioral health services for their youth in RMHT. Similarly, the youth number of youth in Table 9 (n=3 at Baseline and n=35 in Year 2) represents the number of youth in RMHT who self-reported barriers to continuing services. Percentages in the table are based off the total number of caregivers and youth who indicated barriers were experienced (at the top of each respective column).

Table 9: Barriers Encountered by Caregivers and Youth When Continuing Services by Year

Barriers to Continuing Services	Caregivers at Baseline	Caregivers at Year 2	Youth at Baseline	Youth at Year 2
	n=26	n=58	n=3	n=35
The people you needed to contact to continue services were unavailable, unresponsive, or too busy.	42%	45%	-	17%
The system was too complicated.	23%	33%	33%	23%
You didn't understand what you needed to do.	19%	19%	-	23%
Services were at a time that you or your child could not make.	12%	16%	-	6%
Services were at a location that you or your child could not get to.	12%	19%	-	3%
Services used technology that you or your child do not have or know how to use.	-	10%	33%	9%
None of the programs chosen for your child were a good fit for your child and/or your family.	23%	26%	33%	34%
You couldn't afford the services needed.	12%	12%	-	-
There was a long waiting time between when a program was chosen for your child and when your child was able to continue the program.	19%	34%	67%	14%
The services that were chosen for my child were no longer available in my area.	8%	-	33%	-
The services that were chosen for my child were no	4%	-	-	-

Barriers to Continuing Services	Caregivers at Baseline	Caregivers at Year 2	Youth at Baseline	Youth at Year 2
	n=26	n=58	n=3	n=35
longer available at times when I could join.				
The services that were chosen for your child were for a different age group.	-	7%	-	11%
You or your child did not have a way to get to and from the services that were chosen for them.	15%	10%	-	3%
You decided your child did not need services.	-	2%	-	20%
You were unable to balance the time commitment for your child's services with your job and other family commitments.	15%	17%	-	26%
The services did not seem to be working.	58%	38%	-	40%
Other (please specify).	35%	47%	33%	14%

Interestingly, few indicated that transportation, technology, cost, and age-appropriateness were barriers to starting or continuing services in Year 2. Case series results echoed these findings; a caregiver interviewed in Round 3 of the case series reported new use of DHHR transportation assistance for visiting youth in a RMHTF. The transportation assistance directly addressed a barrier; the caregiver expressed that knowing about this service sooner could have decreased frustration. As noted in the table above, caregivers and youth also reported "other" challenges when continuing services. Qualitative analysis of the write-ins revealed that caregivers experience similar barriers to starting and continuing services (Appendix C, Continuing Service Barriers, Table 5.2). Namely, the reported challenges to continuing services clustered around the themes of lack of communication/involvement in decision making and barriers related to service availability such as:

- Eligibility criteria
- Long wait times
- Inconvenient hours

- Lack of providers
- Multiple attempts had to be made to receive help
- Insurance issues

Youth mentioned a lack of support and follow-through from their assigned workers, issues with transitioning out of RMHT, being tired of taking medication, and services interfering with school (Appendix D, Continuing Service Barriers, Table 5.3).

Caregivers were asked whether they had anything else regarding the challenges they encountered in starting and continuing services that they would like to share (Appendix C, Starting Service Barriers, Table 4.5; Appendix C, Continuing Service Barriers, Table 5.4). With respect to starting services, many of these responses were consistent with the previously discussed themes; the most commonly reported barriers were communication issues (i.e., caregivers feel unheard and uninvolved in decision making, the system is difficult to navigate) and service availability issues (e.g., long wait times, inconvenient hours, lack of local providers, restrictive age eligibility criteria, multiple attempts to receive help). Other reported challenges included technology barriers (e.g., issues with conference calls and telehealth), and a lack of youth engagement. These same types of communication issues and the restrictiveness of eligibility criteria were also commonly cited by caregivers as barriers to continuing services. Other reported challenges to service continuation included a lack of local providers, staff turnover (i.e., there is a lack of consistency with staff members, exacerbated by the COVID-19 pandemic), and limited services designed to address the unique, intensive, and complex needs of the youth population.

5.2.6 Services That Were Needed but Not Available

Caregivers and youth reported a number of services that were needed but were perceived as not available. The Year 2 surveys asked more explicitly about barriers that prevented youth from getting needed services.

- 44% of caregivers and 26% of their youth in RMHT in Year 2 reported that there were services they needed that were not available (Appendix C, Starting Service Barriers, Table 4.5; Appendix D, Starting Services, Table 4.4).

When asked to write-in what services were needed but not available, caregivers and their youth in RMHT reported the following:

- At Baseline both caregivers and their youth in RMHT expressed the need for more psychiatric and therapeutic services, and professional services (e.g., mentoring opportunities such as the Big Brothers Big Sisters program, recreational activities, alternative providers). At Baseline caregivers also reported the need for more residential and in-home services, and their youth in RMHT reported the need for family support.
- In Year 2, caregivers wrote in that more behavioral health services (e.g., counseling, medication management) are needed, as well as school-based supports (e.g., counseling, special education support), in-home services, family-based services, and specialized services, such as anger management, mentoring programs, and PTSD focused therapy.

Caregivers also mentioned in Year 2 the need for more community resources/local providers, existing services to be offered with increased consistency and greater frequency, services that better fit the needs of their youth, shorter wait times, less restrictive age eligibility criteria (i.e., being too young/old for a potentially beneficial service), and similar to youth reports, increased communication and earlier intervention. Youth in RMHT in Year 2 expressed in the write-ins wanting more therapy, including school-based, home-based, drug use, depression, trauma, and animal. Several noted having received therapy but wanting more. Others mentioned the need for mentoring opportunities, more independent living facilities, group homes, and rehabilitation facilities. Youth in RMHT in Year 2 also described in the write-ins the need for more communication, particularly with their case workers, the need for basic necessities (i.e., food and clothes), and earlier intervention to delay or avoid RMHT.

In general, caregivers across Round 1 and Round 2 of the case series expressed that they wanted access to more in-home and in-school services, more providers, and more intensive, consistent, individualized services.

One caregiver-youth dyad in the case series described attempting to access community-based therapy after RMHTF discharge. They reported that the facility cancelled an appointment about a month into therapy. When asked if any services have followed up with the family, the caregiver shared that the facility had indicated that they would reach out to reschedule but never did. Thus, this pair was not receiving services during Round 2 interviews and the youth reported no desire for more services. The youth explained, “I just don’t, I don’t know, want to do [counseling] anymore I guess. I got a little older, prefer to work most of the time, and then one day I can step back and deal with it a little bit later" (Youth). In this instance, the facility’s lack of follow-up may have reinforced a belief that the service was not important. However, the caregiver indicated that the youth was seeming more receptive to pursuing services again during the Round 3 interview.

5.2.7 Barriers to Accessing Additional Services and Supports

The surveys ask if youth needed services that they perceived were not available, and if yes, which ones. For example, caregivers and youth indicated the need for more assistance with medication management, and that more stepdown programs were needed. The surveys then ask what barriers were impacting access. Table 10 provides a breakdown of the percentage of caregivers and youth who experienced specific barriers when trying to obtain needed services that were perceived as not available. To summarize:

- Twice as many caregivers reported that there were needed services that were unavailable for youth, and there was greater agreement among caregivers than their youth in RMHT on which barriers they experienced in Year 2.
- Half of caregivers of youth in RMHT in Year 2 felt that they were unable to reach the people responsible for initiating services (Appendix C, Starting Service Barriers, Table 4.4).

- 40% of caregivers indicated that services recommended for their youth in RMHT in Year 2 were no longer available in their areas (Appendix C, Starting Service Barriers, Table 4.4). This was also the biggest barrier reported by youth (28%; Appendix D, Starting Service Barriers, Table 4.4).

The number of caregivers included in Table 10 (n=80) represents the number of caregivers who responded “Yes” to perceiving that there were mental and behavioral health services that youth in RMHT needed but were not available. Similarly, the youth number of youth in Table 10 (n=40) represents the number of youth in RMHT who self-reported that they needed services that were not available. Percentages in the table are based off the total number of caregivers and youth who indicated barriers were experienced (at the top of each respective column).

Table 10: Barriers Preventing Youth from Getting Needed Services That Were Not Available

Barriers Preventing Youth and Caregivers from Accessing Needed Services	Caregivers at Year 2	Youth at Year 2
	n=80	n=40
The people you needed to contact to start services were unavailable, unresponsive, or too busy.	50%	15%
The system was too complicated.	40%	18%
You didn't understand what you needed to do.	30%	18%
Meetings where things were decided about your child's care were at times that you could not make.	15%	8%
Meetings where things were decided about your child's care were at a location that you could not get to.	14%	5%
Meetings where things were decided about your child's care used technology that you do not have or know how to use.	5%	5%
None of the programs chosen for your child were a good fit for your child and/or your family.	26%	23%
You couldn't afford the services needed.	10%	5%
There was a long waiting time between when a program was chosen for your child and when your child was able to start the program.	35%	15%
The services that were chosen for my child were no longer available in my area.	40%	28%
The services that were chosen for my child were no longer available at times when I could join.	8%	8%
The services that were chosen for your child were for a different age group.	16%	15%
You or your child did not have a way to get to and from the services that were chosen for them.	10%	10%
Other (please specify).	24%	30%

Several themes emerged from the qualitative analysis of the write-ins for "other" barriers that prevented youth from getting needed services (Appendix C, Starting Service Barriers, Table 4.4; Appendix D, Starting Service Barriers, Table 4.4). Caregivers reported:

- A lack of suitable services (e.g., restrictive eligibility criteria, distant locations, lack of continuity of care)
- Youth behavioral health and /or medical issues
- Unresponsive/uncommunicative programs
- Feeling uninvolved in decision making regarding the youth's treatment.

Youth reported the following:

- Being unable to locate services
- There are not enough services
- Family not wanting youth to receive services
- Lack of support from the system
- Their symptoms being too severe for available services.

Despite some of the barriers encountered with starting and continuing services**, caregivers are optimistic about knowing who to contact if services are needed again in the future,** according to the survey data. When asked to indicate their levels of agreement on scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree), caregivers reported the following:

- Caregivers of youth in RMHT at Baseline (3.8) and caregivers of youth in RMHT in Year 2 (3.6) agreed that they know who to contact if youth mental and behavioral health services are needed again in the future (Appendix C, Future Service Needs, Table 7.2).

However, caregivers were unsure if mental and behavioral services will be available in the future.

- Caregivers of youth in RMHT at Baseline agreed (3.7) but caregivers of youth in RMHT in Year 2 neither agreed nor disagreed (3.4) that the mental and behavioral health services that their youth need will be available to them again in the future (Appendix C, Future Service Needs, Table 7.2). This might be related to reports of services that were needed but were perceived as not available at the time of the survey.

Similarly, participants in the case series interviews acknowledged that youth would continue to need mental and behavioral health services after discharge from RMHT, but expressed concerns that not enough services were available, especially at higher levels of intensity. More details about discharge planning and transitions out of RMHT can be found in Section 8.1 below. Briefly, all caregivers were open to continuing mental and behavioral health services after youth are discharged from RMHT. However, they were concerned that the specialized community-based services that can help transition their youth back home were far away and/or not available in their areas. **Two of the three youth who had transitioned back home from RMHT by Round 2 of the case series were receiving individual and family therapy, Wraparound, and/or in-home crisis support from a Children's Mobile Crisis Response and Stabilization/CSED Waiver Mobile Response provider,** as well as services that were mandated as part of discharge, such as substance use counseling, probation, juvenile detention, day report, and youth advocate programs. The other youth who had transitioned back home was not receiving community-based

services and expressed no interest in them. At Round 2, caregivers continued to express a need and desire for future community-based services but with low confidence that they would be able to secure the services needed to meet their youths' complex and ongoing needs outside of RMHT.

Providers also share concerns about the adequacy of available mental and behavioral health services for youth. When asked to indicate their level of agreement on a scale from 1 (Disagree) to 5 (Agree), providers reported the following:

- Providers somewhat disagreed at Baseline and in Year 2 that there are adequate youth mental and behavioral health in the areas that they work (1.9 respectively; Appendix E, Referral Policies, Table 8.3). Little variation was observed across provider types or regions.

Taken together, survey and interview data indicated that many caregivers and youth viewed RMHT as the right fit for youth because youth needs are particularly complex and require higher-intensity services that they do not feel are available in the community. Providers also indicated that there is room for growth in the mental and behavioral health services available to youth, and as described in greater detail in Section 6.1, some organizations agreed. Caregivers and youth expressed the need for more and varied types of therapy for youth and their families. They also desired more and higher quality communication with providers. Long wait times also emerged as a theme, despite the fact that caregivers and youth reported that few youths were waiting for additional services at the time of data collection, which is discussed in greater detail in Section 5.3 below. Briefly, there are a number of factors that can contribute to longer wait times, not all which are related to service availability and accessibility; for example, the time it takes for families to complete the steps to enroll in services and obtain assessments, which factor into the time that it takes to process referrals. Lastly, caregivers and youth had difficulty navigating the mental and behavioral health system, leading to the recommendations below.

5.2.8 Recommendations

Recommendation: Continue to develop ways to identify services that are the best fit for youths' needs and strengths, such as the CANS assessment.

Recommendation: Continue to expand the number of providers (e.g., Wraparound facilitators) who are positioned to help caregivers and youth navigate the mental and behavioral health system. Caregivers and youth reported wanting more communication with their providers and case managers, and the need for supports to help promote continuity of care and identify needed services and supports (see Section 8 for more details).

Finding: Length of time to access services varied over time by data source and by service

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- Can WV families with children who need mental health services access those services in a reasonable period of time?
- How has the length of time to access services changed?
- How has the length of time to respond to a child crisis situation changed?
- How has the length of time to access PBS services changed?
- How has the length of time to access wraparound services changed?
- How have waiting periods changed for mental health services?
- How have crisis response times changed?
- How has the average response time for crisis response services changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

5.3.1 Summary

Forty percent of organizations reported having waitlists in Year 2. This represents a 10% increase compared to Baseline. The greatest percentage of organizations with waitlists in Year 2 were those that offered RMHT (67%) and CSED Waiver Wraparound (57%). Region 5 had the smallest percentage of organizations with waitlists at Baseline but the greatest percentage of organizations with waitlists in Year 2.

Caregivers and youth are experiencing fewer challenges with wait times than they have in the past.

5.3.2 Statewide Survey Findings on Waitlists

A larger percentage of organizations reported having waitlists for services in Year 2 compared to Baseline. Statewide, 30% of organizations at Baseline and 40% in Year 2 reported having waitlists (Appendix F, Coordination, Table 5.1).

- Regionally:
  - Region 2 had the greatest percentage of organizations with waitlists at Baseline (52%), and Region 5 had the smallest percentage (31%).
  - Region 5 had the greatest percentage of organizations with waitlists in Year 2 (55%), and Region 1 had the smallest percentage (46%; Appendix F, Coordination, Table 5.1). The number of waitlists reported in Region 5 likely corresponds with staffing and capacity challenges reported in Preston County when asked about service coverage (see Section 5.1 above for more details).
- By Service:
  - RMHTFs had the greatest percentage of organizations with waitlists at Baseline (45%), followed by PBS (40%), and the smallest percentage with waitlists were organizations that offered Assertive Community Treatment (7%).

- RMHTFs still had the greatest percentage with waitlists in Year 2 (67%), and the smallest percentage with waitlists were organizations that offered Children's Mobile Crisis Response and Stabilization and/or WV Children's Mental Health Wraparound (0%; Appendix F, Coordination, Table 5.1).

The following sections provide detailed accounts of waitlists by service and region.

5.3.3 Service-Specific Findings on Waitlists

5.3.3.1 Children's Mobile Crisis Response and Stabilization

Organizations that offered Children's Mobile Crisis Response and Stabilization in Regions 2 and 6 reported having waitlists at Baseline; **none had waitlists in Year 2**, although one organization from Region 2 and one from Region 3 were unsure, and data were not available for Region 5.

Statewide:

- 9% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline had a waitlist for new clients.
- None of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 reported having a waitlist for new clients, although two were unsure (Appendix F, Coordination, Table 5.1).

Region 1:

- The one organization that offered Children's Mobile Crisis Response and Stabilization in Region 1 at Baseline did not have a waitlist.
- The one organization that offered Children's Mobile Crisis Response and Stabilization in Region 1 in Year 2 also did not have a waitlist (Appendix F, Coordination, Table 5.1).

Region 2:

- Two of the organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline (66%) had waitlists.
- One organization that offered Children's Mobile Crisis Response and Stabilization in Region 2 in Year 2 did not have a waitlist for new clients; the other organization providing Children's Mobile Crisis Response and Stabilization in Region 2 in Year 2 was unsure (Appendix F, Coordination, Table 5.1).

Region 3:

- None of the six organizations that offered Children's Mobile Crisis Response and Stabilization in Region 3 at Baseline had waitlists.
- The one organization that offered Children's Mobile Crisis Response and Stabilization in Region 3 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 4:

- None of the 11 organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline had waitlists.
- None of the three organizations that offered Children's Mobile Crisis Response and Stabilization in Region 4 in Year 2 had waitlists (Appendix F, Coordination, Table 5.1).

Region 5:

- None of the 15 organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline had waitlists.
- No organizations or facilities that offered Children's Mobile Crisis Response and Stabilization in Region 5 were captured in the Year 2 Organization and Facility Survey (Appendix F, Coordination, Table 5.1).

Region 6:

- One of 12 organizations that offered Children's Mobile Crisis Response and Stabilization in Region 6 at Baseline (8%) had waitlists.
- The one organization that offered Children's Mobile Crisis Response and Stabilization in Region 6 in Year 2 did not have a waitlist (Appendix F, Coordination, Table 5.1).

5.3.3.2 Children with Serious Emotional Disorders (CSED) Waiver Mobile Response

The Baseline Organization and Facility Survey captured CSED Waiver services in general but did not specify services under the waiver program. During this time the Assessment Pathway was being implemented to ensure that screenings and assessments are conducted in a timely manner, and that families who might be eligible for the CSED Waiver have initiated the application process. The goal set out by DHHR is to have CSED Waiver applications processed within 45 days. The 2023 DHHR Semi-Annual Report indicated that this goal is being met—it took an average of 35 days to determine CSED Waiver eligibility between July and December 2021, and an average of 42 days for eligibility determination between January and June 2022, a change that is likely due in part to an increase in enrollment.

CSED Waiver Mobile Response was added to the Year 2 Organization and Facility Survey to better understand possible nuances across different services under the CSED Waiver. More organizations that offered CSED Waiver Mobile Response had waitlists in Year 2 compared to organizations that offered "CSED Waiver services" at Baseline, but the same percentage had waitlists both years in Region 1. Regions 2, 4, and 6 had smaller percentages with waitlists compared to Baseline. Regions 3 and 5 had greater percentages with waitlists compared to Baseline.

Statewide:

- 31% of organizations that offered CSED Waiver services at Baseline had waitlists for new clients.

- 43% of organizations that offered CSED Waiver Mobile Response in Year 2 had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- Two organizations that offered CSED Waiver services in Region 1 at Baseline (50%) had waitlists.
- One organization that offered CSED Waiver Mobile Response in Region 1 in Year 2 (50%) had a waitlist (Appendix F, Coordination, Table 5.1).

Region 2:

- Four organizations that offered CSED Waiver services in Region 2 at Baseline (67%) had waitlists.
- One organization that offered CSED Waiver Mobile Response in Region 2 in Year 2 (33%) had a waitlist (Appendix F, Coordination, Table 5.1).

Region 3:

- Four organizations that offered CSED Waiver services in Region 3 at Baseline (44%) had waitlists.
- Two organizations that offered CSED Waiver Mobile Response in Region 3 in Year 2 (67%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 4:

- Three organizations that offered CSED Waiver services in Region 4 at Baseline (27%) had waitlists.
- Two organizations that offered CSED Waiver Mobile Response in Region 4 in Year 2 (50%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 5:

- Four organizations that offered CSED Waiver services in Region 5 at Baseline (21%) had waitlists.
- Two organizations that offered CSED Waiver Mobile Response in Region 5 in Year 2 (67%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 6:

- Three organizations that offered CSED Waiver services in Region 6 at Baseline (43%) had waitlists.
- One organization that offered CSED Waiver Mobile Response in Region 6 in Year 2 (33%) had a waitlist (Appendix F, Coordination, Table 5.1).

5.3.3.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

The Baseline Organization and Facility Survey captured CSED Waiver services in general but did not specify services under the waiver program. As mentioned, the Assessment Pathway is helping ensure that more families are being assessed for CSED Waiver services, and data through June 2022 indicate that DHHR is meeting their goals for how quickly applications are processed.

CSED Waiver Wraparound was added to the Year 2 Organization and Facility Survey to better understand possible nuances across different services under the CSED Waiver. Compared to CSED Waiver at Baseline, organizations that offered CSED Waiver Wraparound in Year 2 had a greater percentage with waitlists in every region.

Statewide:

- 31% of organizations that offered CSED Waiver services at Baseline had waitlists for new clients.
- 57% of organizations that offered CSED Waiver Wraparound in Year 2 had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- Two organizations that offered CSED Waiver services in Region 1 at Baseline (50%) had waitlists.
- Two organizations that offered CSED Waiver Wraparound in Region 1 in Year 2 (67%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 2:

- Four organizations that offered CSED Waiver services in Region 2 at Baseline (67%) had waitlists.
- Four organizations that offered CSED Waiver Wraparound in Region 2 in Year 2 (80%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 3:

- Four organizations that offered CSED Waiver services in Region 3 at Baseline (44%) had waitlists.
- Four organizations that offered CSED Waiver Wraparound in Region 3 in Year 2 (67%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 4:

- Three organizations that offered CSED Waiver services in Region 4 at Baseline (27%) had waitlists.
- Five organizations that offered CSED Waiver Wraparound in Region 4 in Year 2 (83%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 5:

- Four organizations that offered CSED Waiver services in Region 5 at Baseline (21%) had waitlists.
- Six organizations that offered CSED Waiver Wraparound in Region 5 in Year 2 (75%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 6:

- Three organizations that offered CSED Waiver services in Region 6 at Baseline (43%) had waitlists.
- Four organizations that offered CSED Waiver Wraparound in Region 6 in Year 2 (57%) had waitlists (Appendix F, Coordination, Table 5.1).

5.3.3.4 WV Children's Mental Health Wraparound

Recent efforts to direct youth and families to the Assessment Pathway have resulted in increased use of the CSED Waiver. To meet increased demand, BMS has expanded CSED Waiver Wraparound services, and as a result WV Children's Mental Health Wraparound is now primarily serving youth who are waiting for their CSED Waiver application to process or who have been determined to be ineligible for CSED Waiver services. BBH is expected to contact families within 5 weekdays to initiate interim WV Children's Mental Health Wraparound services if youth are not already enrolled in the program. The 2023 DHHR Semi-Annual Report indicated that initial contact occurred on average within 2.1 business days, with contact occurring within 5 days for 84% of families. The average wait time for WV Children's Mental Health Wraparound services is 9.2 weekdays; however, some youths are placed on wait lists and can wait an average of 30 days to start services, according to DHHR.

Three of five organizations that offered WV Children's Mental Health Wraparound responded to the Year 2 survey. Two of the three organizations that offered WV Children's Mental Health Wraparound that were captured in Year 2 answered the question about waitlists; one did not have a waitlist and the other was unsure.

Statewide:

- 29% of organizations that offered WV Children's Mental Health Wraparound at Baseline had a waitlist for new clients.
- None of organizations that offered WV Children's Mental Health Wraparound in Year 2 had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- Two of the organizations that offered WV Children's Mental Health Wraparound in Region 1 at Baseline (33%) had a waitlist for new clients.
- The one organization that offered WV Children's Mental Health Wraparound in Region 1 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 2:

- Three organizations that offered WV Children's Mental Health Wraparound in Region 2 at Baseline (75%) had a waitlist for new clients.
- The one organization that offered WV Children's Mental Health Wraparound in Region 2 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 3:

- None of the two organizations that offered WV Children's Mental Health Wraparound in Region 3 at Baseline had a waitlist for new clients.
- The one organization that offered WV Children's Mental Health Wraparound in Region 3 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 4:

- One of the organizations that offered WV Children's Mental Health Wraparound in Region 4 at Baseline (33%) had a waitlist for new clients.
- The one organization that offered WV Children's Mental Health Wraparound in Region 4 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 5:

- None of the eight organizations that offered WV Children's Mental Health Wraparound in Region 5 at Baseline had a waitlist for new clients.
- The one organization that offered WV Children's Mental Health Wraparound in Region 5 in Year 2 was unsure whether they had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 6:

- Two of the organizations that offered WV Children's Mental Health Wraparound in Region 6 at Baseline (22%) had a waitlist for new clients.
- One of the organizations that offered WV Children's Mental Health Wraparound in Region 6 in Year 2 did not have a waitlist and the other was unsure (Appendix F, Coordination, Table 5.1).

5.3.3.5 Behavioral Support Services (including Positive Behavior Support; PBS)

Regions 2, 3, and 6 had a greater percentage of organizations with waitlists for Behavioral Support Services (including PBS) compared to organizations that offered PBS at Baseline; a smaller percentage had waitlists in Regions 1, 4, and 5.

Statewide:

- 40% of organizations that offered PBS at Baseline had a waitlist for new clients.
- 26% of organizations that offered Behavioral Support Services (including PBS) in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- Four of the organizations that offered PBS in Region 1 at Baseline (67%) had waitlists.
- Three of the organizations that offered Behavioral Support Services (including PBS) in Region 1 in Year 2 (50%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 2:

- Five of the organizations that offered PBS in Region 2 at Baseline (38%) had waitlists.
- Seven of the organizations that offered Behavioral Support Services (including PBS) in Region 2 in Year 2 (47%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 3:

- Three of the organizations that offered PBS in Region 3 at Baseline (30%) had waitlists.
- Four of the organizations that offered Behavioral Support Services (including PBS) in Region 3 in Year 2 (40%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 4:

- Four of the organizations that offered PBS in Region 4 at Baseline (67%) had waitlists.
- Five of the organizations that offered Behavioral Support Services (including PBS) in Region 4 in Year 2 (50%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 5:

- Five of the organizations that offered PBS in Region 5 at Baseline (56%) had waitlists.
- Six of the organizations that offered Behavioral Support Services (including PBS) in Region 5 in Year 2 (43%) had waitlists (Appendix F, Coordination, Table 5.1).

Region 6:

- Three of the organizations that offered PBS in Region 6 at Baseline (38%) had waitlists.
- Five of the organizations that offered Behavioral Support Services (including PBS) in Region 6 in Year 2 (42%) had waitlists (Appendix F, Coordination, Table 5.1).

5.3.3.6 Assertive Community Treatment

A greater percentage of organizations had waitlists for Assertive Community Treatment in Year 2 than at Baseline in every region except for Region 6, which had the same percentages (50%) both years.

Statewide:

- 7% of organizations that offered Assertive Community Treatment at Baseline had a waitlist for new clients.
- One (20%) of organizations that offered Assertive Community Treatment in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- The organization that offered Assertive Community Treatment in Region 1 at Baseline did not have a waitlist for new clients.
- The one organization that offered Assertive Community Treatment in Region 1 in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 2:

- No organizations that offered Assertive Community Treatment in Region 2 were captured at Baseline.
- The one organization that offered Assertive Community Treatment in Region 2 in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 3:

- None of the six organizations that offered Assertive Community Treatment in Region 3 at Baseline had waitlists.
- The one organization that offered Assertive Community Treatment in Region 3 in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 4:

- No Assertive Community Treatment providers were captured by the Organization and Facility Survey in Region 4 at Baseline.
- One of four organizations that offered Assertive Community Treatment in Region 4 in Year 2 (25%) reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 5:

- None of the six organizations that offered Assertive Community Treatment in Region 5 at Baseline had waitlists.
- The one organization that offered Assertive Community Treatment in Region 5 in Year 2 reported having a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 6:

- One of two organizations that offered Assertive Community Treatment in Region 6 at Baseline (50%) reported having waitlists.
- One of two organizations that offered Assertive Community Treatment in Region 6 in Year 2 (50%) reported having waitlists (Appendix F, Coordination, Table 5.1).

5.3.3.7 Residential Mental Health Treatment Facilities (RMHTFs)

Compared to Baseline, more RMHTFs had waitlists in Year 2. Regionally there were fewer RMHTFs with waitlists in Region 1, but more RMHTFs had waitlists in Regions 2-6 than at Baseline.

Statewide:

- 45% of RMHTFs at Baseline had a waitlist for new clients.
- 67% of RMHTFs in Year 2 had a waitlist for new clients (Appendix F, Coordination, Table 5.1).

Region 1:

- Nine RMHTFs in Region 1 at Baseline (75%) had waitlists.
- Three RMHTFs in Region 1 in Year 2 (50%) had waitlists; one was unsure (Appendix F, Coordination, Table 5.1).

Region 2:

- Eight RMHTFs in Region 2 at Baseline (80%) had waitlists.
- Two RMHTFs in Region 2 in Year 2 (67%) had waitlists; one did not provide an answer to this survey question (Appendix F, Coordination, Table 5.1).

Region 3:

- Eight RMHTFs in Region 3 at Baseline (53%) had waitlists.
- Two RMHTFs in Region 3 in Year 2 (67%) had waitlists; one did not provide an answer to this survey question (Appendix F, Coordination, Table 5.1).

Region 4:

- Eight RMHTFs in Region 4 at Baseline (80%) had waitlists.
- Five RMHTFs in Region 4 in Year 2 (63%) had waitlists; one was unsure, and one did not provide an answer to this survey question (Appendix F, Coordination, Table 5.1).

Region 5:

- Eight RMHTFs in Region 5 at Baseline (62%) had waitlists.
- Seven RMHTFs in Region 5 in Year 2 (78%) had waitlists; one did not provide an answer to this survey question (Appendix F, Coordination, Table 5.1).

Region 6:

- Eight RMHTFs in Region 6 at Baseline (80%) had waitlists.
- Three RMHTFs in Region 6 in Year 2 (60%) had waitlists; one did not provide an answer to this survey item (Appendix F, Coordination, Table 5.1).

5.3.3.8 Children's Crisis and Referral Line

Waitlist data was not collected in the Year 2 Organization and Facility Survey for First Choice Services. DHHR reports a 14-second wait time for callers to the Children's Crisis and Referral Line.

5.3.4 Length of Waitlist Time

Unfortunately, there was insufficient survey data to compare waitlist times from Baseline to Year 2. Data from the Year 2 Organization and Facility Survey were often missing or reported in a format that did not allow for quantitative analysis; for example, some participants simply wrote that the wait time for services was "a few months." If available, data on length of waitlist times for Year 3 will be included in next year's report.

Case series interviews revealed that any gap in time between identifying a service and initiating that service is particularly challenging for youths and their families. Case series participants described response lag and long wait times to initiate services as ongoing issues impacting the "reasonable period of time" for youth and families to access care needed. For example, one caregiver whose youth had returned home from RMHT by Round 2 of data collection recounted how they were able to receive counseling and other services from their local Children's Mobile Crisis Response and Stabilization team (e.g., during regularly scheduled appointments); however, because the facility was an hour way, they did not feel that they would be able to reach them in an emergent manner. When immediate services were needed, the caregiver previously relied on a neighbor and a local bus driver who worked with the sheriff's reserve because their youth had severe needs and was described as big, physically and verbally abusive, destructive, and fixated on weapons and violence. Several caregivers recounted how their youth ended up placed or had to stay longer in RMHT due to wait times and the lack of available higher intensity community-based mental and behavioral health services in their area. In these instances, caregivers described RMHT as a "holding place" for their youth while alternative treatment plans were developed, and step-down/transitional services were identified.

Overall, perceptions of wait times were mixed. Both caregivers and youth reported that wait times made it difficult for youth to start and/or continue using services, and little variation was observed over time (see Section 5.2 for more details); however, caregivers at Baseline and in Year 2 neither agreed nor disagreed that their youth in RMHT were able to get mental and behavioral health services in the last 12 months without having to wait too long. Youth in RMHT at Baseline also neither agreed nor disagreed. **Youth in Year 2 agreed that they were able to access services in the last 12 months without having to wait too long**. More specifically, when asked to reflect on the last 12 months and report their agreement on scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree), caregivers and youth reported the following:

- Caregivers of youth in RMHT at Baseline and caregivers of youth in Year 2 neither agreed nor disagreed that their youth was able to get mental and behavioral health services without having to wait too long (2.8 respectively; Appendix C, Crisis Support and Access, Table 2.2).

- Youth in RMHT at Baseline neither agreed nor disagreed (3.4) that they could get mental and behavioral health services without having to wait too long. Youth in RMHT in Year 2 agreed (3.7; Appendix D, Experiences with Mental Health, Table 2.1).

Even though a greater percentage of organizations reported having waitlists in Year 2 than at Baseline, **fewer caregivers and youth reported experiencing challenges with wait times during recent periods of data collection**. As reported above, few youths in RMHT were waiting for additional mental and behavioral health services at the time of data collection, and youth in RMHT in Year 2 agreed that over the last 12 months they were able to access services without having to wait too long. Similarly, in Round 3 of the case series, caregivers spoke to past issues with access and timeliness but were not experiencing any current issues with wait times. For example, as mentioned previously, one youth who had been waiting for services at Round 2 was able to get their medication reassessed and started more intensive services that were provided as part of a Medicaid Waiver program and was showing significant improvements as a result. Other caregivers echoed this experience in that they were satisfied with mental and behavioral health services once they were able to access them (see Section 8.2 for more details).

When asked to reflect over the next 12 months, caregivers neither agreed nor disagreed that their youth will be able to access services in a timely manner in the future, and little variation was observed over time. When asked to indicate their level of agreement on a scale that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree), caregivers reported the following:

- Caregivers neither agreed nor disagreed at Baseline (3.3) and in Year 2 (3.2) that their youth in RMHT will be able to access services in the future without having to wait too long (Appendix C, Future Service Needs, Table 7.2).

Caregiver uncertainty about access to future services is likely reflective of past challenges, although next year's report will be able to provide greater insights into trends over time.

5.3.5 Recommendations

Recommendation: Consider ways to reduce the number of organizations with waitlists, particularly in Region 5. It might be helpful, for example, to consider whether there have been recent changes that could explain the increase in waitlists in Region 5, and whether and how this is affecting the length of waitlist times in Region 5.

5.4 Finding: More families are turning to social services rather than calling the police or going to hospital emergency departments to gain access mental and behavioral health services

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How have QA/PI processes improved Children's Mobile Crisis Response services?
- What proportion of families contact the crisis line more than once?

- What is the frequency of Children's Mobile Crisis Response usage and how has this changed over time?
- What is the frequency of Mobile Crisis usage and how has this changed over time?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

5.4.1 Summary

Several data sources provided evidence that fewer families are calling the police or going to hospital emergency departments (ED) to access mental and behavioral health support. For example, **there was a 7% decrease in the number of caregivers who reportedly called the police for assistance with a mental or behavioral health emergency involving their youth compared to Baseline**.

Syndromic data indicate that **fewer youths 21 years of age or younger went to the ED to access mental and behavioral health services compared to Baseline**, and survey data from youth are also reflective of this. Caregivers reported similar use of the ED to gain access to mental and behavioral health services over time, but **youth self-reported a 14% decrease compared to Baseline**. **Youth in RMHT at Baseline and in Year 2 also agreed that they would be able to obtain mental and behavioral health services outside of a hospital setting if services are needed again in the future**. Caregivers at Baseline agreed but in Year 2 neither agreed nor disagreed.

Caregivers and youth were more likely to call social services or another support system than they were to go to the ED or call the police for help, and usage of these alternative supports increased over time. DHHR also reported an increase in the use of the Children's Crisis and Referral Line over time. Further analysis of caller data indicated that there were similar percentages (8%) of repeat calls to 844-HELP4WV made by youth 25 years of age or younger or on behalf of youth (mainly by parents and guardians) in 2021 and 2022. Additional data on recidivism among youth needing crisis services will be included as they become available.

Lastly, **many providers reported that they deliver services to address crises and to support stabilization when interacting with youth with mental and behavioral health needs**. Approximately one third of providers have capacity to provide more crisis intervention and stabilization services in an average week, and little variation was observed over time. **Two thirds of providers expressed an interest in obtaining additional training in this area, indicating provider support for continued efforts to expand community-based services that can mitigate crises and help with stabilization**.

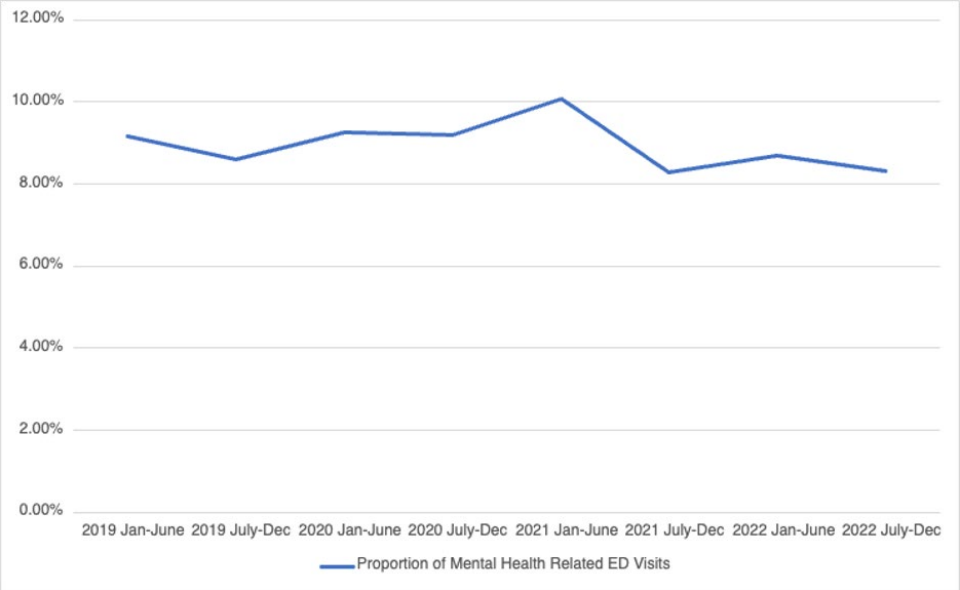
5.4.2 Use of Hospital Emergency Departments to Access Mental and Behavioral Health Services

Immediate mental and behavioral health crises can result in visits to hospital emergency departments (EDs) or calls to the police. DHHR is working to reduce these instances by encouraging the use of the Children's Crisis and Referral Line (844-HELP4WV) and community-

based services such as Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response when crisis services are needed.

Syndromic data allowed for trends to be observed over time for children and youth 21 years of age and younger who presented to EDs across WV for complications related to diagnoses indicative of serious emotional disorders of interest to the Evaluation. Syndromic data pulled in the first quarter of 2023 indicated an overall decline in ED visits between 2019 and 2022. Details on the diagnoses used in this assessment can be found in Appendix B, Table 58. As shown in Figure 2, the ratio of mental health-related ED visits to overall ED visits of those 21 years and younger peaked in the first half of 2021 (10.08%). The ratio declined in the second half of 2021 (8.29%) and maintained a similar ratio throughout 2022 (8.69% to 8.31%).

Figure 2: Trends in Syndromic Data Reflecting Use of Hospital Emergency Departments to Access Youth Mental and Behavioral Health Services



As in-home and community-based mental and behavioral health services continue to expand across WV, the rates of ED usage to treat and stabilize youth diagnosed with serious emotional disorders should decline in response. These data will continue to be monitored and included in next year's report.

While the syndromic data indicated some variation in the use of the ED to access mental and behavioral health services over the last two years, little variation was observed in caregiver reports.

- When asked to reflect over the last 12 months, caregivers of 20% of the youth in RMHT at Baseline and caregivers of 22% of youth in RMHT in Year 2 visited the ED to get their youth mental and behavioral health services (Appendix C, Crisis Support and Access, Table 2.1).

However, **there was a 14% decrease in the number of youths in RMHT who self-reported visits hospital EDs to gain access to mental and behavioral health services.**

- When asked to reflect over the last 12 months, 28% of youth in RMHT at Baseline and 14% in RMHT in Year 2 visited the ED to get mental and behavioral health services (Appendix D, Experiences with Mental Health Services, Table 2.5).

Youth in RMHT at Baseline and in Year 2 also agreed that they would be able to obtain mental and behavioral health services outside of a hospital setting if services are needed again in the future. Caregivers at Baseline agreed but in Year 2 neither agreed nor disagreed. When asked to think about the next 12 months and rate their levels of agreement on scales anchored by 1 (Strongly Disagree) to 5 (Strongly Agree):

- Caregivers of youth in RMHT at Baseline agreed that they would be able to get mental and behavioral health services outside of a hospital setting (3.9), whereas caregivers of youth in RMHT in Year 2 neither agreed nor disagreed (3.3; Appendix C, Future Service Needs, Table 7.2).
- Youth in RMHT at Baseline and in Year 2 agreed that they would be able to get the mental and behavioral health help needed outside of a hospital setting (4.3 respectively; Appendix D, Future Service Needs, Table 6.1).

5.4.3 Involving Law Enforcement During Mental and Behavioral Health Emergencies

There was a 7% decrease from Baseline to Year 2 in the number of caregivers who called the police for a mental and behavioral health emergency involving their youth. When asked to reflect over the last 12 months:

- Caregivers of 40% of youth in RMHT at Baseline and caregivers of 33% of youth in RMHT in Year 2 called the police for help with a mental and behavioral health emergency involving their youth (Appendix C, Crisis Support and Access, Table 2.1).

Compared to Baseline, there was little variation in the percentage of youths in RMHT who self-reported calling the police for help with a mental health emergency.

- 10% of youth in RMHT at Baseline and 9% in RMHT in Year 2 called the police for help with a mental health emergency (Appendix D, Experiences with Mental Health, Table 2.5).

When asked to describe the most recent time the police were called, youth primarily mentioned exhibiting aggressive behaviors and domestic violence situations. Other precipitating factors included accidents, running away, suicide attempts, or general “unlawful” behavior.

5.4.3.1 Law Enforcement Officers’ Training and Experience

As mentioned in Section 4.6, many law enforcement officers expressed an interest in obtaining more training and resources for interacting with youth with mental and behavioral health needs who are experiencing crisis. However, one law enforcement officer mentioned that they did not feel that the police should be responsible for assisting youth with complex needs, stating that it “should not be a LE problem.”

5.4.4 Use of the Children's Crisis and Referral Line and Other Community-Based Crisis Services

The Children's Crisis and Referral Line is set up to serve as an access point to services for caregivers and families. The 2023 DHHR Semi-Annual Report indicated that calls to 844-HELP4WV have significantly increased between 2021 and 2022, with more calls occurring in the last part of 2022 than in all of 2021. However, the greatest percentage of calls (45%) were informational and only 20% were designated as urgent, for example in an emergency or during crises. Further analysis of the caller data indicated that there were similar percentages of repeat calls to 844-HELP4WV made by youth 25 years of age or younger or on behalf of youth (mainly by parents and guardians) in 2021 and 2022.

- In 2021 there were 1,038 calls that could be linked to youth 25 years of age or younger who called 844-HELPWV or had another person (mainly caregivers) call on their behalf. There were 83 of the 1,038 calls (8%) that were identified as repeat calls regarding the same youth in 2021.
- In 2022 there were 849 calls that could be linked to youth 25 years of age or younger who called 844-HELPWV or had another person (mainly caregivers) call on their behalf. There were 68 of the 849 calls (8%) that were identified as repeat calls regarding the same youth in 2022.

Additional data on recidivism among youth needing crisis services will be included in future reports as they become available.

Fewer families are turning to the police or hospital EDs for help, and survey data suggests that usage of the Children's Crisis and Referral Line, Children's Mobile Crisis Response and Stabilization, and CSED Waiver Mobile Response remained relatively low. These results are not surprising among families with youth in RMHT. According to caregivers and their youth in RMHT, less than 10% called and/or received services from the Children's Crisis and Referral Line, and fewer youth used Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response services compared to Baseline (see Section 5.2 for more details). More data are needed to determine whether caregivers and youth feel that these community-based crisis services help delay or prevent youth placement in RMHT; perhaps the data from the at-risk population will be able to provide more insights.

5.4.5 Use of Social Services

Although few caregivers and their youth in RMHT reported using the community-based crisis services included in this Evaluation, an increasing number are calling social services or other support services. In fact, **caregivers and youth were more likely to call social services or another support system than they were to go to the ED or call the police for help**. Compared to Baseline, there was a 9% increase among caregivers who called social services or other support systems and an 11% increase among their youth in RMHT in Year 2.

- Caregivers of 38% of youth in RMHT at Baseline and caregivers of 47% of youth in RMHT called social services or another support service (Appendix C, Crisis Support and Access, Table 2.1).
- 10% of youth in RMHT at Baseline and 21% of youth in RMHT in Year 2 also reported calling social services or another support service for mental and behavioral health help (Appendix D, Experiences with Mental Health, Table 2.5).

5.4.6 Screenings and Assessments During Crisis Encounters

DHHR is also working to ensure that community-based crisis services connect families with the help that they need, both immediately and longer term, through the Children's Crisis and Referral Line, the Assessment Pathway and with screenings and assessments. However, screening and assessments can be challenging during emergency situations. DHHR provided EPDST training for staff at the Children's Crisis and Referral Line, and to provider organizations that offer Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response at the end of 2022, in the event that they are able to conduct screenings and assessments during interactions with youth with mental and behavioral health needs. None of the organizations and facilities that offered Children's Mobile Crisis and Stabilization and/or CSED Waiver Mobile Response reported using the EPDST in Year 2 (Appendix F, Background, Table 1.5); however, the training took place during the data collection period, so changes might not be detectable until Year 3.

5.4.7 Providers' Use of Methods to Address Crises and Promote Stabilization

Seventy-five percent of Year 2 providers reported delivering crisis response and stabilization services as part of their delivery of care to youth with mental and behavioral health needs. Approximately one-third have capacity to provide more crisis and stabilization intervention services in an average week, and little variation was observed over time.

- 86% of providers at Baseline and 75% in Year 2 reported that crisis response and youth stabilization is applicable to their jobs (Appendix E, Skillset & Training, Table 4.1).

Two-thirds of all providers expressed interest in obtaining additional training in crisis and stabilization, and little variation was observed over time.

- 66% of providers at Baseline and 65% in Year 2 expressed an interest in receiving more training on crisis response and stabilization (Appendix E, Skillset & Training, 4.1).
- Social service providers and probation officers indicated in Year 2 that they have the necessary training and skills to respond to youth with mental and behavioral health needs, but also expressed interest in additional training for responding to a mental health crisis involving youth (Appendix E, Social Services & Probation, Tables 13.1).

As reported in Section 3.1, providers are becoming increasingly aware of the Children's Crisis and Referral Line. The delivery of and interest in additional training in crisis and stabilization services implies supportive attitudes towards DHHR's continued efforts to expand community-based crisis and stabilization services.

5.4.8 Recommendations

Recommendation: Continue to increase awareness of the Children's Crisis and Referral Line as a resource for immediate services during crisis, either from staff at the call center or from Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response teams that can provide services over the phone, over video, or in-person. This should continue to minimize use of police and the ED for mental and behavioral health services and increase caregivers' confidence in getting help outside of a hospital setting if services are needed again in the future.

6 Evaluation Results: Workforce Capacity

6.1 Finding: Some stakeholders reported improvements in workforce capacity for youth mental and behavioral services compared to Baseline

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How many mental health providers are available to treat children in WV?
- How has the capacity of the mental health service system workforce changed?
- How has wraparound workforce capacity changed?
- How has the capacity to provide PBS services changed at the region and state levels?
- How have the mobile crisis teams changed?
- How have the hotline staff changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

6.1.1 Summary

DHHR continues to make progress on expanding workforce capacity across the mental and behavioral health system. Some organizations reported using different staffing models to maximize capacity, but fewer contracted with outside providers, or used joint staffing or supervision compared to Baseline. This could be due to the fact that **more organizations reported having adequate staff and staff with the necessary training and skills to provide youth mental and behavioral health services in Year 2 than at Baseline**. However, organizations continued to report issues with capacity, and these findings varied by service and region. **Providers, on the other hand, continue to report capacity and in some cases reported increased capacity to provide needed mental and behavioral health interventions. The most recent round of case series interviews indicated that caregivers are noticing**

these improvements to capacity, which are leading to higher levels of satisfaction and engagement.

Organizations identified a number of strategies to help maximize workforce capacity to enhance service delivery, including offering providers hybrid schedules and increasing the delivery of services virtually. DHHR has been developing and implementing alternative models of care and are also focused on hiring and retention.

Fewer organizations reported that there were particular staff skillsets or credentials that were difficult to hire and/or retain, but this still remains an issue for approximately half of the organizations that responded to the Year 2 survey. Existing providers might be able to help meet these demands—**many providers continued to express interest in obtaining additional training in services and interventions to help support youth with mental and behavioral health needs.** Many also recognize that turnover affects the quality of care delivered to West Virginia youth. **Providers expressed a commitment to staying in their current roles and organizations for the foreseeable future**.

6.1.2 Statewide Findings for Workforce Capacity

DHHR continues to increase the capacity to provide statewide coverage of the services included in this Evaluation. As seen in the Baseline data, organizations will sometimes use different staffing models to help with capacity. There was a slight decrease in the statewide percentages of organizations and facilities that contracted with outside providers, or used joint staffing or joint supervision in Year 2 than at Baseline:

- 65% of organizations at Baseline and 58% in Year 2 contracted with health providers who were not employees of their organizations (Appendix F, Workforce & Capacity, Table 3.1).
- 48% of organizations at Baseline and 31% in Year 2 had joint staffing arrangements (Appendix F, Supervision Staffing, Table 2.1).
- 64% of organizations at Baseline and 37% in Year 2 had joint supervision arrangements (Appendix F, Supervision Staffing, Table 2.1)

It could be that fewer organizations used alternative staffing models due to increases in workforce. **More organizations and facilities reported having adequate staff and having the staff with the necessary training and skills to provide youth mental and behavioral health services compared to Baseline.**

Statewide:

- 41% of organizations at Baseline and 62% in Year 2 had adequate staff (Appendix F, Workforce & Capacity, Table 3.1).
- 53% of organizations at Baseline and 73% in Year 2 agreed that they have staff with the necessary training and skills (Appendix F, Workforce & Capacity, Table 3.1).

Organizations reported improvements in staffing over time but continued to experience challenges hiring and retaining providers with advanced education, training, and certification. Statewide, the survey data indicated that:

- 75% of organizations at Baseline reported that there are staff capabilities, skillsets, or credentials that are hard to recruit or retain, compared to 52% in Year 2 (Appendix F, Workforce & Capacity, Table 3.3). These findings varied by service and region (see more below).

When asked about challenges with hiring and retention, organizations reported at Baseline that they need more staff with graduate degrees that would qualify for licensure. Organizations also expressed at Baseline the need more licensed social workers and therapists. Similarly, **in Year 2 organizations reported the need for more therapists, social workers, nurses, staff with undergraduate and/or master's level degrees, staff with credentials and experience, and staff that are willing to work nights and weekends**. DHHR has implemented several methods for expanding and maximizing existing workforce, including wage increases, developing alternative models of care in partnership with Chapin Hall and the Casey Family Programs, recruitment of more foster families, expanding transitional living options (especially for older youth), and utilizing kinship care when possible. Qualitative analysis of write-in data from Year 2 indicate that organizations have also implemented a number of strategies to help overcome capacity challenges, including: increasing salaries and bonuses, offering hybrid schedules, and utilizing technology for virtual meetings and service delivery. Other agency-wide changes were mentioned, such as investing in training, using collaborative approaches to service delivery, and increasing/strengthening partnerships at the local- and state-level.

Organizations continued to report some challenges with capacity, even with expansions made to the workforce. A greater percentage of organizations indicated that they are experiencing challenges with meeting new referrals and requests for services compared to Baseline. Specifically, fewer organizations reported the capacity to deliver services to all of the youth being referred to them for mental and behavioral health services compared to Baseline:

- 57% of organizations at Baseline and 35% in Year 2 had the capacity to serve the youth receiving referrals to obtain mental and behavioral health services (Appendix F, Workforce & Capacity, Table 3.1).

As reported in greater detail below, several organizations noted that they lacked capacity because youth needed services that they did not offer.

Capacity also varied by region:

- The greatest percentage of organizations reported capacity challenges in Regions 1 and 2 at Baseline.
- The greatest percentage of organizations that reported capacity challenges in Year 2 were in Regions 2 and 5 (Appendix F, Workforce & Capacity, Table 3.1). It is worth noting that Regions 2 and 5 also reported the greatest percentage of organizations with waitlists for

services in Year 2, even though Regions 4 and 6 reported the greatest difficulties with providing service coverage (see Sections 5.1 and 5.3 for more details).

Capacity also varied by service:

- The greatest percentage of organizations that reported challenges with workforce capacity at Baseline were those that provided PBS and WV Children's Mental Health Wraparound services.
- Challenges with workforce capacity remained an issue for Behavioral Support Services (including PBS) but the greatest percentage with said challenges in Year 2 were RMHTFs (Appendix F, Workforce & Capacity, Table 3.1).
- Organizations that reported a lack of workforce and capacity indicated that salary had "a great deal" or "much" to do with challenges hiring and retaining adequate staff and staff with the necessary training and skills at Baseline and in Year 2 (Appendix F, Workforce & Capacity, Table 3.2).

Some organizations that lacked capacity attributed it to a lack of services, meaning youth needed services that some organizations did not offer.

- Lack of services had "much" to do with lack of capacity for organizations that offered Children's Mobile Crisis Response and Stabilization, PBS, and WV Children's Mental Health Wraparound at Baseline.
- Lack of services continued to be a challenge for Behavioral Support Services (including PBS) in Year 2 and was also reported as having "much" to do with capacity for organizations that offered CSED Waiver Wraparound in Year 2. One organization that offered ACT and one organization that offered CSED Waiver Mobile Response in Year 2 also indicated that lack of services had "a great deal" to do with the lack of capacity (Appendix F, Workforce & Capacity, Table 3.2).

Service-specific challenges with workforce and mitigation strategies are reported below.

6.1.3 Workforce Capacity by Service

Organizations were asked about each service that they offer, including whether they use alternative staffing models, about their current capacity, and underlying reasons for lack of capacity among those that were unable to serve all of the youth receiving referrals for services.

6.1.3.1 Children's Mobile Crisis Response and Stabilization

As noted above, no data were available in Year 2 for Children's Mobile Crisis Response and Stabilization in Region 5, but data were available for the remaining regions. Findings suggest that while more organizations that offered Children's Mobile Crisis Response and Stabilization have adequate staff with the necessary training and skills to provide youth mental and behavioral health services compared to Baseline, more providers with advanced degrees are still needed.

- Use of outside providers:

- 67% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 75% in Year 2 contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).

- Joint staffing:
  - 52% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 25% in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline that had joint staffing arrangements were in Region 1 (100%), and the smallest percentage (9%) were in Region 4.
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 with joint staffing arrangements were in Region 2 (50%), and the smallest percentage were in Region 1, 3, and 6 (0% respectively; Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:
  - 64% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 38% in Year 2 used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline that had joint supervision arrangements were in Regions 1 and 3 (100% respectively), and the smallest percentage (9%) were in Region 4.
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 that had joint supervision arrangements were in Region 6 (100%), and the smallest percentage (0%) were in Regions 1 and 3 (Appendix F, Supervision Staffing, Table 2.1).
- Adequate staff:
  - 64% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 50% in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported that salary ranges in WV had "much" to do with staff recruitment; none of the organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 answered this survey question.
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization reporting adequate staff at Baseline were in Regions 1 and 4 (100%), and the smallest percentage (0%) were in Region 2.

        - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that reported adequate staff in Year 2 were in Region 6 (100%), and the smallest percentage were in Regions 1, 2, and 3 (0% respectively; Appendix F, Workforce & Capacity, Table 3.1).
- Staff with necessary training and skills:
    - 61% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 88% in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
    - Statewide, organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported that salary ranges in WV had "a great deal" to do with recruiting staff with the necessary training and skills; none of the organizations or facilities that offered Children's Mobile Crisis Response and Stabilization in Year 2 responded to this survey item.
    - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that reported having the staff with the necessary training and skills at Baseline were in Region 1 (100%), and the smallest percentage (33%) were in Region 2.
    - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that reported having the staff with the necessary training and skills in Year 2 were in Regions 1, 2, 4 and 6 (100% respectively), and the smallest percentage (0%) were in Region 3 (Appendix F, Workforce & Capacity, Table 3.1).
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
    - 91% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials.
        - At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and organizations that offered Children's Mobile Crisis Response and Stabilization also reported the need for more licensed psychologists and traditional healthcare providers.
    - 50% of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials (Appendix F, Workforce & Capacity, Table 3.3).
        - Organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 reported the need for more staff with undergraduate

and/or master's degrees, providers with more experience, and providers with availability to work nights and weekends.

- Capacity to serve all youth being referred:
  - 82% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline responded "Yes" to having the capacity to serve all the youth currently being referred to them, compared to 50% in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported that legal processes such as MOUs or contracts had a "little" to do with the lack of capacity to serve all of the youth being referred; organizations and facilities that offered Children's Mobile Crisis Response and Stabilization in Year 2 reported that it was not at all related to issues with capacity.
  - Statewide, organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported that lack of services had "somewhat" of an impact on the capacity to serve all of the youth being referred; none of the organizations or facilities that offered Children's Mobile Crisis Response and Stabilization in Year 2 responded to this survey item.
  - Statewide, organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline reported that the lack of workforce had "a great deal" to do with a lack of capacity to serve all of the youth being referred; none of the organizations or facilities that offered Children's Mobile Crisis Response and Stabilization in Year 2 responded to this survey item.
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that reported having the capacity to serve all of the youth being referred at Baseline were in Regions 1, 3, and 4 (100% respectively), and the smallest percentage (33%) were in Region 2.
  - The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that reported having the capacity to serve all of the youth being referred in Year 2 were in Regions 1 and 6 (100% respectively), and the smallest percentage (0%) were in Region 3 (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. There were six organizations (18%) that offered Children's Mobile Crisis Response and Stabilization at Baseline that lacked the capacity to serve all of the youth being referred, one of which (17%) said that there were nearby providers who could help meet youth needs. There were four organizations (50%) that offered Children's Mobile Crisis Response and Stabilization in Year 2 that lacked the capacity to serve all of the youth being referred, two of which (50%) said that there were nearby providers who could help meet youth needs; one responded "No," and the other did not know (Appendix F, Workforce & Capacity, Table 3.5.

- Region 2 had the greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that lacked capacity but had nearby providers who could meet youth's needs at Baseline (50%), and Regions 2 and 3 had the greatest percentage with nearby providers in Year 2 (100%).
- None of the organizations that offered Children's Mobile Crisis Response and Stabilization in Regions 5 and 6 that lacked capacity at Baseline had other nearby providers who could meet youth's needs. Neither of the two organizations that offered Children's Mobile Crisis Response and Stabilization in Region 4 in Year 2 that lacked capacity had other nearby providers.
- To help offset capacity challenges in Year 2, 75% split staff across programs (Appendix F, Workforce & Capacity, Table 3.5).

6.1.3.2 Children with Serious Emotional Disorders (CSED) Waiver Mobile Response

The Baseline Organization and Facility Survey asked about the CSED Waiver in general, not the different CSED Waiver services. CSED Waiver Mobile Response was added to the Year 2 Organization and Facility Survey. Few of the organizations that offered CSED Waiver Mobile Response in Year 2 had adequate staff, although many reported that existing staff have the necessary training and skills to help youth with mental and behavioral health needs. Positions that required college degrees were difficult to fill and retain staff, and more providers with experience with youth mental and behavioral health were needed.

- Use of outside providers:
    - 73% of organizations that offered CSED Waiver services at Baseline and 71% of organizations that offered CSED Waiver Mobile Response in Year 2 contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).
- Joint staffing:
    - 62% of organizations that offered CSED Waiver services at Baseline and 29% of organizations that offered CSED Waiver Mobile Response services in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
    - The greatest percentage of organizations that offered CSED Waiver services at Baseline with joint staffing arrangements (68%) were in Region 5, and the smallest percentage (33%) were in Region 2.
    - The greatest percentage of organizations that offered CSED Waiver Mobile Response services in Year 2 with joint staffing arrangements (67%) were in Region 6, and the smallest percentage (25%) were in Region 4 (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:

- 72% of organizations that offered CSED Waiver services at Baseline and 29% of organizations that offered CSED Waiver Mobile Response services in Year 2 used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
- The greatest percentage of organizations that offered CSED Waiver services at Baseline (75%) with joint supervision arrangements were in Region 1, and the smallest percentage (56%) were in Region 3.
- The greatest percentage of organizations that offered CSED Waiver Mobile Response services in Year 2 (67%) with joint supervision arrangements were in Region 6, and the smallest percentage (25%) were in Region 4 (Appendix F, Supervision Staffing, Table 2.1).

- Adequate staff:
  - 50% of organizations that offered CSED Waiver services at Baseline and 29% of organizations that offered CSED Waiver Mobile Response services in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered CSED Waiver services at Baseline reported that salary ranges in WV had “much” to do with staff recruitment; organizations that offered CSED Waiver Mobile Response in Year 2 reported that it had a great deal to do with staff recruitment.
  - The greatest percentage of organizations reporting adequate staff for CSED Waiver services at Baseline (58%) were in Region 6, and the smallest percentage (0%) were in Regions 1 and 2.
  - The most organizations reporting adequate staff for CSED Waiver Mobile Response services in Year 2 (33%) were in Region 6, and the smallest percentage (0%) were in Regions 1, 2, 3, and 5 (Appendix F, Workforce & Capacity, Table 3.1).
- Staff with necessary training and skills:
  - 62% of organizations that offered CSED Waiver services at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 71% that offered CSED Waiver Mobile Response services in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered CSED Waiver services at Baseline reported that salary ranges in WV had “a great deal” to do with recruiting staff with the necessary training and skills; none of the organizations that offered CSED Waiver Mobile Response services in Year 2 responded to this survey item.
  - The greatest percentage of organizations that offered CSED Waiver services at Baseline that reported having the staff with the necessary training and skills (67%) were in Region 3, and the smallest percentage (17%) were in Region 2.

        - The greatest percentage of organizations that offered CSED Waiver Mobile Response services in Year 2 that reported having the staff with the necessary training and skills (75%) were in Region 4, and the smallest percentage (50%) were in Region 1 (Appendix F, Workforce & Capacity, Table 3.1).
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
    - 85% of organizations that offered CSED Waiver services at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials.
        - At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and CSED Waiver service-specific organizations reported the need for more licensed psychologists, in home support staff, and healthcare providers.
    - 86% of organizations that offered CSED Waiver Mobile Response services in Year 2 reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials (Appendix F, Workforce & Capacity, Table 3.3).
        - The organizations that offered CSED Waiver Mobile Response services in Year 2 reported the need for more staff with an undergraduate or master's level degree, staff with experience providing mental and behavioral health services to youth, and flexible schedules that would allow them to work nights and weekends.
- Capacity to serve all youth being referred:
    - 62% of organizations that offered CSED Waiver services at Baseline responded “Yes” to having the capacity to serve all the youth currently being referred to them, compared to 86% that offered CSED Waiver Mobile Response services in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that legal processes such as MOUs or contracts had a “little” to do with the lack of capacity to serve all of the youth being referred; none of the organizations and facilities that offered CSED Waiver Mobile Response services in Year 2 responded to this survey item.
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that lack of services “somewhat” affected the lack of capacity to serve all of the youth being referred. One organization that offered CSED Waiver Mobile Response services in Year 2 responded to this survey item and reported that lack of services had a great deal to do with lack of capacity to provide services to all of the youth being referred.
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that the lack of workforce had “a great deal” to do with a lack of capacity to serve

all of the youth being referred. One organization that that offered CSED Waiver Mobile Response services in Year 2 responded to this survey item and reported that lack of workforce had a great deal to do with lack of capacity to provide services to all of the youth being referred.

- The greatest percentage of organizations that offered CSED Waiver services that reported having the capacity to serve all of the youth being referred at Baseline (68%) were in Region 5, and the smallest percentage (25%) were in Region 1.
- All organizations that offered CSED Waiver Mobile Response services reported having the capacity to serve all of the youth being referred in Year 2 (100%) in every region except Region 5, where 67% reported having capacity to serve all of the youth who needed mobile response services (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. There were 38% of organizations that offered CSED Waiver services that lacked capacity at Baseline and 14% that offered CSED Waiver Mobile Response services that lacked capacity in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).

- Region 3 had the greatest percentage of organizations that offered CSED Waiver services that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (50%), and Regions 2 and 6 had the smallest percentage of organizations that offered CSED Waiver services that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (25% respectively).
- There was one organization that offered CSED Waiver Mobile Response services that lacked capacity in Year 2 that responded to this survey item; they indicated that they did not know if there were other nearby providers to meet youth needs, but they did report that they sought alternative grant funds, they split staff across programs, and reduced the hours that services were available during the day to help with capacity issues (Appendix F, Workforce & Capacity, Table 3.5).

6.1.3.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

The Baseline Organization and Facility Survey asked about CSED Waiver services in general, but not different services offered under the waiver program. CSED Waiver Wraparound was added to the Year 2 Organization and Facility Survey. Many organizations and facilities that offered CSED Waiver Wraparound in Year 2 reported that their existing staff have the training and skills necessary for interacting with youth with mental and behavioral health needs, but did not have enough staff, and expressed the need for staff with more experience or other qualifications such as a college degree in particular.

- Use of outside providers:
    - 73% of organizations that offered CSED Waiver services at Baseline and 67% of organizations and facilities that offered CSED Waiver Wraparound in Year 2

contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).

- Joint staffing:
  - 62% of organizations that offered CSED Waiver services at Baseline and 38% of organizations that offered CSED Waiver Wraparound in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
  - The greatest percentage of organizations that offered CSED Waiver services at Baseline with joint staffing arrangements (68%) were in Region 5, and the smallest percentage (33%) were in Region 2.
  - The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 with joint staffing arrangements (57%) were in Region 5, and the smallest percentage (20%) were in Regions 3 and 4 (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:
  - 72% of organizations that offered CSED Waiver services at Baseline and 62% of organizations that offered CSED Waiver Wraparound in Year 2 used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
  - The greatest percentage of organizations that offered CSED Waiver services at Baseline (75%) with joint supervision arrangements were in Region 1, and the smallest percentage (56%) were in Region 3.
  - The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 (86%) with joint supervision arrangements were in Region 5, and the smallest percentage (33%) were in Region 1 (Appendix F, Supervision Staffing, Table 2.1).
- Adequate staff:
  - 50% of organizations that offered CSED Waiver services at Baseline and 40% of organizations had offered CSED Waiver Wraparound in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered CSED Waiver services at Baseline reported that salary ranges in WV had “much” to do with staff recruitment; in Year 2 organizations that offered CSED Waiver Wraparound reported that it had a great deal to do with recruitment.
  - The greatest percentage of organizations reporting adequate staff for CSED Waiver services at Baseline (58%) were in Region 6, and the smallest percentage (0%) were in Regions 1 and 2.

        - The most organizations reporting adequate staff for CSED Waiver Wraparound in Year 2 (50%) were in Region 3, and the smallest percentage (20%) were in Region 2 (Appendix F, Workforce & Capacity, Table 3.1).
- Staff with necessary training and skills:
    - 62% of organizations that offered CSED Waiver services at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 67% that offered CSED Waiver Wraparound in Year 2, although one organization/facility did not know and the other preferred not to answer.
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that salary ranges in WV had "a great deal" to do with recruiting staff with the necessary training and skills. There were two organizations that offered CSED Waiver Wraparound in Year 2 that responded to this survey item, both of whom reported that salary ranges in WV had "a great deal" to do with recruiting staff with the necessary training and skills.
    - The greatest percentage of organizations that offered CSED Waiver services at Baseline that reported having the staff with the necessary training and skills (67%) were in Region 3, and the smallest percentage (17%) were in Region 2.
    - The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 that reported having the staff with the necessary training and skills (100%) were in Regions 1, and the smallest percentage (60%) were in Region 2 (Appendix F, Workforce & Capacity, Table 3.1).
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
    - 85% of organizations that offered CSED Waiver services at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials.
        - At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and CSED Waiver service-specific organizations and facilities reported the need for more licensed psychologists, in home support staff, and healthcare providers.
    - 47% of organizations and facilities that offered CSED Waiver Wraparound in Year 2 reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials (Appendix F, Workforce & Capacity, Table 3.3).
        - Organizations that offered CSED Waiver Wraparound in Year 2 reported challenges with hiring and retention of qualified staff, staff with an undergraduate or master's degree, and staff with experience providing mental and behavioral health services to youth. One organization mentioned that they struggle to fill all of their positions.

- Capacity to serve all youth being referred:
    - 62% of organizations that offered CSED Waiver services at Baseline responded "Yes" to having the capacity to serve all the youth currently being referred to them, compared to 47% that offered CSED Waiver Wraparound in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that legal processes such as MOUs or contracts had little to do with the lack of capacity to serve all of the youth being referred, and in Year 2 organizations that offered CSED Waiver Wraparound reported that legal processes did "not at all" affect capacity.
    - Statewide, organizations that offered CSED Waiver services at Baseline reported that lack of services "somewhat" affected the lack of capacity to serve all of the youth being referred, whereas organizations that offered CSED Waiver Wraparound in Year 2 reported that it had "much" to do with lack of capacity to serve all of the youth being referred.
    - Statewide, organizations that offered CSED Waiver services at Baseline and organizations that offered CSED Waiver Wraparound in Year 2 reported that the lack of workforce had "a great deal" to do with a lack of capacity to serve all of the youth being referred.
    - The greatest percentage of organizations that offered CSED Waiver services that reported having the capacity to serve all of the youth being referred at Baseline (68%) were in Region 5, and the smallest percentage (25%) were in Region 1.
    - The greatest percentage of organizations that offered CSED Waiver Wraparound that reported having the capacity to serve all of the youth being referred in Year 2 (67%) were in Region 3, and the smallest percentage (33%) were in Region 1 (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. There were 38% of organizations and facilities that offered CSED Waiver services that lacked capacity at Baseline and 53% that offered CSED Waiver Wraparound in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).

- Region 3 had the greatest percentage of organizations that offered CSED Waiver services that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (50%), and Regions 2 and 6 had the smallest percentage of organizations that offered CSED Waiver services that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (25% respectively).
- There was one organization that offered CSED Waiver Wraparound in Year 2 (13%) that reported having other nearby providers who could help meet youth needs; that organization was one of two that covers Region 1.

6.1.3.4 WV Children's Mental Health Wraparound

There were 24 organizations that provided WV Children's Mental Health Wraparound that responded to the Baseline survey. Due to changes in the sampling strategy to reduce redundancies in reporting, only three of the five organizations that offered WV Children's Mental Health Wraparound were captured in Year 2, making it challenging to generalize or make direct comparisons to Baseline. Nevertheless, organizations that provided WV Children's Mental Health Wraparound reported the following:

- Use of outside providers:
    - 79% of organizations that offered WV Children's Mental Health Wraparound at Baseline and 67% in Year 2 contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).
- Joint staffing:
    - 71% of organizations that offered WV Children's Mental Health Wraparound at Baseline and both that responded to this item in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
    - The greatest percentage of organizations that offered WV Children's Mental Health Wraparound at Baseline with joint staffing arrangements (88%) were in Region 5, and the smallest percentage (0%) were in Region 3.
    - There was one organization in Regions 1-5 and both in Region 6 had joint staffing arrangements (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:
    - 83% of organizations that offered WV Children's Mental Health Wraparound at Baseline and one of two that responded to this item in Year 2 used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
    - The greatest percentage of organizations that offered WV Children's Mental Health Wraparound at Baseline with joint supervision arrangements (100%) were in Region 6, and the smallest percentage (50%) were in Regions 2 and 3 respectively.
    - Two organizations responded to this item in Year 2; they both offered WV Children's Mental Health Wraparound in Region 6 but only one indicated that they have joint supervision (Appendix F, Supervision Staffing, Table 2.1).
- Adequate staff:
    - 38% of organizations that offered WV Children's Mental Health Wraparound at Baseline and one of the two that responded to this item in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).

- Statewide, organizations that offered WV Children's Mental Health Wraparound at Baseline reported that salary ranges in WV had "much" to do with staff recruitment. The one organization that reported lacking adequate staff in Year 2 also reported that it had "a great deal" to do with salary ranges in WV (Appendix F, Workforce & Capacity, Table 3.2).
- The greatest percentage of organizations and facilities reporting adequate staff at Baseline (75%) were in Region 5, and the smallest percentage (0%) were in Regions 2 and 6 respectively.
- Two organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to this item, and the one with adequate staff was one of two that cover Region 6 (Appendix F, Workforce & Capacity, Table 3.1).

- Staff with necessary training and skills:
  - 50% of organizations that offered WV Children's Mental Health Wraparound at Baseline and both that responded to this item in Year 2 agreed that they have staff with the necessary training and skills to serve all youth needs (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered WV Children's Mental Health Wraparound at Baseline reported that salary ranges in WV had "a great deal" to do with recruiting staff with the necessary training and skills. The Year 2 organizations that offered WV Children's Mental Health Wraparound did not receive this survey item because none of them reported difficulties with recruiting staff with the necessary training and skills (Appendix F, Workforce & Capacity, Table 3.2).
  - The most organizations that offered WV Children's Mental Health Wraparound that reported having the staff with the necessary training and skills at Baseline (75%) were in Region 5, and the smallest percentage (11%) were in Region 6.
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
  - 88% of organizations that offered WV Children's Mental Health Wraparound at Baseline and both that responded to this item in Year 2 reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials (Appendix F, Workforce & Capacity, Table 3.3).
    - At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and that offered WV Children's Mental Health Wraparound-specific organizations reported the need for more providers with new and/or innovative approaches to mental and behavioral health for youth with complex needs. They also expressed a need for providers who have been cross trained in multiple services.
    - Two of the organizations that offered WV Children's Mental Health Wraparound reported challenges with hiring and retention in Year 2. They

reported the need for more qualified providers, more master's prepared staff, and indicated that all positions have been difficult for them to fill.

- Capacity to serve all youth being referred:
    - 46% of organizations that offered WV Children's Mental Health Wraparound at Baseline and two of three that responded to this item in the Year 2 survey responded "Yes" to having the capacity to serve all the youth currently being referred to them (Appendix F, Workforce & Capacity, Table 3.1).
    - Statewide, organizations that offered WV Children's Mental Health Wraparound at Baseline reported that legal processes such as MOUs or contracts had "somewhat" to do with the lack of capacity to serve all of the youth being referred. The one organization that responded to this item in Year 2 reported that legal processes did "not at all" affect their capacity (Appendix F, Workforce & Capacity, Table 3.2).
    - Statewide, organizations that offered WV Children's Mental Health Wraparound at Baseline reported that lack of services had "somewhat" to do with the lack of capacity to serve all of the youth being referred. None of the organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to this survey item (Appendix F, Workforce & Capacity, Table 3.2).
    - Statewide, organizations that offered WV Children's Mental Health Wraparound at Baseline reported that the lack of workforce had "much" to do with a lack of capacity to serve all of the youth being referred. None of the organizations that offered WV Children's Mental Health Wraparound in Year 2 responded to this survey item (Appendix F, Workforce & Capacity, Table 3.2).
    - The greatest percentage of organizations that offered WV Children's Mental Health Wraparound that reported having the capacity to serve all of the youth being referred at Baseline (75%) were in Region 5, and the smallest percentage (0%) were in Region 4.
    - The organization that lacked capacity to serve all of the youth who needed WV Children's Mental Health Wraparound services in Year 2 did not indicate which region(s) they cover (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. There were 54% of organizations that offered WV Children's Mental Health Wraparound at Baseline and 33% in Year 2 that lacked capacity (Appendix F, Workforce & Capacity, Table 3.1). At Baseline 23% of organizations that lacked capacity to provide WV Children's Mental Health Wraparound at Baseline had a nearby provider to meet youth needs. The one organization that offered WV Children's Mental Health Wraparound that lacked capacity in Year 2 did not have another nearby provider to help meet youth needs (Appendix F, Workforce & Capacity, Table 3.5).

- Region 3 had the greatest percentage of organizations that offered WV Children's Mental Health Wraparound that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (100%), and Region 6 had the smallest percentage of organizations that offered WV Children's Mental Health Wraparound that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (14%).
- The one organization that offered WV Children's Mental Health Wraparound that lacked capacity in the Year 2 survey indicated that they split staff across programs to help with capacity issues (Appendix F, Workforce & Capacity, Table 3.5).

6.1.3.5 Behavioral Support Services (including Positive Behavior Support; PBS)

The Baseline survey asked about PBS. The language in the Year 2 survey was updated to say Behavioral Support Services (including PBS) at the request of DHHR to better describe the services of interest. Approximately half of the organizations that offered Behavioral Support Services (including PBS) in Year 2 had adequate staff, which was an increase compared to Baseline organizations that offered PBS. Many of the organizations that offered Behavioral Support Services (including PBS) in Year 2 reported that existing staff had the necessary training and skills for interacting with youth with mental and behavioral health needs, but needed more therapists, staff with experience, certified staff, classroom teachers, and staff with college degrees.

- Use of outside providers:
    - 63% of organizations that offered PBS at Baseline contracted with health providers outside of their organization. Fifteen organizations that offered Behavioral Support Services (including PBS) in Year 2 (43%) contracted with health providers outside of their organizations (Appendix F, Workforce & Capacity, Table 3.1).
- Joint staffing:
    - 37% of organizations that offered PBS at Baseline and 29% of organizations that offered Behavioral Support Services (including PBS) in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
    - The greatest percentage of organizations that offered PBS with joint staffing arrangements at Baseline (50%) were in Region 1, and the smallest percentage (0%) were in Region 6.
    - The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 with joint staffing arrangements (29%) were in Region 5, although three this region did not know and two selected that they preferred not to answer. The smallest percentage of organizations that offered Behavioral Support Services (including PBS) with joint staffing arrangements (17%) were in Region 1 (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:

- 46% of organizations that offered PBS at Baseline and 29% that offered Behavioral Support Services (including PBS) in Year 2 used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
- The greatest percentage of organizations that offered PBS at Baseline with joint supervision arrangements (69%) were in Region 2, and the smallest percentage (30%) was in Region 3.
- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 with joint supervision arrangements (42%) were in Region 6, and the smallest percentage (17%) was in Region 1 (Appendix F, Supervision Staffing, Table 2.1).

- Adequate staff:
  - 23% of organizations that offered PBS at Baseline and 49% of organizations and facilities that offered Behavioral Support Services (including PBS) in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered PBS at Baseline and that offered Behavioral Support Services (including PBS) in Year 2 that did not have the number of staff needed to provide to youth indicated that salary ranges in WV had “much” to do with difficulties with staff recruitment (Appendix F, Workforce & Capacity, Table 3.2).
  - The greatest percentage of organizations that offered PBS reporting adequate staff at Baseline (30%) were in Region 3, and the smallest percentage (8%) were in Region 2.
  - The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 that had adequate staff (53%) were in Region 5, and the smallest percentage (29%) were in Region 1 (Appendix F, Workforce & Capacity, Table 3.1).
- Staff with necessary training and skills:
  - 43% of organizations that offered PBS at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 63% that offered Behavioral Support Services (including PBS) in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered PBS at Baseline and that offered Behavioral Support Services (including PBS) in Year 2 that needed more staff with the necessary training and skills to serve youth with mental and behavioral health needs reported that salary ranges in WV had “a great deal” to do with challenges with hiring and recruitment.

- The greatest percentage of organizations that offered PBS at Baseline that reported having the staff with the necessary training and skills (50%) were in Region 1, and the smallest percentage (17%) were in Region 4.
- Approximately half of organizations that offered Behavioral Support Services (including PBS) in Year 2 in every region reported having staff with the necessary training and skills to meet youth mental and behavioral health needs. The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 that reported having the staff with the necessary training and skills (69%) were in Region 6, and the smallest percentage (43%) were in Region 1 (Appendix F, Workforce & Capacity, Table 3.1).

- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
  - 66% of organizations that offered PBS at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials, compared to 46% that offered Behavioral Support Services (including PBS) in Year 2. It is worth noting that 11 organizations that offered Behavioral Support Services (including PBS) in Year 2 (31%) responded that they did not know or preferred not to answer (Appendix F, Workforce & Capacity, Table 3.3).
    - At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and PBS-specific organizations and facilities reported additional needs for a variety of providers, including in-home support providers and those with knowledge of how to teach and engage families.
    - Organizations that offered Behavioral Support Services (including PBS) in Year 2 reported the need for more therapists, those with an undergraduate or master's level degree, providers with experience providing mental and behavioral health services to youth, individuals with proper certification, and classroom teachers. Two organizations mentioned that the requirements set by the State make it particularly difficult to fill open positions.
- Capacity to serve all youth being referred:
  - 46% of organizations that offered PBS at Baseline responded “Yes” to having the capacity to serve all the youth currently being referred to them, and 37% that offered Behavioral Support Services (including PBS) in Year 2 also responded “yes” (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered PBS at Baseline reported that legal processes such as MOUs or contracts “somewhat” affected the lack of capacity to serve all of the youth being referred. Organizations that offered Behavioral Support Services (including PBS) in Year 2 indicated that legal processes such as MOUs or contracts had only a little to do with their lack of capacity.

- Organizations that offered PBS at Baseline reported that lack of services "somewhat" affected the lack of capacity to serve all of the youth being referred; organizations that offered Behavioral Support Services (including PBS) in Year 2 reported that it had much to do with it (Appendix F, Workforce & Capacity, Table 3.2).
- Organizations that offered PBS at Baseline reported that the lack of workforce had "much" to do with the lack of capacity to serve all of the youth being referred; organizations that offered Behavioral Support Services (including PBS) in Year 2 reported that it had a great deal to do with it (Appendix F, Workforce & Capacity, Table 3.2).
- The greatest percentage of organizations that offered PBS at Baseline that reported having the capacity to serve all of the youth being referred (60%) were in Region 3, and the smallest percentage (11%) were in Region 5.
- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 that reported having the capacity to serve all of the youth being referred (64%) were in Region 3, and the smallest percentage (44%) were in Region 2 (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. There were 54% of organizations and facilities that offered PBS at Baseline that lacked the capacity to serve all of the youth being referred, 26% of which had another nearby provider to help youth. There were 60% of organizations that offered Behavioral Support Services (including PBS) in Year 2 that lacked the capacity to serve all of the youth being referred, 29% of which had another nearby provider to help youth, although eight organizations did not know (Appendix F, Workforce & Capacity, Table 3.5).

- Region 1 had the greatest percentage of organizations that offered PBS at Baseline that lacked capacity but had nearby providers who could meet youth's needs (50%), and Region 1 continued to have the greatest percentage with nearby providers in Year 2 (33%; Appendix F, Workforce & Capacity, Table 3.5).
- Region 6 had the smallest percentage of organizations that offered PBS at Baseline that lacked capacity but had nearby providers who could meet youth's needs (14%), and Region 6 continued had the smallest percentage with nearby providers in Year 2 (14%; Appendix F, Workforce & Capacity, Table 3.5).
- Organizations that offered Behavioral Support Services (including PBS) in Year 2 helped mitigate capacity issues by obtaining alternative grant funding, splitting staff across programs, reducing the hours that services are available during the day, and reduced the days that services were available.

6.1.3.6 Assertive Community Treatment

The Year 2 Organization and Facility Survey captured 5 organizations that indicated that they provide statewide coverage for Assertive Community Treatment. Staffing was a challenge for many organizations that offered Assertive Community Treatment in Year 2, and more therapists, staff with college degrees, and nurses are needed but tended to be difficult to hire or retain.

- Use of outside providers:
    - 100% of organizations that offered Assertive Community Treatment at Baseline and 80% in Year 2 contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).
- Joint staffing:
    - 50% of organizations that offered Assertive Community Treatment at Baseline and one organization that responded to this item in the Year 2 survey (20%) used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
        - The greatest percentage of organizations using joint staffing at Baseline (100%) were in Region 5, and the smallest percentage (0%) were in Regions 1 and 3, although data were missing for Regions 2 and 4.
        - The one organization that used joint staffing in Year 2 reported that they offered Assertive Community Treatment in all six regions (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:
    - 86% of organizations that offered Assertive Community Treatment at Baseline one organization that responded to this item in the Year 2 survey (20%) used joint supervision (Appendix F, Supervision Staffing, Table 2.1).
        - The greatest percentage of organizations using joint supervision at Baseline (100%) were in Region 6, and the smallest percentage (83%) were in Region 3 and 5, although data were missing for Regions 2 and 4.
        - The one organization that used joint supervision in Year 2 reported that they offered Assertive Community Treatment in all six regions (Appendix F, Supervision Staffing, Table 2.1).
- Adequate staff:
    - 64% of organizations that offered Assertive Community Treatment at Baseline and two of the organizations that responded to this item in the Year 2 survey (40%) reported having the number of staff required to serve all of the youth who need Assertive Community Treatment services (Appendix F, Workforce & Capacity, Table 3.1).

- Both organizations that responded “No” to having adequate staff in Year 2 indicated that salary ranges had a great deal to do with salary ranges in West Virginia (Appendix F, Workforce & Capacity, Table 3.2).
- The greatest percentage of organizations that offered Assertive Community Treatment reporting adequate staff at Baseline (100%) were in Regions 1 and 5, and the smallest percentage (0%) were in Region 6.
- In Year 2, one organization that offered Assertive Community Treatment in Region 4 and one in Region 6 reported having adequate staff; none of the organizations that offered ACT in Regions 1, 2, 3, and 5 reported having adequate staff (Appendix F, Workforce & Capacity, Table 3.1).

- Staff with necessary training and skills:
  - 64% of organizations that offered Assertive Community Treatment at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs. Three organizations that offered Assertive Community Treatment that responded to this item in the Year 2 survey (60%) agreed that they have staff with the necessary training and skills to serve all youth needs (Appendix F, Workforce & Capacity, Table 3.1).
  - One of the two organizations that offered Assertive Community Treatment that lacked the staff with the necessary training and skills responded to follow up questions about why; the one organization that responded to this survey item indicated that salary ranges in WV had a great deal to do with recruiting staff with the necessary training and skills (Appendix F, Workforce & Capacity, Table 3.2).
  - The greatest percentage of organizations that offered Assertive Community Treatment that reported having the staff with the necessary training and skills at Baseline (100%) were in Regions 1 and 5, and the smallest percentage (0%) were in Region 6.
  - Two of three organizations that offered Assertive Community Treatment in Year 2 that reported having staff with the necessary training and skills to serve all the youth who need services responded to follow up questions; both indicated that they have the necessary staff for their Region 4 locations but only one of the two in Region 6 had necessary staff. None of the organizations that offered Assertive Community Treatment in Regions 1, 2, 3, and 5 reported having the staff with the necessary training and skills (Appendix F, Workforce & Capacity, Table 3.1).
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:
  - 86% of organizations that offered Assertive Community Treatment at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials. Four organizations that offered Assertive Community Treatment in Year 2 (80%) indicated that they also had difficulties hiring and/or retaining staff

with certain capabilities, skillsets, or credentials (Appendix F, Workforce & Capacity, Table 3.3).

- At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, and the need for more licensed social workers and therapists, and Assertive Community Treatment-specific organizations reported the need for more licensed psychologists and licensed practical nurses.
- Organizations that offered Assertive Community Treatment in Year 2 that reported challenges with hiring and retention in Year 2 expressed the need for more therapists, staff with an undergraduate degree, and nurses.

- Capacity to serve all youth being referred:
  - 79% of organizations that offered Assertive Community Treatment at Baseline responded "yes" to having the capacity to serve all the youth currently being referred to them. Two of the five organizations that offered Assertive Community Treatment in Year 2 (40%) reported having the capacity to serve all of the youth currently being referred to them (Appendix F, Workforce & Capacity, Table 3.1).
  - Statewide, organizations that offered Assertive Community Treatment at Baseline reported that legal processes such as MOUs or contracts did not affect the lack of capacity to serve all of the youth being referred. In Year 2, two of the three organizations that lacked capacity responded to this survey item stating that MOUs had little to no impact on their ability to serve all of the youth being referred.
  - Statewide, organizations that offered Assertive Community Treatment at Baseline reported that lack of services had "somewhat" to do with the lack of capacity to serve all of the youth being referred. One organization that lacked capacity in Year 2 responded to this survey item and indicated that lack of services had a great deal to do with their lack of capacity to provide Assertive Community Treatment to all of the youth who needed it in Year 2.
  - Statewide, organizations that offered Assertive Community Treatment at Baseline reported that the lack of workforce had "much" to do with a lack of capacity to serve all of the youth being referred. One organization that lacked capacity in Year 2 responded to this survey item and indicated that lack of workforce had a great deal to do with their lack of capacity to provide Assertive Community Treatment to all of the youth who needed it in Year 2.
  - The greatest percentage of organizations that offered Assertive Community Treatment that reported having the capacity to serve all of the youth being referred at Baseline (100%) were in Regions 1 and 3, and the smallest percentage (0%) was in Region 6.
  - In Year 2, both organizations that responded to the survey item reported that they offered Assertive Community Treatment in Regions 4 and 6. Both organizations

from Region 4 reported having adequate capacity, but only one of the two in Region 6 reported having the capacity to serve all of the youth currently being referred to them for services. None of the organizations that offered Assertive Community Treatment in Regions 1, 2, 3, and 5 in Year 2 responded "Yes" to having the adequate staff to provide ACT to all of the youth who needed it in their areas.

Organizations that responded "No" to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth's needs. At Baseline, there were three organizations that did not have the capacity to serve all of the youth being referred for mental and behavioral health services, none of which had other nearby providers to meet youth needs.

- In Year 2, none of the three organizations that lacked capacity to serve all of the youth being referred to them for mental and behavioral health services had other nearby providers to meet youth needs.
- In response to a lack of capacity, two of the three Year 2 organizations (67%) split staff across programs and one location sought alternative grant funding to help with service coverage (Appendix F, Workforce & Capacity, Table 3.5).

6.1.3.7 Residential Mental Health Treatment (RMHT)

Most organizations that offered RMHT reported having adequate staff in Year 2, which is a considerable improvement compared to Baseline. Most organizations that offered RMHT also reported that existing staff have the necessary training and skills, but had challenges hiring and retaining therapists, staff with undergraduate degrees, nurses, and providers who are willing to work with complex mental and behavioral health needs.

- Use of outside providers:
    - 85% of organizations that offered RMHT at Baseline and 78% in Year 2 contracted with health providers outside of their organization (Appendix F, Workforce & Capacity, Table 3.1).
- Joint staffing:
    - 35% of organizations that offered RMHT at Baseline and 28% in Year 2 used joint staffing (Appendix F, Supervision Staffing, Table 2.1).
    - The greatest percentage of organizations that offered RMHT at Baseline with joint staffing arrangements (46%) were in Region 5, and the smallest percentage (20%) were in Region 3.
    - The greatest percentage of organizations that offered RMHT in Year 2 with joint staffing arrangements (40%) were in Region 6, and the smallest percentage (0%) were in Regions 1, 2, and 3 (Appendix F, Supervision Staffing, Table 2.1).
- Joint supervision:

- 65% of organizations that offered RMHT at Baseline and 39% in Year 2 used joint supervision.
- The greatest percentage of organizations that offered RMHT at Baseline with joint supervision arrangements (83%) were in Region 1, and the smallest percentage (30%) were in Regions 2, 4, and 6 respectively.
- The greatest percentage of organizations that offered RMHT in Year 2 with joint supervision arrangements (60%) were in Region 6, and the smallest percentage were in Regions 1, 2, 3, and 5 (33% respectively; Appendix F, Supervision Staffing, Table 2.1).

- Adequate staff:
  - 50% of organizations that offered RMHT at Baseline and 83% in Year 2 had the number of staff required to serve all of the youth who need services (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered RMHT at Baseline and in Year 2 reported that salary ranges in WV had “much” to do with staff recruitment.
  - The greatest percentage of organizations that offered RMHT and reporting adequate staff at Baseline (54%) were in Region 5, and the smallest percentage (47%) were in Region 3.
  - The greatest percentage of organizations that offered RMHT and reporting adequate staff in Year 2 (89%) were in Region 5, and the smallest percentage (50%) were in Region 1 (Appendix F, Workforce & Capacity, Table 3.1).
- Staff with necessary training and skills:
  - 55% of organizations that offered RMHT at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 83% in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered RMHT at Baseline reported that salary ranges in WV had “a great deal” to do with recruiting staff with the necessary training and skills, whereas organizations that offered RMHT in Year 2 reported it had “much” to do with it.
  - The greatest percentage of organizations that offered RMHT that reported having the staff with the necessary training and skills at Baseline (62%) were in Region 5, and the smallest percentage (53%) were in Region 3.
  - The greatest percentage of organizations that offered RMHT that reported having the staff with the necessary training and skills in Year 2 (88%) were in Region 4, and the smallest percentage (67%) were in Regions 2, 3, and 5 (Appendix F, Workforce & Capacity, Table 3.1).
- Difficulties hiring and retaining staff with certain capabilities, skillsets, or credentials:

- 75% of organizations that offered RMHT at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials, compared to 50% in Year 2 (Appendix F, Workforce & Capacity, Table 3.3). At Baseline, all organizations reported the need for more graduate degrees that would qualify for licensure, the need for more licensed social workers and therapists, and more providers with experience helping youth with advanced, complex needs.
- Organizations that offered RMHT in Year 2 reported the need for more therapists, staff with an undergraduate degree, nurses, staff with availability to work nights and weekends, and staff who are willing to work with youth with mental and behavioral health needs.

- Capacity to serve all youth being referred:
  - 65% of organizations that offered RMHT at Baseline responded “Yes” to having the capacity to serve all the youth currently being referred to them, compared to 33% in Year 2 (Appendix F, Workforce & Capacity, Table 3.1).
  - Organizations that offered RMHT at Baseline reported that legal processes such as MOUs or contracts had “a little” to do with the lack of capacity to serve all of the youth being referred, whereas organizations that offered RMHT in Year 2 said legal processes did “not at all” affect their capacity to serve all of the youth being referred.
  - Organizations that offered RMHT at Baseline reported that lack of services did “not at all” affect the lack of capacity to serve all of the youth being referred. There was one RMHTF that responded to this item in Year 2, and they reported that lack of services had “much” to do with their lack of capacity to serve all of the youth being referred.
  - Organizations that offered RMHT at Baseline and in Year 2 reported that the lack of workforce had “much” to do with a lack of capacity to serve all of the youth being referred.
  - The greatest percentage of organizations that reported having the capacity to serve all of the youth being referred to RMHT at Baseline (60%) were in Region 3, and the smallest percentage (40%) were in Regions 2 and 4 respectively.
  - The greatest percentage of organizations that reported having the capacity to serve all of the youth being referred to RMHT in Year 2 (60%) were in Region 6, and the smallest percentage (22%) were in Region 5 (Appendix F, Workforce & Capacity, Table 3.1).

Organizations that responded “No” to having capacity to serve all youth currently being referred to them were asked whether there were other nearby providers who could meet youth’s needs. There were 35% of organizations that offered RMHT at Baseline and 67% in Year 2 that lacked capacity (Appendix F, Workforce & Capacity, Table 3.1).

- Regions 2-6 had the greatest percentage of organizations that offered RMHT that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (33%), and Region 1 had the smallest percentage of organizations that offered RMHT that lacked capacity but had other nearby providers who could meet youth's needs at Baseline (29%)
- None of the organizations that offered RMHT in Year 2 had other nearby providers that could meet youth needs, although four were unsure. Some organizations that offered RMHT tried to seek alternative grant funding, split staff across programs, or other approaches for minimizing the effect of lack of capacity on the ability to meet youth needs (Appendix F, Workforce & Capacity, Table 3.5).

In previous years, COVID protocols emerged as a theme across data sources as something that was impacting mental and behavioral health services, especially on RMHTF campuses. However, few RMHTFs that responded to the Year 2 Organization and Facility Survey (33%) reported that COVID protocols were affecting youth RMHT (Appendix F, Workforce and Capacity, Table 3.4). Six organizations that offered RMHT reported that staff had COVID and were unable to work, and several other organizations that offered RMHT reported that COVID protocols limited the ability to coordinate care with other providers and limited their ability to engage with caregivers.

6.1.3.8 Children's Crisis and Referral Line

There was an increase in the occupancy rates and number of FTEs allocated to the Children's Crisis and Referral Line. According to the 2022 and 2023 DHHR Semi-Annual Reports, the occupancy rate for helpline specialists increased by one FTE (from 85% to 91%), and two additional crisis counselors were hired in 2022. There were three shift lead positions budgeted for in FY 2021, two of which were filled during that time. An additional FTE was added for an additional shift lead in FY 2022, and all four positions were filled during this time.

6.1.4 Provider Perceptions of Workforce Capacity

Providers reported that they have the knowledge and skills to function in their current roles and continued to report capacity and in some cases reported increased capacity to delivery mental and behavioral health interventions.

Most existing providers feel that they have the necessary training to function in their current roles. When asked to rate their levels of agreement on scales that ranged from 1 (Disagree) to 5 (Agree), providers reported the following:

- Providers agreed at Baseline (4.8) and in Year 2 (4.6) they have the necessary training to function in their current role. Little variation observed by provider type—all providers at Baseline and in Year 2 either agreed or somewhat agreed (Appendix E, Skillset & Training, Table 4.2).

Providers are also interested in additional training that might meet some of the needs expressed by organizations.

- At Baseline providers expressed interest in support service integration, cross-training in different services, care coordination, and administration of screenings and assessments.

- In Year 2 more than half of providers expressed interest in trainings focused on specific services (e.g., Assertive Community Treatment, Wraparound) as well as additional training on methods for coordinating care, evidence-based practices such as cognitive behavioral therapy and motivational interventions, screenings and assessments, parental education and training, trauma-informed care, and crisis response and stabilization (Appendix E, Skillset & Training, Table 4.1). Law enforcement officers also expressed the desire for additional training with juveniles experiencing acute mental health crises (43% at Baseline and 44% in Year 2) and more training with Children's Mobile Crisis Response and Stabilization teams (67% at Baseline and 70% in Year 2) (Appendix E, LEOs, Table 12.3).

Providers are also noticing some improvements in others' training and expertise. Most providers neither agreed nor disagreed at Baseline (3.4) that there are other service providers with the experience and expertise to support youth with mental and behavioral health needs, whereas providers in Year 2 somewhat agreed (3.6; Appendix E, Skillset & Training, Table 4.2). On the other hand, providers varied in their agreement that they were aware of well-trained service provider agencies to whom they could refer youth in their area:

- At Baseline, behavior analysts and RMHT social workers somewhat agreed, registered/licensed nurses and RMHT direct care staff somewhat disagreed, and the remaining providers neither agreed nor disagreed.
- In Year 2, RMHT social workers and the one internal medicine practitioner somewhat agreed, family medicine practitioners and psychiatrists somewhat disagreed, and the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.3).

Existing providers continued to report capacity to provide mental and behavioral health interventions, or other forms of support aimed at coordinating care. Providers were asked to select the services, supports, and mental and behavioral health interventions they deliver, and of those which ones they have additional capacity to provide to more youth during an average week (Appendix E, Capacity & Resources, Table 5.1).

- Approximately half of providers continued to report capacity to assist with medication management.
- Approximately half of Year 2 providers had additional capacity for case management, representing a 42% increase compared to Baseline.
- Approximately half of Year 2 providers had additional capacity to deliver family therapy, representing a 24% increase compared to Baseline.

Most of the existing providers in WV remain committed to their positions and organizations. When asked to indicate their levels of agreement on a scale from 1 (Disagree) to 5 (Agree), providers reported the following:

- Most providers intended to stay in their current role, with an average level of agreement of 4.7 at Baseline and an average level of agreement of 4.5 in Year 2 (Appendix E, Plans, Table 6.1).
- Most providers intended to stay in their current organization for the foreseeable future, with an average level of agreement of 4.7 at Baseline and an average level of agreement of 4.6 in Year 2 (Appendix E, Plans, Table 6.1).

Many providers agree that staff turnover affects the quality of care for some providers.

- At Baseline, behavioral analysts, psychiatrists and residential mental health treatment facilities social workers, and most providers in Regions 5 and 6 agreed or somewhat that staff turnover affected their ability to deliver quality care.
- In Year 2, all provider types except for registered/licensed nurses agreed or somewhat agreed that staff turnover affected their ability to deliver quality care and little variation was observed across regions (Appendix E, Referral Policies, Table 8.1.3).

Participants in the case series also agreed that turnover affects the quality and timeliness of care. In Round 3, caregivers continued to report negative past experiences with limited providers, turnover and waitlists. For example, one caregiver mentioned that that there was high therapist turnover in RMHTFs, and that existing staff were not able to provide the level of intensive therapy needed. This led to a three-month gap in therapy services for their youth. Overall, though, **during the most recent round of interviews caregivers felt more engaged and supported by staff and providers in the system, signaling that things may be getting better in terms of turnover.** For example, one youth-caregiver pair is currently waiting for a suitable transitional group home placement that will accept the youth given her specialized needs. The caregiver explained that a DHHR worker is trying to find a placement for the youth closer to home. When asked if she had the support she needed, this caregiver said, “Yeah, it’s better since I have more people on board. Yeah” (Caregiver, Adoptive Mother). Moreover, since Round 1, another youth who had been awaiting a foster home placement after several years in a West Virginia RMHTF was placed in a foster home by Round 3. These experiences are described in greater detail in Sections 8.1 and 8.2 but it is worth noting here that caregivers tended to attribute their levels of engagement or disengagement directly to workforce capacity and staff turnover.

Taken together, these findings support the continued investment in statewide workforce expansion.

6.1.5 Recommendations

Recommendation: Develop strategies that facilitate provider/caregiver partnerships to address youth mental and behavioral health needs.

7 Evaluation Results: System-Level Alignment

7.1 Finding: There is more communication and coordination among bureaus and agencies within DHHR

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How have coordination and communication among agencies and bureaus changed?
- How has coordination/communication among the wraparound programs changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

7.1.1 Summary

DHHR continues to facilitate communication, collaboration, and partnerships at the system-level.

7.1.2 Examples of Collaborations Among Bureaus and Agencies within DHHR

The 2023 DHHR Semi-Annual Report documented many system-level collaborations between the Office of Quality Assurance for Children's Programs, the Bureau for Medical Services (BMS), the Bureau for Behavioral Health (BBH), the Bureau of Juvenile Services (BJS), Child Protective Services (CPS), and Managed Care Organizations, as well as with healthcare, RMHT, and community-based mental and behavioral health service providers. These stakeholders continue to collaborate on policy updates, trainings, and technical support for conducting screenings and assessments, discharge planning, expanded data collection efforts, and engaging and connecting families to the Children's Crisis and Referral Line and the Assessment Pathway. Several examples include but are not limited to:

- Daily collaborations between BMS and BBH to monitor and triage new and existing cases to connect youth and families with needed interim or long-term wraparound services and resources as soon as possible.
- The multistakeholder performance improvement team that meets weekly or bi-weekly to introduce fidelity to the National Wraparound Initiatives across the three programs: West Virginia Children's Mental Health Wraparound, CSED Waiver Wraparound, and Safe at Home.
- Ongoing work with Marshall University and Concord University to implement provider trainings for Wraparound and PBS (respectively) to promote continuity in care practices across the different bureaus and funding mechanisms.

As described in the next section, there is quite a bit of collaboration occurring among bureaus and agencies (e.g., The Department of Education, Child Protective services) and service provider organizations.

7.2 Finding: Stakeholder communication varies over time and by stakeholder

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How well-integrated are mental health services with community healthcare organizations?
- How well-integrated are Children's Mobile Crisis Response services with community healthcare organizations?
- How has coordination/communication between PBS providers and non-PBS providers changed?
- How has coordination/communication between wraparound providers and non-wraparound providers changed?
- How has coordination and communication between Children's Mobile Crisis Response and community-based organizations changed?
- How engaged are stakeholders with Children's Mobile Crisis Response services?
- How have communication and working relationships between mental health and traditional healthcare providers changed?
- What are the working relationships between Children's Mobile Crisis Response services and traditional medical providers?
- How well do Children's Mobile Crisis Response services communicate with traditional medical providers?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

7.2.1 Summary

The greatest percentage of organizations in Year 2 collaborated with CPS and healthcare provider agencies. In fact, Children's Mobile Crisis Response and Stabilization, RMHTFs, Assertive Community Treatment, and WV Children's Mental Health Wraparound reported the greatest amount of collaboration with healthcare providers.

There are several ways that stakeholders communicate and collaborate. One primary method of collaboration is participation in multidisciplinary teams. Most organizations participate in multiagency meetings at least once a month. Otherwise, data indicate that while a decent amount of stakeholder communication occurred in Year 2, many reported that less took place compared to Baseline; however, findings varied by service, provider type, and in some cases by region. For example, social service providers and probation officers generally reported more communication and collaboration than mental and behavioral health and healthcare providers.

7.2.2 Statewide Findings for Stakeholder Communication and Collaboration

Organizations reported a substantial amount of collaboration between agencies, bureaus, and different types of mental and behavioral health, healthcare, and other non-mental and behavioral health providers. Statewide:

- The most common collaborative activity that organizations engaged in at Baseline (89%) and Year 2 (62%) was participation in multidisciplinary meetings on specific cases (Appendix F, Coordination, Table 5.2).
- 71% of organizations collaborated with healthcare providers at Baseline and 38% in Year 2.
- At Baseline, Children's Mobile Crisis Response and Stabilization, Assertive Community Treatment, and RMHTFs had the greatest percentage of organizations that collaborated with healthcare providers, and little regional variation was observed.
- In Year 2 the greatest percentage of organizations that collaborated with healthcare providers were Children's Mobile Crisis Response and Stabilization, WV Children's Mental Health Wraparound, and Assertive Community Treatment (100% respectively), with the only noteworthy regional variation: all three CSED Waiver Mobile Response providers in Region 1 also collaborated with healthcare providers (Appendix F, Coordination, Table 5.2).
- Organizations were asked to report which non-mental health agencies that they collaborate with. Of the non-mental health agencies included in the survey, the greatest percentage of organizations and facilities collaborated with CPS (84%), followed by the Department of Education (80%) at Baseline. Although fewer organizations reported that they collaborated with non-mental health agencies in Year 2, the greatest percentage continued to collaborate with CPS (41%), followed by healthcare provider agencies (38%; Appendix F, Coordination, Table 5.2). Other non-mental health organizations reported in write-in responses included adult protective services, child advocacy centers, crisis referrals, and schools.

Overall, organizations reported less communication and coordination compared to Baseline, but the level of coordination and types of collaborative activities occurring varied by service within and across data collection years.

7.2.2.1 Children's Mobile Crisis Response and Stabilization

All organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 collaborated with healthcare providers. Many also collaborated with CPS, the Department of Education, and juvenile probation.

Collaborative activities:

- Case consultation:

        - 79% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 50% in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
    - Care coordination/scheduling:
        - 64% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 25% in Year 2 coordinated care (Appendix F, Coordination, Table 5.2).
    - Coordinated planning across programs:
        - 64% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 25% in Year 2 engaged in coordinated planning with other programs (Appendix F, Coordination, Table 5.2).
    - Multidisciplinary team meetings:
        - 94% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 63% in Year 2 participated in multidisciplinary meetings (Appendix F, Coordination, Table 5.2).
    - Release of information between agencies:
        - 85% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 63% in Year 2 released information to other agencies (Appendix F, Coordination, Table 5.2).
    - Other:
        - One organization that offered Children's Mobile Crisis Response and Stabilization in Year 2 indicated they participated in "other" collaborative activities such as referrals for appropriate care and treatment (Appendix F, Coordination, Table 5.2). Please see 7.3 below for more information about referral processes.
    - Frequency of participation in multiagency meetings:
        - 81% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 51% in Year 2 participated in multiagency meetings at least once a month; four (50%) were unsure (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- Most organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline (91%) and all organizations and facilities in Year 2 (100%) collaborated with primary healthcare provider agencies (Appendix F, Coordination, Table 5.2).
- 67% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 88% in Year 2 coordinated with community-based youth health services (Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
    - 91% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 100% in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
    - 79% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 75% in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
    - 61% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 50% in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
    - 52% of organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline and 75% in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).

7.2.2.2 Children with Serious Emotional Disorders (CSED) Waiver Mobile Response

The Baseline Organization and Facility Survey asked about CSED Waiver services in general; the Year 2 Organization and Facility Survey separated the CSED Waiver by service. All of the organizations that offered CSED Waiver Mobile Response in Year 2 collaborated with the Department of Education. Many also collaborated with healthcare providers, CPS, and juvenile probation.

Collaborative activities:

- Case consultation:
    - 77% of organizations that offered CSED Waiver services at Baseline and 43% that offered CSED Waiver Mobile Response in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
    - 69% of organizations that offered CSED Waiver services at Baseline and 43% that offered CSED Waiver Mobile Response in Year 2 (Appendix F, Coordination, Table 5.2)
- Coordinated planning across programs:

        - 81% of organizations that offered CSED Waiver services at Baseline and 43% that offered CSED Waiver Mobile Response in Year 2 (Appendix F, Coordination, Table 5.2)
    - Multidisciplinary team meetings:
        - 88% of organizations that offered CSED Waiver services at Baseline and 43% that offered CSED Waiver Mobile Response in Year 2 (Appendix F, Coordination, Table 5.2)
    - Release of information between agencies:
        - 88% of organizations that offered CSED Waiver services at Baseline and 57% that offered CSED Waiver Mobile Response in Year 2 (Appendix F, Coordination, Table 5.2)
    - None of the above:
        - Two organizations that offered CSED Waiver services at Baseline (8%) and two organizations that offered CSED Waiver Mobile Response in Year 2 indicated that they do not participate in any of the collaborative activities listed above.
    - Frequency of participation in multiagency meetings:
        - 88% of the organizations that offered CSED Waiver at Baseline participated in multiagency meetings at least once a month. Fifty seven percent of organizations that offered CSED Waiver Mobile Response in Year 2 indicated that they participated in multiagency meetings at least once a month; two were unsure (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- Most of the organizations that offered CSED Waiver services at Baseline (91%) collaborated with primary healthcare provider agencies, compared to 86% of organizations and facilities that offered CSED Waiver Mobile Response in Year 2 (Appendix F, Coordination, Table 5.2).
- 67% of organizations that offered CSED Waiver at Baseline and 71% that offered CSED Waiver Mobile Response in Year 2 coordinated with community-based youth health services (Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
    - 88% of organizations that offered CSED Waiver services at Baseline and 86% that offered CSED Waiver Mobile Response in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:

        - 81% of organizations that offered CSED Waiver services at Baseline and 100% that offered CSED Waiver Mobile Response in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
    - 77% of organizations that offered CSED Waiver services at Baseline and 57% that offered CSED Waiver Mobile Response in Year 2 collaborated with Juvenile Justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
    - 73% of organizations that offered CSED Waiver services at Baseline and 86% that offered CSED Waiver Mobile Response in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).
- Not applicable because they do not collaborate with non-mental health organizations:
    - Three organizations that offered CSED Waiver at Baseline (12%) indicated that they do not collaborate with non-mental health agencies. All of the organizations that offered CSED Waiver Mobile Response in Year 2 collaborated with at least one non-mental health agency (Appendix F, Coordination, Table 5.2).

7.2.2.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

The Baseline Organization and Facility Survey asked about CSED Waiver services in general; the Year 2 Organization and Facility Survey separated the CSED Waiver by service. Organizations that offered CSED Waiver Wraparound in Year 2 tended to collaborate most with healthcare providers and CPS.

Collaborative activities:

- Case consultation:
    - 77% of organizations that offered CSED Waiver services at Baseline reported that they consulted on cases. Thirty three percent of the organizations that offered CSED Waiver Wraparound in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
    - 69% of organizations that offered CSED Waiver services at Baseline and 60% of organizations that offered CSED Waiver Wraparound in Year 2 indicated that they coordinate care with other provider agencies (Appendix F, Coordination, Table 5.2).
- Coordinated planning across programs:
    - 81% of organizations that offered CSED Waiver services at Baseline and 53% of organizations that offered CSED Waiver Wraparound in Year 2 indicated that they

engage in coordinated planning with other programs (Appendix F, Coordination, Table 5.2).

- Multidisciplinary team meetings:
    - 88% of organizations that offered CSED Waiver services at Baseline and 60% of organizations that offered CSED Waiver Wraparound in Year 2 participated in multidisciplinary meetings (Appendix F, Coordination, Table 5.2).
- Release of information between agencies:
    - 88% of organizations that offered CSED Waiver services at Baseline and 53% of organizations that offered CSED Waiver Wraparound in Year 2 released information to other agencies (Appendix F, Coordination, Table 5.2).
- None of the above:
    - Two organizations that offered CSED Waiver services at Baseline (8%) indicated that they do not participate in any of the above activities; none of the organizations that offered CSED Waiver Wraparound in Year 2 selected this option (Appendix F, Coordination, Table 5.2).
- Frequency of participation in multiagency meetings:
    - 88% of the organizations that offered CSED Waiver at Baseline and 60% of the organizations that offered CSED Waiver Wraparound in Year 2 participated in multiagency meetings at least once a month (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- Most of the organizations that offered CSED Waiver services at Baseline (91%) collaborated with primary healthcare provider agencies, compared to 73% of organizations that offered CSED Waiver Wraparound in Year 2 (Appendix F, Coordination, Table 5.2).
- 67% of organizations that offered CSED Waiver services at Baseline and 60% that offered CSED Waiver Wraparound in Year 2 coordinated with community-based youth health services (Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
    - 88% of organizations that offered CSED Waiver services at Baseline and 73% of organizations that offered CSED Waiver Wraparound in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
    - 81% of organizations that offered CSED Waiver services at Baseline and 67% of organizations that offered CSED Waiver Wraparound in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:

        - 77% of organizations that offered CSED Waiver services at Baseline and 40% of the organizations that offered CSED Waiver Wraparound in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
    - 73% of organizations that offered CSED Waiver services at Baseline and 53% of the organizations that offered CSED Waiver Wraparound in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).
- Not applicable because they do not collaborate with non-mental health organizations:
    - Three organizations that offered CSED Waiver services at Baseline (12%) and two organizations that offered CSED Waiver Wraparound in Year 2 (13%) indicated that they do not collaborate with non-mental health organizations (Appendix F, Coordination, Table 5.2).

7.2.2.4 WV Children's Mental Health Wraparound

There were three organizations that offered WV Children's Mental Health Wraparound that filled out the Year 2 survey, making it difficult to generalize and compare findings.

Collaborative Activities:

- Case consultation:
    - 92% of organizations that offered WV Children's Mental Health Wraparound at Baseline and % in Year 2 consulted on cases. None of the three organizations that offered West Virginia Children's Mental Health Wraparound in Year 2 indicated that they consult on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
    - 63% of organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 indicated that they coordinate care with other provider organizations (Appendix F, Coordination, Table 5.2).
- Coordinated planning across programs:
    - 75% of organizations that offered WV Children's Mental Health Wraparound at Baseline and one of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 indicated that they engage in coordinated planning (Appendix F, Coordination, Table 5.2).
- Multidisciplinary team meetings:
    - 88% of organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 indicated that they participate in multidisciplinary team meetings (Appendix F, Coordination, Table 5.2).

- Release of information between agencies:
    - 88% of organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 indicated that they release information to other provider agencies (Appendix F, Coordination, Table 5.2).
- Frequency of participation in multiagency meetings
    - 97% of the organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 participated in multiagency meetings at least once a month (Appendix F, Coordination, Table 5.2).
- Collaboration with healthcare providers:
    - 75% of organizations that offered WV Children's Mental Health Wraparound at Baseline and all three of the organizations that offered WV Children's Mental Health Wraparound in Year 2 collaborated with primary healthcare provider agencies (Appendix F, Coordination, Table 5.2).
    - 83% of the organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 coordinated with community-based youth services.

Collaboration with other non-mental health agencies:

- Child protective services:
    - 100% of organizations that offered WV Children's Mental Health Wraparound at Baseline and all three of the organizations that offered WV Children's Mental Health Wraparound in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
    - 96% of organizations that offered WV Children's Mental Health Wraparound at Baseline and all three organizations that offered WV Children's Mental Health Wraparound in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
    - 83% of organizations that offered WV Children's Mental Health Wraparound at Baseline and two of the three organizations that offered WV Children's Mental Health Wraparound in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:

- 92% of organizations that offered WV Children's Mental Health Wraparound at Baseline and all three of the organizations that offered WV Children's Mental Health Wraparound in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).

7.2.2.5 Behavioral Support Services (including Positive Behavior Support; PBS)

The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 collaborated with CPS and the Department of Education.

Collaborative activities:

- Case consultation:
  - 71% of organizations that offered PBS at Baseline and 37% of organizations that offered Behavioral Support Services (including PBS) in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
  - 40% of organizations that offered PBS at Baseline and 26% of organizations that offered Behavioral Support Services (including PBS) in Year 2 coordinated care (Appendix F, Coordination, Table 5.2).
- Coordinated planning across programs:
  - 51% of organizations that offered PBS at Baseline and 37% of organizations of that offered Behavioral Support Services (including PBS) in Year 2 engaged in coordinated planning with other programs (Appendix F, Coordination, Table 5.2).
- Multidisciplinary team meetings:
  - 86% of organizations that offered PBS at Baseline and 69% of organizations that offered Behavioral Support Services (including PBS) in Year 2 participated in multidisciplinary meetings (Appendix F, Coordination, Table 5.2).
- Release of information between agencies:
  - 74% of organizations that offered PBS at Baseline and 34% of organizations that offered Behavioral Support Services (including PBS) in Year 2 released information to other agencies (Appendix F, Coordination, Table 5.2).
- Other:
  - Three of the organizations that offered Behavioral Support Services (including PBS) in Year 2 (9%) indicated that they participate in other collaborative activities such as multi-stakeholder training.
- None of the above:
  - Two organizations that offered PBS at Baseline (6%) and three that offered Behavioral Support Services (including PBS) in Year 2 (9%) reported that they do

not engage in any of the above collaborative activities (Appendix F, Coordination, Table 5.2).

- Frequency of participation in multiagency meetings:
    - 71% of organizations that offered PBS at Baseline. Forty two percent of the organizations that offered Behavioral Support Services (including PBS) in Year 2 participated in multiagency meetings at least once a month, whereas 20% reported participating quarterly or annually, 20% were unsure, and one organization (3%) reported never participating in multiagency meetings (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- Many organizations coordinate with healthcare providers. Sixty three percent of organizations that offered PBS at Baseline and 57% that offered Behavioral Support Services (including PBS) in Year 2 collaborated with primary healthcare provider agencies (Appendix F, Coordination, Table 5.2).
- 40% of organizations that offered PBS at Baseline and 29% that offered Behavioral Support Services (including PBS) in Year 2 coordinated with community-based youth health services (Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
    - 74% of organizations that offered PBS at Baseline and 57% of organizations that offered Behavioral Support Services (including PBS) in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
    - 80% of organizations that offered PBS at Baseline and 49% of organizations that offered Behavioral Support Services (including PBS) in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
    - 37% of organizations that offered PBS at Baseline and 23% of organizations that offered Behavioral Support Services (including PBS) in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
    - 40% of organizations that offered PBS at Baseline and 26% of organizations that offered Behavioral Support Services (including PBS) in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).
- Not applicable because they do not collaborate with non-mental health organizations:

- Five organizations that offered PBS at Baseline (14%) and four organizations that offered Behavioral Support Services (including PBS) in Year 2 (11%) indicated that they do not collaborate with non-mental health organizations (Appendix F, Coordination, Table 5.2).

7.2.2.6 Assertive Community Treatment

All five organizations that offered Assertive Community Treatment in Year 2 collaborated with healthcare providers and CPS. Many also collaborated with juvenile justice and juvenile probation.

Collaborative activities:

- Case consultation:
  - 100% of organizations that offered Assertive Community Treatment at Baseline and 40% in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
  - 86% of organizations that offered Assertive Community Treatment at Baseline and 40% in Year 2 coordinated care (Appendix F, Coordination, Table 5.2).
- Coordinated planning across programs:
  - 93% of organizations that offered Assertive Community Treatment at Baseline and 40% in Year 2 engaged in coordinated planning with other programs (Appendix F, Coordination, Table 5.2).
- Multidisciplinary team meetings:
  - 93% of organizations that offered Assertive Community Treatment at Baseline and 60% in Year 2 participated in multidisciplinary meetings (Appendix F, Coordination, Table 5.2).
- Release of information between agencies:
  - 93% of organizations that offered Assertive Community Treatment at Baseline and 60% in Year 2 released information to other agencies (Appendix F, Coordination, Table 5.2).
- Frequency of participation in multiagency meetings:
  - All of the organizations that offered Assertive Community Treatment at Baseline participated in multiagency meetings at least once a month. Two of the five organizations that offered Assertive Community Treatment in Year 2 indicated that they participated in multiagency meetings at least once a month; two were unsure (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- A substantial amount of coordination occurs between organizations that offered Assertive Community Treatment and healthcare providers. All organizations that offered Assertive

Community Treatment at Baseline and in Year 2 collaborated with primary healthcare provider agencies (Appendix F, Coordination, Table 5.2).

- A greater percentage of organizations that offered Assertive Community Treatment coordinated with community-based youth health services in Year 2 (100%) than at Baseline (57%; Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
  - 93% of organizations that offered Assertive Community Treatment at Baseline and 100% in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
  - 100% of organizations that offered Assertive Community Treatment at Baseline and 60% in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
  - 71% of organizations that offered Assertive Community Treatment at Baseline and 80% in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
  - 64% of organizations that offered Assertive Community Treatment at Baseline and 80% in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).

7.2.2.7 Residential Mental Health Treatment (RMHT)

All of the organizations that offered RMHT that responded to the Year 2 survey indicated that they collaborate with CPS. Many also collaborate with healthcare providers and juvenile justice.

Collaborative activities:

- Case consultation:
  - 80% of organizations that offered RMHT at Baseline and 44% in Year 2 consulted on cases (Appendix F, Coordination, Table 5.2).
- Care coordination/scheduling:
  - 65% of organizations that offered RMHT at Baseline and 44% in Year 2 coordinated care with other provider organizations (Appendix F, Coordination, Table 5.2).
- Coordinated planning across programs:
  - 75% of organizations that offered RMHT at Baseline and 28% in Year 2 engaged in coordinated planning with other programs (Appendix F, Coordination, Table 5.2).

- Multidisciplinary team meetings:
    - 100% of organizations that offered RMHT at Baseline and 56% in Year 2 participated in multidisciplinary meetings (Appendix F, Coordination, Table 5.2).
- Release of information between agencies:
    - 95% of organizations that offered RMHT at Baseline and 39% in Year 2 released information to other provider agencies (Appendix F, Coordination, Table 5.2).
- None of the above:
    - There were four organizations that offered RMHT (22%) in Year 2 that reported that they do not engage in any of the above activities (Appendix F, Coordination, Table 5.2).
- Frequency of participation in multiagency meetings:
    - 95% of the organizations that offered RMHT at Baseline and 73% in Year 2 participated in multiagency meetings at least once a month; three organizations that offered RMHT in Year 2 (17%) were unsure (Appendix F, Coordination, Table 5.2).

Collaboration with healthcare providers:

- Many organizations that offered RMHT services coordinate with healthcare providers. Most organizations that offered RMHT at Baseline (80%) and in Year 2 (83%) collaborated with primary healthcare provider agencies (Appendix F, Coordination, Table 5.2).
- 50% of organizations that offered RMHT at Baseline and 61% in Year 2 coordinated with community-based youth health services (Appendix F, Coordination, Table 5.2).

Collaboration with other non-mental health agencies:

- Child protective services:
    - 90% of organizations that offered RMHT at Baseline and 100% in Year 2 collaborated with CPS (Appendix F, Coordination, Table 5.2).
- Department of Education:
    - 90% of organizations that offered RMHT at Baseline and 72% in Year 2 collaborated with local or State Departments of Education (Appendix F, Coordination, Table 5.2).
- Juvenile justice:
    - 70% of organizations that offered RMHT at Baseline and 78% in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
- Juvenile probation:
    - 60% of organizations that offered RMHT at Baseline and 72% in Year 2 collaborated with juvenile probation (Appendix F, Coordination, Table 5.2).

- Other:
    - One organization that offered RMHT in Year 2 indicated that they collaborate with "other" non-mental health agencies, but they did not write-in any additional information.

7.2.2.8 Children's Crisis and Referral Line (CCRL)

The Organization and Facility Survey was not completed for the CCRL in Year 2. However, the 2023 DHHR Semi-Annual Report provides some insights into communication and collaboration between the CCRL and other stakeholders.

Collaborative Activities:

- The 2023 DHHR Semi-Annual Report described the CCRL as a centralized access point to connect families with the Assessment Pathway and directly to community-based services such as Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response. The CCRL is also a resource for providers, as evidenced by the increasing number of calls coming from community partners and other health professionals.

Collaboration with healthcare providers:

- Collaborations are being fostered with primary care providers—DHHR has supplied healthcare providers with wallet card with information about the CCRL to give out to families, and processes are now in place for primary care providers to make direct referrals to the CCRL.

7.2.3 Provider Insights into Stakeholder Communication and Collaboration

Provider data indicated that opportunities exist to further promote communication and collaboration among stakeholders. Many providers neither agreed nor disagreed that they communicate and collaborate with different stakeholders, or that they share client-level information to coordinate care, although findings varied by provider type and the distribution of provider responses varied over time. When asked to indicate their levels of agreement on scales that ranged from 1 (Disagree) to 5 (Agree), provider reported the following:

Social service providers and probation officers reported the most communication with other youth-serving providers.

- Mental and behavioral health and healthcare providers neither agreed nor disagreed at Baseline (3.1) and in Year 2 (3.0) that they communicate with *other* youth serving providers as a part of care coordination.
    - At Baseline behavior analysts, RMHT staff, and RMHT social workers somewhat agreed, and NPs and PAs somewhat disagreed, and the remaining providers neither agreed nor disagreed.
    - In Year 2 RMHT staff and RMHT social workers somewhat agreed, the internal medicine practitioner disagreed, MDs/DOs, and family medicine and general

medicine practitioners somewhat disagreed, and the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.3).

- Social service providers somewhat agreed at Baseline and in Year 2 that their organization encourages communication with mental and behavioral health organizations (Appendix E, Referral Policies, Table 8.1.3).
- Probation officers agreed at Baseline and somewhat agreed in Year 2 that they communicate with mental and behavioral health organizations as part of care coordination and/or case management (Appendix E, Social Services & Probation, Table 13.1).
- Social service providers neither agreed nor disagreed at Baseline and in Year 2 that service providers from different mental health agencies coordinate when caring for youth with mental health needs (Appendix E, Social Services & Probation, Table 13.1). Attorneys and guardians ad litem also neither agreed nor disagreed at Baseline; they somewhat disagreed in Year 2 (Appendix E, Attorneys & GALs, Table 11.1).

Social service providers and probation officers reported the most communication with non-mental and behavioral health organizations.

- Mental and behavioral health and healthcare providers neither agreed nor disagreed at Baseline (2.8) and in Year 2 (2.9) that they communicate with non-mental health organizations as part of care coordination (Appendix E, Referral Policies, Table 8.3).
    - At Baseline, behavior analysts, the registered/licensed nurse, RMHT staff and RMHT social workers somewhat agreed, psychologists neither agreed nor disagreed, and the remaining providers somewhat disagreed.
    - In Year 2, the one internal medicine practitioner agreed, RMHT social workers somewhat agreed, NPs and PAs, MDs and DOs, and family and general medicine practitioners somewhat disagreed, the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.3).
- Social service providers somewhat agreed that they communicate with non-mental health organizations as part of care coordination and little variation was observed over time (Appendix E, Social Services & Probation, Table 13.1).
- Probation officers agreed that they communicate with non-mental health organizations as part of care coordination and little variation was observed over time (Appendix E, Social Services & Probation, Table 13.1).

Most RMHT social workers share client-level information with others to help coordinate care; agreement among other provider types varied over time.

- Providers neither agreed nor disagreed at Baseline (3.5) and in Year 2 (3.2) that they share client-level information to coordinate care (Appendix E, Referral Policies, Table 8.3).
    - At Baseline, the highest level of agreement was among RMHT social workers and behavior analysts and the lowest level of agreement was among nurse practitioners, physicians assistants, and MDs/DOs.

- In Year 2, the highest level of agreement continued to be among RMHT social workers, as well as nurse practitioners and physician assistants, and the lowest level of agreement was among general medical practitioners. Of note, more provider types neither agreed nor disagreed in Year 2 compared to Baseline (Appendix E, Referral Policies, Table 8.3).

Fewer organizations and facilities reported communication and coordination with juvenile justice partners; findings among juvenile justice partners are mixed.

- 58% of organizations and facilities at Baseline and 21% in Year 2 collaborated with juvenile justice (Appendix F, Coordination, Table 5.2).
    - At Baseline, judges somewhat agreed that they have needed info from multidisciplinary teams to make appropriate placements with some regional variation (3.9), whereas attorneys and GALs neither agree nor disagree at Baseline (3.2) and in Year 2 (3.5) that there is coordination among the courts and multidisciplinary teams for juveniles who are involved in neglect and deprivation cases (Appendix E, Attorneys & GALs, Table 11.1). Court judge perspectives will be captured again in Year 3.

7.2.4 Recommendations

Recommendation: Explore how organizations, facilities, and providers define quality communication and collaboration, and whether and how that meets DHHR expectations. Interviews and focus groups scheduled for Year 3 data collection might be able to provide some additional insights.

7.3 Finding: Referral pathways changed across the system over time

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How have referral pathways changed?
- What are the referral pathways between Children's Mobile Crisis Response and other service providers?
- How have referral pathways changed between traditional and mental health providers?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

7.3.1 Summary

Providers are aware of their organization's policies and procedures for making and following up on referrals for youth with mental and behavioral health needs. However, some providers indicated that there is room for improvement in the clarity and efficiency of these policies and procedures. Overall, though, **more providers exchanged referrals with the community-based mental and behavioral health services included in this evaluation compared to**

Baseline. The strongest referral pathways in Year 2 were between providers and WV Children's Mental Health Wraparound, and similar to Baseline with RMHT and Behavioral Support Services (including PBS). In general, more mental and behavioral health providers exchanged referrals in Year 2 than healthcare providers. Psychologists and psychiatrists were among those most likely to have exchanged referrals with mental and behavioral health services.

Overall, a smaller percentage of organizations exchanged referrals with other stakeholders compared to Baseline. Statewide, the greatest percentage of Year 2 organizations and facilities received referrals from DHHR, and the greatest percentage of referrals were made to community-based health centers (including FQHC), although findings varied by service. The greatest change since Baseline was a 31% decrease in the percentage of Year 2 organizations and facilities that received referrals from and a 30% decrease in referrals sent to private or public hospitals (including inpatient psychiatric units). Regarding referrals with specific services, the greatest percentage of Year 2 organizations exchanged referrals with CSED Waiver Wraparound.

New survey items added to the Year 2 Organization and Facility Survey indicated that **65-77% exchanged referrals with other providers within their regions**, 21-25% exchanged referrals outside of their regions, and 10-13% made referrals to facilities out-of-state, many of which were RMHTFs. When asked about barriers to maximizing their referral networks for youth referred to RMHT, providers reported at Baseline and Year 2 that the top three barriers are: lack of qualified providers in their networks or areas, lack of resources, and lack of information about resources in the community.

7.3.2 Policies for Referring Youth to Providers and Services

Referrals help connect families and youth to different providers and services. Data suggest that there is some room for improvement with regard to the clarity and efficiency of referral policies and procedures involving youth with mental and behavioral health needs.

Level of agreement that organizations have clear referral policies varied by provider type over time. Providers were asked to rate their level of agreement on scales that ranged from 1 (Disagree) to 5 (Agree):

- Mental and behavioral health and healthcare providers somewhat agreed at Baseline (3.9) and in Year 2 (3.6) that their organization has clearly defined referral policies or protocols for youth with mental and behavioral health needs, but findings varied across provider types (Appendix E, Referral Policies, Table 8.1.4).
    - At Baseline the one registered/licensed nurse captured at Baseline agreed, behavior analysts, nurse practitioners and physician's assistants, MDs and DOs, psychiatrists, psychologists, and RMHT social workers somewhat agreed, and RMHT staff somewhat disagreed.
    - In Year 2, RMHT social workers agreed, behavior analysts, the one internal medicine practitioner, psychologists, and RMHT staff somewhat agreed, and the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 8.1.4).

- Social service providers somewhat agreed at Baseline (4.0) and in Year 2 (4.1) that their organization has clearly defined referral policies or protocols for youth with mental and behavioral health needs (Appendix E, Social Services & Probation, Table 13.1).

Level of agreement that organizational policies for referrals are efficient varied by provider type over time.

- Mental and behavioral health and healthcare providers somewhat agreed at Baseline (3.6) but neither agreed nor disagreed in Year 2 (3.2) that their organization's referral processes for youth with mental and behavioral health needs are efficient, but findings varied across provider types (Appendix E, Referral Policies, Table 8.1.4).
- At Baseline behavioral analysts, registered/licensed nurses, nurse practitioners and physician's assistants, psychologists, and RMHT social workers somewhat agreed, MDs and DOs as well as psychiatrists neither agreed nor disagreed, and RMHT staff somewhat disagreed.
- In Year 2 psychologists, RMHT staff, and RMHT social workers somewhat agreed, behavioral analysts, registered/licensed nurses, nurse practitioners and physician's assistants, and MDs and DOs neither agreed nor disagreed, and family medicine, general medicine, and internal medicine practitioners and psychiatrists somewhat disagree.
- Social service providers somewhat agreed at Baseline (4.0) and in Year 2 (4.2) that their organization's referral processes for youth with mental and behavioral health needs are efficient.

Awareness, service availability and workforce capacity affect whether and how providers make referrals. This was expressed by case series participants, and as reported in Section 6.1, some but not all organizations have other nearby providers to whom they can send referrals for youth when they lack capacity. Similarly, providers neither agreed nor disagreed at Baseline (3.0) and in Year 2 (2.9) that they were aware of well-trained service provider agencies to refer youth in their network/area who need mental and behavioral health services not provided by their own organization; little variation observed among provider type or region (Appendix E, Referral Policies, Table 8.3).

In what follows, referral pathways reported by organizations and providers are presented statewide, then findings are broken down by service.

7.3.3 Statewide Referral Pathways

Overall, a smaller percentage of organizations exchanged referrals with community-based health centers, juvenile justice facilities, and other types of organizations and agencies associated with the mental and behavioral health system compared to Baseline. A smaller percentage also reported that they exchanged referrals with other mental and behavioral health services included in this Evaluation in Year 2. It could be that more organizations are referring caregivers and youth to the Assessment Pathway rather than to other provider organizations. It is also possible that the change in sampling strategies that resulted in fewer surveys from organizations in Year 2 than at Baseline might have contributed to some of the observed changes in referral pathways over time.

Year 3 data will be particularly helpful in tracking trends and changes in referral processes and pathways.

Statewide summary of referrals exchanged among different types of organizations, facilities, and agencies for Year 2:

- The greatest percentage of organizations captured in the Year 2 survey (63%) received referrals from DHHR, and the smallest percentage (10%) received referrals from pediatric care centers (Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations captured in the Year 2 survey (33%) made referrals to community-based health centers (including FQHCs), and the smallest percentage (8%) made referrals to juvenile justice facilities (Appendix F, Referrals, Table 4.2).

Statewide summary of changes in referral processes among different types of organizations, facilities, and agencies since Baseline:

- The greatest change since Baseline was a 31% decrease in the percentage of Year 2 organizations that received referrals from and a 30% decrease in referrals sent to private or public hospitals (including inpatient psychiatric units; Appendix F, Referrals, Table 4.2).

Table 11 below displays the percentage of organizations that exchanged referrals with different types of organizations and agencies at Baseline and in Year 2. Each column total in Table 11 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 11: Statewide Summary of Referrals Exchanged Between Organizations, Facilities and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=79	n=52	n=79	n=52
Community-based health centers (including FQHCs)	54%	31%	58%	33%
Other community-based agencies	30%	21%	29%	19%
DHHR government agencies	87%	63%	51%	29%
Foster care or adoption agencies	47%	29%	20%	21%
Group or solo private practice health practice	53%	12%	47%	25%
Juvenile justice facilities	52%	25%	13%	8%
Local school district/county Department of Education	73%	46%	44%	17%
Pediatric care center	30%	10%	28%	13%
Private or public hospital (including inpatient psychiatric units)	58%	27%	53%	23%
Psychiatric residential treatment facility	43%	21%	32%	29%
Residential mental health treatment facility	43%	29%	25%	25%
None of the above	-	12%	-	19%
Other:	9%	29%	3%	8%

The write-in data for “other” types of organizations with which referrals were exchanged included after school programs, the West Virginia Autism Training Center, “DTT,” the Family Resource Network and the Coordinated Council for Independent Living, Career Connects, “SPBS,”

Intellectual/Developmental Disabilities and CSED Waiver programs, BMS, Division of Rehabilitation Services, specific community-based mental and behavioral health services and provider agencies, different types of providers (e.g., therapists, respite providers, healthcare providers), legal aid, families, youth self-referrals, and "other outside agencies." Two organizations noted that they are not able to take referrals when they do not come through DHHR directly. One organization also noted that for youth in DHHR custody, they are not able to make referrals because the responsibility falls to the youths' guardians.

Overall, a smaller percentage of organizations that offered mental and behavioral health services included in this Evaluation exchanged referrals in Year 2 than at Baseline.

Statewide summary for referrals exchanged between mental and behavioral health services in Year 2:

- The greatest percentage of organizations captured in the Year 2 survey (21%) received referrals from CSED Waiver Wraparound and the smallest percent received referrals from Assertive Community Treatment, Behavioral Support Services (including PBS) and Children's Mobile Crisis Response and Stabilization (8% respectively; Appendix F, Referrals, Table 4.3). It was surprising that no Year 2 organizations reported that they exchanged referrals with the Children's Crisis and Referral Line (Appendix F, Referrals, Table 4.3). It is possible that organizations are providing caregivers and youth information about 844-HELP4WV rather than providing referrals much like they would for other mental and behavioral health services.
- The greatest percentage of organizations captured in the Year 2 survey (23%) made referrals to CSED Waiver Wraparound, and the smallest percentage (4%) made referrals to ACT, which was expected due to the smaller size of the program and older population currently being served by Assertive Community Treatment (Appendix F, Referrals, Table 4.3).

Statewide summary for referrals exchanged between services compared to Baseline:

- The greatest change since Baseline was a 29% decrease in referrals received from WV Children's Mental Health Wraparound, and a 22% decrease in referrals made to Behavioral Support Services (including PBS; Appendix F, Referrals, Table 4.3). The decrease in referrals exchanged with WV Children's Mental Health Wraparound seems to have been offset by increases in referrals exchanged with CSED Waiver Wraparound. It is unclear what factors contributed to decreases in referrals made to Behavioral Support Services (including PBS).

Table 12 displays the percentage of organizations that exchanged referrals with mental and behavioral health services in this Evaluation at Baseline and in Year 2. Each column total in Table 12 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 12: Statewide Summary of Referrals Exchanged Between Community-Based Services

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=79	n=52	n=79	n=52
Assertive Community Treatment	10%	8%	19%	4%
Behavioral Support Services (including PBS)	15%	8%	32%	10%
Children's Mobile Crisis Response and Stabilization	25%	8%	33%	13%
Children with Serious Emotional Disorders Waiver Services	39%	-	27%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	17%	-	19%
Children with Serious Emotional Disorders Waiver Wraparound	-	21%	-	23%
West Virginia Children's Mental Health Wraparound	39%	10%	38%	19%

It is possible that more organizations are sending referrals directly to the Assessment Pathway rather than exchanging referrals with other stakeholders. The questions about referrals are being revised so that the Year 3 Organization and Facility Survey can better capture referral processes and practices.

Referral reach was added to the Year 2 Organization and Facility Survey. Most organizations exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies. Statewide:

- Within region(s):
    - 65% of Year 2 organizations made referrals to and 77% received referrals from provider organizations within their region (Appendix F, Referrals, Table 4.4).
- Outside of the region(s):

        - 21% of Year 2 organizations made referrals to and 25% received referrals from provider organizations outside of their regions (Appendix F, Referrals, Table 4.4), which coincides with the percentage that reported lacking other nearby providers to refer youth.
    - From out of state:
        - 10% of Year 2 organizations made referrals to and 13% received referrals from out-of-state provider organizations (Appendix F, Referrals, Table 4.4).

There were seven organizations that exchanged referrals with stakeholders in "other" areas. Write-ins included one response that simply stated "DHHR." Others wrote in community-based services, virtual services, in-state services, and residential services. Of note, 15% reported that they did not make referrals and 10% reported that they did not receive referrals in the last 12 months (Appendix F, Referrals, Table 4.4).

Providers at Baseline and in Year 2 reported that their organizations send referrals to community-based programs with some regularity. Statewide, providers reported some increases in referrals exchanged with other mental and behavioral health services included in this Evaluation in Year 2, but findings varied by service and provider type (see more below).

- Similar to reports by organizations, at Baseline, the strongest referral pathways were between providers and RMHT, the CSED Waiver, and PBS.
    - At Baseline referrals to services varied by provider type, region and length of practice of the providers. Behavioral analysts, psychiatrists and psychologists generally referred to community-based services the most and psychiatrists the least. Psychiatrists and psychologists refer to RMHT the most and behavioral analysts the least. Providers in Regions 4 referred to all services the most, except for Assertive Community Treatment. Providers in Regions 5 and 6 refer to Assertive Community Treatment services the most. The longer the provider has been in practice, the more they exchanged referrals with all services (Appendix E, Referrals, Table 1).
- In Year 2, the strongest referral pathways were between providers and WV Children's Mental Health Wraparound, and similar to Baseline with RMHT and Behavioral Support Services (including PBS).
    - In Year 2 mental and behavioral health providers made more referrals to community-based services than healthcare providers. As reported at Baseline, psychologists referred to RMHT the most in Year 2. In Year 2 nurse practitioners and physician's assistance referred to RMHT the least. There was very little regional variation. The effect of length of practice on referral processes varied by service (Appendix E, Referrals, Table 7.1).

The following sections describe service-specific findings from organizations, facilities, and providers.

7.3.4 Service-Specific Referral Pathways

7.3.4.1 Children's Mobile Crisis Response and Stabilization

A smaller percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 exchanged referrals with other organizations, agencies, and youth mental and behavioral health services included in this Evaluation than at Baseline. Data for Children's Mobile Crisis Response and Stabilization in Region 5 were missing in Year 2 and thus were excluded from the findings reported below. The strongest referral pathways were between organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 and PRTFs. Of the mental and behavioral health services being evaluated in Year 2, the greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization exchanged referrals with CSED Waiver Mobile Response. Most organizations exchanged referrals within their region, although 13% of organizations and facilities that offered Children's Mobile Crisis Response and Stabilization in Year 2 made referrals outside of their region; none made referrals out of state (Appendix F, Referrals, Table 4.4). Providers reported an increase in referrals made to Children's Mobile Crisis Response and Stabilization compared to Baseline, and psychologists exchanged the most referrals with Children's Mobile Crisis Response and Stabilization in Year 2.

Statewide summary of referrals exchanged between Children's Mobile Crisis Response and Stabilization and other organizations and agencies in Year 2:

- The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 (88%) received referrals from DHHR and local school districts or county Departments of Education, and the smallest percentage received referrals from pediatric care centers and PRTFs (13% respectively; Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 (86%) made referrals to PRTFs, and the smallest percentage (0%) made referrals to juvenile justice facilities (Appendix F, Referrals, Table 4.2).

Statewide summary of referrals exchanged between Children's Mobile Crisis Response and Stabilization and other organizations and agencies compared to Baseline:

- The greatest changes since Baseline included a 63% decrease in the percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 that received referrals from private health practices, and a 59% increase in referrals made to PRTFs (Appendix F, Referrals, Table 4.2). There was also a 22% increase in the percentage of referrals made by Children's Mobile Crisis Response and Stabilization to RMHTFs between Baseline and Year 2 (Appendix F, Referrals, Table 4.2).

It is unclear whether the increase in referrals exchanged with PRTFs and RMHTFs is due to the level of intensity of needs of youth and/or the lack of availability of community-based services that can meet those needs, or other factors. The key informant interviews and focus groups with organizations, facilities, and providers during next year's data collection might be able to provide some insights.

Table 13 displays the percentage of organizations that offered Children's Mobile Crisis Response and Stabilization that exchanged referrals with different types of organizations and agencies. Each column total in Table 13 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 13: Summary of Referrals Exchanged Between Children's Mobile Crisis Response and Stabilization and Different Types of Organizations and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=33	n=8	n=33	n=7
Community-based health centers (including FQHCs)	76%	50%	73%	43%
Other community-based agencies	33%	25%	39%	29%
DHHR government agencies	91%	88%	67%	29%
Foster care or adoption agencies	48%	38%	18%	29%
Group or solo private practice health practice	88%	25%	76%	43%
Juvenile justice facilities	58%	38%	12%	0%
Local school district/county Department of Education	88%	88%	64%	29%
Pediatric care center	42%	13%	33%	14%
Private or public hospital (including inpatient psychiatric units)	79%	63%	76%	71%
Psychiatric residential treatment facility	55%	13%	27%	86%
Residential mental health treatment facility	52%	38%	21%	43%

Overall, a smaller percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 exchanged referrals with other mental and behavioral health services included in this Evaluation than at Baseline.

Statewide summary of referrals exchanged between Children's Mobile Crisis Response and Stabilization and other mental and behavioral health services being evaluated in Year 2:

- The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in the Year 2 (50%) received referrals from CSED Waiver Mobile Response and the smallest percent received referrals from Assertive Community Treatment and other Children's Mobile Crisis Response and Stabilization organizations and facilities (0% respectively; (Appendix F, Referrals, Table 4.3).
- The greatest percentage of organizations that offered Children's Mobile Crisis Response and Stabilization in Year 2 made referrals to CSED Waiver Mobile Response, CSED Waiver Wraparound, and WV Children's Mental Health Wraparound (38% respectively), and the smallest percentage made referrals to Assertive Community Treatment, Behavioral Support Services (including PBS), and other organizations that offer Children's Mobile Crisis Response and Stabilization (0% respectively; Appendix F, Referrals, Table 4.3).

Statewide summary of referral exchanges between Children's Mobile Crisis Response and Stabilization and other mental and behavioral health services being evaluated compared to Baseline:

- The greatest changes since Baseline included a 39% decrease in referrals received from other Children's Mobile Crisis Response and Stabilization providers, which seems to have been offset by 50% of referrals received from CSED Waiver Mobile Response teams (Appendix F, Referrals, Table 4.3). There was also a 48% decrease in referrals made to other CMCRS organizations, which also seems to be offset with increased referrals made to CSED Waiver Mobile Response and CSED Waiver Wraparound (Appendix F, Referrals, Table 4.3).

Table 14 displays the data for referrals exchanged between Children's Mobile Crisis Response and Stabilization and other mental and behavioral health services included in this Evaluation. Each column total in Table 14 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 14: Summary of Referrals Exchanged Between Children's Mobile Crisis Response and Stabilization and Other Services in the Evaluation

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=33	n=8	n=33	n=8
Assertive Community Treatment	21%	0%	42%	0%
Behavioral Support Services (including PBS)	15%	13%	39%	0%
Children's Mobile Crisis Response and Stabilization	39%	0%	48%	0%
Children with Serious Emotional Disorders Waiver Services	39%	-	21%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	50%	-	38%
Children with Serious Emotional Disorders Waiver Wraparound	-	25%	-	38%
West Virginia Children's Mental Health Wraparound	45%	38%	58%	38%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to Children's Mobile Crisis Response and Stabilization can be found in Table 15. Most organizations that offered Children's Mobile Crisis Response and Stabilization Year 2 exchanged referrals within their region (Appendix F, Referrals, Table 4.4).

Table 15: Reach of Referral Networks of Year 2 Organizations Offering CMCRS

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary	n=8	n=8
Within their region	63%	63%
Outside of their region	0%	13%
Outside of WV	0%	0%

Of note, one organization that offered Children's Mobile Crisis Response and Stabilization reported that they did not make referrals in the last 12 months (Appendix F, Referrals, Table 4.4). Given the range of health interventions offered by Children's Mobile Crisis Response and Stabilization providers, it could be that youth received the support they needed without additional services, or perhaps they were already enrolled in other services and did not require additional referrals.

Providers reported an increase in referrals made to Children's Mobile Crisis Response and Stabilization compared to Baseline.

- 13% of providers received referrals from Children's Mobile Crisis Response and Stabilization at Baseline and 23% made them.
- 15% of providers received referrals from Children's Mobile Crisis Response and Stabilization in Year 2 and 33% made them.

Psychologists and psychiatrists exchanged referrals with Children's Mobile Crisis Response and Stabilization the most in Year 2, and the one family medicine practitioner that responded to this survey item also exchanged referrals with CMCRS in Year 2 (Appendix E, Referrals, Table 7.1).

7.3.4.2 Children with Serious Emotional Disorders (CSED) Waiver Mobile Response

Overall, a smaller percentage of organizations that offered CSED Waiver Mobile Response in Year 2 exchanged referrals with other stakeholders compared to organizations that offered CSED Waiver services in general and/or organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline. All organizations that offered CSED Waiver Mobile Response received referrals with DHHR (Appendix F, Referrals, Table 4.2). More than half made referrals to group or solo private health practices and PRTFs (Appendix F, Referrals, Table 4.2). The only other mental and behavioral health service that CSED Waiver Mobile Response received referrals from was CSED Waiver Wraparound (29%), and CSED Waiver Mobile Response made referrals to CSED Waiver Wraparound, CMCRS, and RMHT (14% respectively; Appendix F, Referrals, Table 4.3). All referrals exchanged with CSED Waiver Mobile Response were from within their

respective regions; however, two organizations indicated that they did not exchange referrals with the other mental and behavioral health services included in this Evaluation in the last 12 months (Appendix F, Referrals, Table 4.4). More providers received referrals from CSED Waiver Mobile Response in Year 2 than Children's Mobile Crisis Response and Stabilization or the CSED Waiver at Baseline. Similar to Children's Mobile Crisis Response and Stabilization, psychologists exchanged referrals with CSED Waiver Mobile Response the most in Year 2.

Statewide summary of referral exchanges between CSED Waiver Mobile Response and other organizations and facilities in Year 2:

- The greatest percentage of organizations that offered CSED Waiver Mobile Response in Year 2 (100%) received referrals from DHHR, and the smallest percentage received referrals from pediatric care facilities and PRTFs (0% respectively; Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered CSED Waiver Mobile Response in Year 2 made referrals to group or solo private health practices and PRTFs (57% respectively), and the smallest percentage made referrals to community-based agencies other than community-based health centers or FQHCs, DHHR, and juvenile justice facilities (0% respectively; Appendix F, Referrals, Table 4.2). A similar percentage as CMCRS (43%) sent referrals to RMHT in Year 2, although a smaller percentage of organizations that offered CSED Waiver Mobile Response in Year 2 made referrals to PRTFS compared to CMCRS in Year 2 (Appendix F, Referrals, Table 4.2).

Statewide summary of referral exchanges for CSED Waiver Mobile Response compared to Baseline:

- Compared to organizations that offered CSED Waiver services at Baseline, the greatest change was a 58% decrease in the percentage that received referrals from pediatric care centers and PRTFs respectively, and a 38% decrease in referrals sent to DHHR (Appendix F, Referrals, Table 4.2).
- Compared to organizations that offered CMCRS at Baseline, the greatest change was a 74% decrease that received referrals from group or solo private health practices and a 67% decrease in referrals sent to DHHR (Appendix F, Referrals, Table 4.2).

Table 16 displays the percentage of organizations that offered CSED Waiver Mobile Response that exchanged referrals with different types of organizations and agencies. Each column total in Table 16 represents the number of organizations and facilities that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 16: Summary of Referrals Exchanged Between the Children with Serious Emotional Disorders Waiver Mobile Response and Different Types of Organizations and Agencies in Year 2

Types of Organizations and Agencies	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Mobile Response	n=7	n=7
Community-based health centers (including FQHCs)	29%	43%
Other community-based agencies	14%	0%
DHHR government agencies	100%	0%
Foster care or adoption agencies	43%	29%
Group or solo private practice health practice	14%	57%
Juvenile justice facilities	57%	0%
Local school district/county Department of Education	86%	29%
Pediatric care center	0%	29%
Private or public hospital (including inpatient psychiatric units)	57%	43%
Psychiatric residential treatment facility	0%	57%
Residential mental health treatment facility	14%	43%

Overall, a smaller percentage of organizations that offered CSED Waiver Mobile Response in Year 2 exchanged referrals with other mental and behavioral health services included in this Evaluation compared to those that offered CSED Waiver services or CMCRS at Baseline.

Statewide summary of referrals exchanged between CSED Mobile Response and other mental and behavioral health services in this Evaluation in Year 2:

- The greatest percentage of organizations that offered CSED Waiver Mobile Response in Year 2 (29%) received referrals from CSED Waiver Wraparound, whereas none of the organizations and facilities that offered CSED Waiver Mobile Response in Year 2 reported receiving from Assertive Community Treatment, Behavioral Support Services (including PBS), Children's Mobile Crisis Response and Stabilization, other CSED Waiver Mobile Response providers, RMHT, or WV Children's Mental Health Wraparound (Appendix F, Referrals, Table 4.3).
- The greatest percentage of organizations that offered CSED Waiver Mobile Response in Year 2 made referrals to Children's Mobile Crisis Response and Stabilization, CSED Waiver Wraparound, and RMHT (14% respectively), whereas none made referrals to Assertive Community Treatment, Behavioral Support Services (including PBS), other organizations that offered CSED Waiver Mobile Response, or WV Children's Mental Health Wraparound (Appendix F, Referrals, Table 4.3).

Statewide summary of referrals exchanged by CSED Waiver Mobile Response compared to Baseline:

- Compared to organizations that offered CSED Waiver services at Baseline, the greatest change was a 42% decrease in the percentage that received referrals from RMHTFs, and a 42% decrease in referrals sent to Behavioral Support Services (including PBS; Appendix F, Referrals, Table 4.3).
- Compared to organizations that offered Children's Mobile Crisis Response and Stabilization at Baseline, the greatest change was a 45% decrease in the percentage that received referrals from WV Children's Mental Health Wraparound and also a 58% decrease in referrals sent to WV Children's Mental Health Wraparound (Appendix F, Referrals, Table 4.2).

Table 17 displays the percentage of organizations that offered CSED Waiver Mobile Response in Year 2 that exchanged referrals with other services in this Evaluation. Each column total in Table 17 represents the number of organizations that responded to the Year 2 survey and were used to calculate the percentages in the table.

Table 17: Summary of Referrals Exchanged Between Children with Serious Emotional Disorders Waiver Mobile Response and Other Services in the Evaluation in Year 2

Service	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Mobile Response	n=7	n=7
Assertive Community Treatment	0%	0%
Behavioral Support Services (including PBS)	0%	0%
Children's Mobile Crisis Response and Stabilization	0%	14%
Children with Serious Emotional Disorders Waiver Mobile Response	0%	0%
Children with Serious Emotional Disorders Waiver Wraparound	29%	14%
West Virginia Children's Mental Health Wraparound	0%	0%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to CSED Waiver Mobile Response can be found in Table 18. Most organizations that offered CSED Waiver Mobile Response in Year 2 exchanged referrals within their region, but two indicated that they did not exchange referrals with other provider organizations in the last 12 months (Appendix F, Referrals, Table 4.4).

Table 18: Reach of Referral Networks of Year 2 Organizations and Facilities Offering Children with Serious Emotional Disorders Waiver Mobile Response

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Mobile Response	n=7	n=7
Within their region	57%	71%
Outside of their region	0%	0%
Outside of WV	0%	0%

Providers reported an increase in referrals received from CSED Waiver Mobile Response than CMCRS or organizations that offered CSED Waiver services in general at Baseline.

- 13% of providers received referrals from Children's Mobile Crisis Response and Stabilization at Baseline and 23% made them.
- 16% of providers received referrals from the CSED Waiver at Baseline 37% made them.
- 22% of providers received referrals from CSED Waiver Mobile Response in Year 2 and 22% made them.

Similar to Children's Mobile Crisis Response and Stabilization, psychologists and psychiatrists exchanged referrals with CSED Waiver Mobile Response the most in Year 2. One registered/licensed nurse that responded to this survey item also reported exchanging referrals with CSED Waiver Mobile Response in Year 2 (Appendix E, Referrals, Table 7.1).

7.3.4.3 Children with Serious Emotional Disorders (CSED) Waiver Wraparound

Overall, a smaller percentage of organizations that offered CSED Waiver Wraparound in Year 2 exchanged referrals than organizations that offered CSED Waiver services or WV Children's Mental Health Wraparound at Baseline. CSED Waiver Wraparound exchanged the most referrals with DHHR and community-based health centers (including FQHCs) in Year 2 (Appendix F, Referrals, Table 4.2). Few organizations that offered CSED Waiver Wraparound in Year 2 exchanged referrals with other mental and behavioral health services included in this Evaluation. More providers exchanged referrals with CSED Waiver Wraparound in Year 2 than they did with WV Children's Mental Health Wraparound at Baseline. More providers received referrals from CSED Waiver Wraparound in Year 2 than the CSED Waiver at Baseline, but fewer made referrals. Psychologists, psychiatrists, and behavior analysts were among those who exchanged referrals with CSED Wavier Wraparound in Year 2.

Statewide summary of referrals exchanged between CSED Waiver Wraparound and other organizations in Year 2:

- The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 (93%) received referrals from DHHR, and the smallest percentage (13%) received referrals from pediatric care centers (Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 (67%) made referrals to community-based health centers (including FQHCs), and the smallest percentage (8%) made referrals to juvenile justice facilities (Appendix F, Referrals, Table 4.2).

Statewide summary of referrals exchanged by CSED Waiver Wraparound compared to Baseline:

- Compared to organizations that offered CSED Waiver services at Baseline, the greatest change was a 45% decrease in referrals received from pediatric care facilities, and a 25% decrease in referrals sent to local school districts and/or county Departments of Education (Appendix F, Referrals, Table 4.2).
- Compared to organizations that offered WV Children's Mental Health Wraparound at Baseline, the greatest change was a 51% decrease in the percentage that received referrals from group or solo private practices and a 38% decrease in referrals sent to local school districts and/or county Departments of Education (Appendix F, Referrals, Table 4.2).

Table 19 displays the percentage of organizations that offered CSED Waiver Wraparound that exchanged referrals with different types of organizations. Each column in Table 19 represents the number of organizations that responded to the Year 2 survey and were used to calculate the percentages in the table.

Table 19: Summary of Referrals Exchanged Between the Children with Serious Emotional Disorders Waiver Wraparound and Different Types of Organizations and Agencies in Year 2

Types of Organizations and Agencies	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Wraparound	n=15	n=12
Community-based health centers (including FQHCs)	47%	67%
Other community-based agencies	33%	25%
DHHR government agencies	93%	42%
Foster care or adoption agencies	60%	42%
Group or solo private practice health practice	20%	58%
Juvenile justice facilities	53%	8%
Local school district/county Department of Education	73%	33%
Pediatric care center	13%	42%
Private or public hospital (including inpatient psychiatric units)	47%	50%
Psychiatric residential treatment facility	33%	58%
Residential mental health treatment facility	40%	50%

Overall, a smaller percentage of organizations that offered CSED Wavier Wraparound in Year 2 exchanged referrals than organizations that offered CSED Waiver services or WV Children's Mental Health Wraparound at Baseline.

Statewide summary of referrals exchanged between CSED Waiver Wraparound and other mental and behavioral health services included in this Evaluation in Year 2:

- The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 (27%) received referrals from Behavioral Support Services (including PBS) and the smallest percent (0%) received referrals from other organizations that offered CSED Waiver Wraparound (Appendix F, Referrals, Table 4.3).
- The greatest percentage of organizations that offered CSED Waiver Wraparound in Year 2 (33%) made referrals to Behavioral Support Services (including PBS), and none of the Year 2 organizations that offered CSED Waiver Wraparound made referrals to other organizations that offered CSED Waiver Wraparound or to WV Children's Mental Health Wraparound (0% respectively; Appendix F, Referrals, Table 4.3).

Table 20 displays the percentage of organizations that offered CSED Waiver Wraparound in Year 2 that exchanged referrals with other services in this Evaluation. Each column total in Table 20 represents the number of organizations that responded to the Year 2 survey and were used to calculate the percentages in the table.

Table 20: Summary of Referrals Exchanged Between the Children with Serious Emotional Disorders Waiver Wraparound and Other Services in the Evaluation

Service	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Wraparound	n=15	n=15
Assertive Community Treatment	13%	7%
Behavioral Support Services (including PBS)	27%	33%
Children's Mobile Crisis Response and Stabilization	7%	13%
Children with Serious Emotional Disorders Waiver Mobile Response	7%	20%
Children with Serious Emotional Disorders Waiver Wraparound	0%	0%
West Virginia Children's Mental Health Wraparound	7%	0%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to CSED Waiver Wraparound can be found in Table 21. Most organizations that offered CSED

Waiver Wraparound in Year 2 exchanged referrals within their region (Appendix F, Referrals, Table 4.4).

Table 21: Reach of Referral Networks of Year 2 Organizations and Facilities Offering the Children with Serious Emotional Disorders Waiver Wraparound

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary for CSED Waiver Wraparound	n=15	n=15
Within their region	80%	73%
Outside of their region	20%	7%
Outside of WV	7%	0%

There was one organization that offered CSED Waiver Wraparound in Year 2 that indicated that they did not exchange referrals with other provider organizations in the last 12 months (Appendix F, Referrals, Table 4.4).

Providers made more referrals to CSED Waiver Wraparound compared to WV CMHW at Baseline. More providers also received referrals from CSED Waiver Wraparound than the CSED Waiver at Baseline.

- 12% of providers received referrals from WV Children's Mental Health Wraparound at Baseline and 26% made them.
- 16% of providers received referrals from the CSED Waiver at Baseline 37% made them.
- 31% of providers received referrals from CSED Waiver Wraparound in Year 2 and 33% made them.

Psychologists and psychiatrists exchanged referrals with CSED Waiver Mobile Response the most in Year 2 (Appendix E, Referrals, Table 7.1).

7.3.4.4 WV Children's Mental Health Wraparound

Three of five organizations that offered WV Children's Mental Health Wraparound responded to the Year 2 survey. Given that there were 24 organizations that responded to the Baseline survey, it is difficult to make comparisons across years. In general, more providers exchanged referrals with WV Children's Mental Health Wraparound in Year 2 than at Baseline. Healthcare providers, psychiatrists, psychologists, RMHT social workers and behavioral analysts were among those who exchanged referrals with WV Children's Mental Health Wraparound the most in Year 2.

Statewide summary of referrals exchanged between WV Children's Mental Health Wraparound and other organizations and agencies in Year 2:

- All three of the WV Children's Mental Health Wraparound organizations captured in the Year 2 survey received referrals from DHHR and local school districts or county Departments of education, whereas none received referrals from CBHCs, FQHCs, or other community-based agencies, or from pediatric care centers or PRTFs (Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered WV Children's Mental Health Wraparound in the Year 2 survey (67%) made referrals to private healthcare practices (Appendix F, Referrals, Table 4.2). None of the three WV Children's Mental Health Wraparound organizations captured in the Year 2 survey made referrals to CBHCs, FQHCs, other community-based agencies, juvenile justice facilities, schools, pediatric care centers or RMHTFs (Appendix F, Referrals, Table 4.2).

Table 22 displays the percentage of organizations that offered WV CMHW that exchanged referrals with different types of organizations and agencies. Each column total in Table 22 represents the number of organizations and facilities that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 22: Summary of Referrals Exchanged Between WV Children's Mental Health Wraparound and Different Types of Organizations and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=24	n=3	n=24	n=3
Community-based health centers (including FQHCs)	63%	0%	67%	0%
Other community-based agencies	42%	0%	38%	0%
DHHR government agencies	75%	100%	58%	0%
Foster care or adoption agencies	75%	67%	29%	33%
Group or solo private practice health practice	71%	33%	50%	67%
Juvenile justice facilities	75%	33%	25%	0%
Local school district/county Department of Education	96%	100%	71%	0%
Pediatric care center	63%	0%	54%	0%
Private or public hospital (including inpatient psychiatric units)	79%	33%	75%	33%
Psychiatric residential treatment facility	71%	0%	38%	33%
Residential mental health treatment facility	63%	33%	33%	0%

Statewide summary of referrals exchanged between WV Children's Mental Health Wraparound and other mental and behavioral health services included in this Evaluation in Year 2:

- Few referrals were exchanged between WV Children's Mental Health Wraparound and other mental and behavioral services in this Evaluation. When asked to reflect over the last 12 months, one WV Children's Mental Health Wraparound organization received referrals from Children's Mobile Crisis Response and Stabilization, one received referrals

from CSED Waiver Mobile Response, and one made referrals to Children's Mobile Crisis Response and Stabilization (Appendix F, Referrals, Table 4.3).

Table 23 displays the percentage of organizations that offered WV Children's Mental Health Wraparound in Year 2 that exchanged referrals with other services in this Evaluation. Each column total in Table 23 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 23: Summary of Referrals Exchanged Between WV Children's Mental Health Wraparound and Other Services in the Evaluation

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=24	n=3	n=24	n=3
Assertive Community Treatment	17%	0%	25%	0%
Behavioral Support Services (including PBS)	21%	0%	42%	0%
Children's Mobile Crisis Response and Stabilization	50%	33%	71%	33%
Children with Serious Emotional Disorders Waiver Services	46%	-	33%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	0%	-	0%
Children with Serious Emotional Disorders Waiver Wraparound	-	0%	-	0%
West Virginia Children's Mental Health Wraparound	58%	0%	50%	0%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to WV Children's Mental Health Wraparound can be found in Table 24.

Table 24: Reach of Referral Networks of Year 2 Organizations and Facilities Offering WV Children's Mental Health Wraparound

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary	n=3	n=3
Within their region	67%	33%
Outside of their region	0%	0%
Outside of WV	0%	0%

One organization that offered WV Children's Mental Health Wraparound in Year 2 reported that they did not exchange referrals with other provider organizations in the last 12 months (Appendix F, Referrals, Table 4.4).

More providers exchanged referrals with WV Children's Mental Health Wraparound in Year 2 than at Baseline.

- 12% of providers received referrals from WV Children's Mental Health Wraparound at Baseline and 26% made them.
- 27% of providers received referrals from WV Children's Mental Health Wraparound in Year 2 and 42% made them.

Healthcare providers, psychiatrists, psychologists, RMHT social workers and behavioral analysts were among those who exchanged referrals the most in Year 2 (Appendix E, Referrals, Table 7.1).

7.3.4.5 Behavioral Support Services (including Positive Behavior Support; PBS)

Overall, a smaller percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 exchanged referrals with other stakeholders and services compared to organizations that offered PBS at Baseline. The greatest percentage exchanged referrals with CSED Waiver Wraparound. Most organizations that offered Behavioral Support Services (including PBS) in Year 2 exchanged referrals within their region, but some exchange referrals outside of their regions and several with out-of-state provider agencies. Slight increases were observed in the percentage of providers who exchanged referrals with offered Behavioral Support Services (including PBS) in Year 2 compared to PBS at Baseline. RMHT social workers, behavior analysts, nurse practitioners and physician's assistants, psychiatrists, and psychologists were among those who exchanged referrals the most with Behavioral Support Services (including PBS) in Year 2.

Statewide summary for referrals exchanged between Behavioral Support Services (including PBS) and other organizations in Year 2:

- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 received referrals from DHHR (55%), and the smallest percentage (6%) received referrals from group or solo private health practices (Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 made referrals to community-based health centers (including FQHCs; 34%), and the smallest percentage made referrals to juvenile justice facilities and pediatric care centers (10% respectively; Appendix F, Referrals, Table 4.2). Of note, 31% of organizations that offered Behavioral Support Services (including PBS) reported that they did not exchange referrals with any of these types of organizations or agencies in Year 2 (Appendix F, Referrals, Table 4.2).

Statewide summary of referrals exchanged between Behavioral Support Services (including PBS) compared to organizations that offered PBS at Baseline:

- The greatest change since Baseline was a 37% decrease in the percentage of organizations that received referrals from private health practices, and a 26% decrease in referrals sent to DHHR and private or public hospitals (including inpatient psychiatric units respectively (Appendix F, Referrals, Table 4.2).

Table 25 displays the percentage of organizations that offered Behavioral Support Services (including PBS) that exchanged referrals with different types of organizations and agencies in Year 2 compared to PBS at Baseline. Each column total in Table 25 represents the number of organizations that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 25: Summary of Referrals Exchanged Between Behavioral Support Services (including PBS) and Different Types of Organizations and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=35	n=33	n=35	n=29
Community-based health centers (including FQHCs)	46%	30%	51%	34%
Other community-based agencies	20%	27%	20%	31%
DHHR government agencies	71%	55%	57%	31%
Foster care or adoption agencies	29%	21%	14%	14%
Group or solo private practice health practice	43%	6%	34%	24%
Juvenile justice facilities	46%	18%	14%	10%
Local school district/county Department of Education	66%	45%	20%	14%
Pediatric care center	14%	9%	14%	10%
Private or public hospital (including inpatient psychiatric units)	49%	21%	40%	14%
Psychiatric residential treatment facility	26%	24%	23%	24%
Residential mental health treatment facility	23%	24%	17%	21%

Overall, a smaller percentage of organizations that offered Behavioral Support Services (including PBS) exchanged referrals with other mental and behavioral health services included in this Evaluation in Year 2 compared to organizations and facilities that offered PBS at Baseline.

Statewide summary of referrals exchanged between Behavioral Support Services (including PBS) and other mental and behavioral health services included in this Evaluation in Year 2:

- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 (26%) received referrals from CSED Waiver Wraparound and the smallest percent (0%) received referrals from other organizations that offered Behavioral Support Services (including PBS) in Year 2, followed by 3% that received referrals from Assertive Community Treatment (Appendix F, Referrals, Table 4.3).
- The greatest percentage of organizations that offered Behavioral Support Services (including PBS) in Year 2 (17%) made referrals to CSED Waiver Wraparound, and the smallest percentage made referrals to Assertive Community Treatment and other organizations that offered Behavioral Support Services (including PBS; 0% respectively; Appendix F, Referrals, Table 4.3).

Statewide summary of referrals exchanged between Behavioral Support Services (including PBS) and other mental and behavioral health services included in this Evaluation in Year 2 compared to organizations that offered PBS Baseline:

- The greatest change since Baseline was a 28% decrease in referrals received from WV Children's Mental Health Wraparound, and a 34% decrease in referrals made to other organizations that offered Behavioral Support Services (including PBS; Appendix F, Referrals, Table 4.3). The decrease in referrals exchanged with WV Children's Mental Health Wraparound seem to be offset with referrals exchanged with CSED Waiver Wraparound.

Table 26 displays the percentage of organizations that offered Behavioral Support Services (including PBS) that exchanged referrals with other services in this Evaluation in Year 2 compared to PBS at Baseline. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 26: Summary of Referrals Exchanged Between Behavioral Support Services (including PBS) and Other Services in the Evaluation

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=35	n=35	n=35	n=35
Assertive Community Treatment	9%	3%	17%	0%
Behavioral Support Services (including PBS)	23%	0%	34%	0%
Children's Mobile Crisis Response and Stabilization	14%	6%	26%	6%
Children with Serious Emotional Disorders Waiver Services	37%	-	17%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	9%	-	11%
Children with Serious Emotional Disorders Waiver Wraparound	-	26%	-	17%
West Virginia Children's Mental Health Wraparound	37%	9%	26%	9%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to Behavioral Support Services (including PBS) can be found in Table 27. Most organizations that offered Behavioral Support Services (including PBS) in Year 2 exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies (Appendix F, Referrals, Table 4.4).

Table 27: Reach of Referral Networks of Year 2 Organizations and Facilities Offering Behavioral Support Services (including PBS)

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary	n=35	n=35
Within their region	71%	49%
Outside of their region	9%	6%
Outside of WV	9%	6%

Additionally, there were 11% of Behavioral Support Services (including PBS) organizations captured in the Year 2 survey that reported that they did not receive referrals in the last 12 months, and 20% that reported that they did not make referrals in the last 12 months (Appendix F, Referrals, Table 4.4).

Slight increases were observed in the percentage of providers who exchanged referrals with Behavioral Support Services (including PBS) in Year 2 compared to PBS at Baseline.

- 6% of providers received referrals from PBS at Baseline and 31% made them.
- 15% of providers received referrals from Behavioral Support Services (including PBS) in Year 2 and 39% made them.

RMHT social workers, behavior analysts, nurse practitioners and physician's assistants, psychiatrists, and psychologists were among those who exchanged referrals the most with Behavioral Support Services (including PBS) in Year 2 (Appendix E, Referrals, Table 7.1).

7.3.4.6 Assertive Community Treatment

Overall, a smaller percentage of organizations that offered Assertive Community Treatment exchanged referrals in Year 2 than at Baseline. Many organizations that offered Assertive Community Treatment in Year 2 exchanged referrals with DHHR and hospitals. The greatest percentage of organizations that offered Assertive Community Treatment in Year 2 exchanged referrals with RMHTFs, although several made referrals to Behavioral Support Services (including PBS) and WV Children's Mental Health Wraparound as well. Most organizations that offered Assertive Community Treatment in Year 2 exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies.

Statewide summary of referrals exchanged between Assertive Community Treatment and other organizations in Year 2:

- The greatest percentage of organizations that offered Assertive Community Treatment in Year 2 (100%) received referrals from DHHR and hospitals (including inpatient psychiatric units;), and the smallest percentage (0%) received referrals from community-based agencies other than community-based health centers and FQHCs (Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered Assertive Community Treatment in Year 2 (80%) made referrals to hospitals (including inpatient psychiatric units), and the smallest percentage (0%) made referrals to pediatric care centers (Appendix F, Referrals, Table 4.2).

Statewide summary of referrals exchanged between Assertive Community Treatment and other organizations in Year 2 compared to Baseline:

- The greatest change since Baseline was a 47% decrease in the percentage of organizations that offered Assertive Community Treatment that received referrals from community-based health centers (including FQHCs), a 47% decrease in referrals received from private health practices, and a 47% decrease in referrals sent to pediatric care centers (Appendix F, Referrals, Table 4.2).

Table 28 displays the percentage of organizations that offered Assertive Community Treatment that exchanged referrals with different types of organizations and agencies. Each column total in Table 28 represents the number of organizations and facilities that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table.

Table 28: Summary of Referrals Exchanged Between Assertive Community Treatment and Different Types of Organizations and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=15	n=5	n=15	n=5
Community-based health centers (including FQHCs)	87%	40%	80%	40%
Other community-based agencies	13%	0%	13%	20%
DHHR government agencies	87%	100%	60%	20%
Foster care or adoption agencies	53%	40%	13%	40%
Group or solo private practice health practice	87%	40%	73%	40%
Juvenile justice facilities	73%	40%	13%	20%
Local school district/county Department of Education	93%	80%	47%	20%
Pediatric care center	53%	20%	47%	0%
Private or public hospital (including inpatient psychiatric units)	93%	100%	87%	80%
Psychiatric residential treatment facility	60%	20%	20%	60%
Residential mental health treatment facility	53%	40%	7%	60%

Overall, a smaller percentage of organizations that offered Assertive Community Treatment exchanged referrals with other mental and behavioral health services included in this Evaluation in Year 2 than at Baseline.

Statewide summary of referrals exchanged between Assertive Community Treatment and other mental and behavioral health services included in this Evaluation in Year 2:

- Few organizations that offered Assertive Community Treatment in Year 2 exchanged referrals with other mental and behavioral health services included in this Evaluation. The greatest percentage of organizations that offered Assertive Community Treatment in Year 2 (40%) received referrals from RMHT, which is expected given the role of Assertive Community Treatment in transitioning older youth out of RMHT (Appendix F, Referrals, Table 4.3; see Section 8.1 for more). One organization indicated that they made referrals to Behavioral Support Services (including PBS), RMHT, and WV Children's Mental Health Wraparound respectively (Appendix F, Referrals, Table 4.3).

Statewide summary of referrals exchanged between Assertive Community Treatment and other mental and behavioral health services compared to Baseline:

- The greatest change since Baseline was a 67% decrease in referrals received from WV Children's Mental Health Wraparound, and an 80% decrease in referrals made to Children's Mobile Crisis Response and Stabilization (Appendix F, Referrals, Table 4.3).

Table 29 displays the percentage of organizations that offered Assertive Community Treatment that exchanged referrals with other services in this Evaluation. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 29: Summary of Referrals Exchanged Between Assertive Community Treatment and Other Services in the Evaluation

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=15	n=5	n=15	n=5
Assertive Community Treatment	20%	0%	60%	0%
Behavioral Support Services (including PBS)	13%	0%	53%	20%
Children's Mobile Crisis Response and Stabilization	40%	0%	80%	0%
Children with Serious Emotional Disorders Waiver Services	60%	-	13%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	0%	-	0%
Children with Serious Emotional Disorders Waiver Wraparound	-	20%	-	0%
West Virginia Children's Mental Health Wraparound	67%	0%	40%	20%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to Assertive Community Treatment can be found in Table 30. Most organizations that offered Assertive Community Treatment in Year 2 exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies (Appendix F, Referrals, Table 4.4).

Table 30: Reach of Referral Networks of Year 2 Organizations and Facilities Offering Assertive Community Treatment

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary	n=5	n=5
Within their region	80%	100%
Outside of their region	20%	40%
Outside of WV	20%	20%

Slight increases were observed in the percentage of providers who exchanged referrals with Assertive Community Treatment in Year 2 compared to Baseline.

- 5% of providers received referrals from Assertive Community Treatment at Baseline and 8% made them.
- 12% of providers received referrals from Assertive Community Treatment in Year 2 and 12% made them.

Few providers exchanged referrals with Assertive Community Treatment in Year 2 overall; MDs and DOs, and RMHT social workers were among those who exchanged referrals with Assertive Community Treatment the most in Year 2 (Appendix E, Referrals, Table 7.1).

As mentioned, Assertive Community Treatment is still in development and at the time of this report is providing services to clients who are into adulthood and therefore are outside of the target age range of this Evaluation; therefore, it is not surprising that Assertive Community Treatment continued to exchange few referrals with other youth-serving mental and behavioral health RMHT and community-based services. The small number of organizations that offered Assertive Community Treatment at the time of data collection makes it difficult to quantify and generalize survey findings. The expansion of Assertive Community Treatment to all CBHCs in the coming years might also fall outside of the timeline for this Evaluation, but data will be included in these annual reports as they develop.

7.3.4.7 Residential Mental Health Treatment (RMHT)

Overall, a smaller percentage of organizations that offered RMHT exchanged referrals in Year 2 than at Baseline. Most organizations that offered RMHT received referrals from DHHR, and many exchanged referrals with other RMHTFs in Year 2. Few organizations that offered RMHT exchanged referrals with the community-based services included in this Evaluation in Year 2. Most organizations that offered RMHT exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies. There was a 21% decrease in the percentage of providers who received referrals from organizations

that offered RMHT in Year 2 compared to Baseline, as well as a 7% decrease in the percentage of providers who made referrals to organizations that offered RMHT in Year 2 compared to Baseline. That said, all providers made referrals to or received referrals from organizations that offered RMHT in Year 2.

Providers pointed to a few areas for opportunities regarding the policies and procedures for following up after a referral has been made to RMHT. Providers neither agreed nor disagreed that policies for following up with youth after a referral has been made to RMHT are clear and indicated that they only "sometimes" follow up after these referrals. Providers also reported the same top three barriers to maximizing providers' referral networks at Baseline and in Year 2: lack of qualified providers within their networks or areas, lack of resources, and lack of information about resources in the community.

Statewide summary of referrals exchanged between organizations that offered RMHT with other types of organizations and agencies in Year 2:

- The greatest percentage of organizations that offered RMHT in Year 2 (94%) received referrals from DHHR, and the smallest percentage received referrals from community-based agencies other than community-based health centers and FQHCs (6%), followed by group or solo private health practices and pediatric care centers (11% respectively: Appendix F, Referrals, Table 4.2).
- The greatest percentage of organizations that offered RMHT in Year 2 (53%) made referrals to other RMHTFs, and the smallest percentage made referrals to community-based agencies other than community-based health centers or FQHCs, juvenile justice facilities, and pediatric care centers (18% respectively; Appendix F, Referrals, Table 4.2).

Statewide summary of referrals exchanged between organizations that offered RMHT with other types of organizations and agencies compared to Baseline:

- The greatest change since Baseline was a 33% decrease in the percentage of organizations that offered RMHT that received referrals from PRTFs, and a 31% decrease in referrals sent to group or solo private health practices. There was also a 28% increase in referrals sent to other organizations that offered RMHT compared to Baseline (Appendix F, Referrals, Table 4.2).

Table 31 displays the percentage of organizations that offered RMHT that exchanged referrals with different types of organizations and agencies. Each column total in Table 31 represents the organizations that offered RMHT that responded to the Baseline and Year 2 surveys and were used to calculate the percentages in the table. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 31: Summary of Referrals Exchanged Between RMHT and Different Types of Organizations and Agencies by Year

Types of Organizations and Agencies	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=20	n=18	n=20	n=18
Community-based health centers (including FQHCs)	55%	33%	65%	41%
Other community-based agencies	15%	6%	15%	18%
DHHR government agencies	95%	94%	50%	29%
Foster care or adoption agencies	45%	33%	25%	41%
Group or solo private practice health practice	-	11%	60%	29%
Juvenile justice facilities	60%	39%	25%	18%
Local school district/county Department of Education	65%	39%	35%	24%
Pediatric care center	30%	11%	40%	18%
Private or public hospital (including inpatient psychiatric units)	55%	33%	55%	41%
Psychiatric residential treatment facility	55%	22%	25%	47%
Residential mental health treatment facility	55%	44%	25%	53%

Overall, a smaller percentage of organizations that offered RMHT exchanged referrals with other mental and behavioral health services included in this Evaluation in Year 2 compared to Baseline.

Statewide summary of referrals exchanged between organizations that offered RMHT and community-based mental and behavioral health services included in this Evaluation in Year 2:

- Few referrals were exchanged between organizations that offered RMHT in Year 2 and other mental and behavioral health services included in this Evaluation. Results from the

case series interviews suggest that this might be due to the lack of high-intensity mental and behavioral health services in the community. The greatest percentage of organizations that offered RMHT captured in the Year 2 Organization and Facility Survey (17%) received referrals from CSED Waiver Wraparound and the smallest percent (0%) received referrals from other RMHTFs (Appendix F, Referrals, Table 4.3).

- The greatest percentage of organizations that offered RMHT (33%) exchanged referrals with CSED Waiver Wraparound, and the smallest percentage (0%) made referrals to other RMHTFs.

Statewide summary of referrals exchanged between organizations that offered RMHT and community-based mental and behavioral health services compared to Baseline:

- The greatest change since Baseline was a 55% decrease in referrals received from other organizations that offered RMHT and WV Children's Mental Health Wraparound respectively (Appendix F, Referrals, Table 4.3). There was also 40% decrease in referrals made to other organizations that offered RMHT and a 39% decrease in referrals made to Children's Mobile Crisis Response and Stabilization compared to Baseline (Appendix F, Referrals, Table 4.3).

Table 32 displays the percentage of organizations that offered RMHT that exchanged referrals with the community-based mental and behavioral health services in this Evaluation. Dashes represent "missing" data in that some of the wording of the services changed over time.

Table 32: Summary of Referrals Exchanged Between Residential Mental Health Treatment Facilities and Other Services in the Evaluation

Service	% Receiving Referrals at Baseline	% Receiving Referrals in Year 2	% Making Referrals at Baseline	% Making Referrals in Year 2
Statewide Summary	n=20	n=18	n=20	n=18
Assertive Community Treatment	15%	6%	35%	6%
Behavioral Support Services (including PBS)	20%	6%	45%	17%
Children's Mobile Crisis Response and Stabilization	30%	11%	45%	6%
Children with Serious Emotional Disorders Waiver Services	60%	-	30%	-
Children with Serious Emotional Disorders Waiver Mobile Response	-	11%	-	11%
Children with Serious Emotional Disorders Waiver Wraparound	-	17%	-	33%
West Virginia Children's Mental Health Wraparound	55%	0%	55%	17%

Referral reach was added to the Year 2 Organization and Facility Survey and findings specific to RMHT can be found in Table 33. Most organizations that offered RMHT exchanged referrals within their region, but some exchange referrals outside of their region and several with out-of-state provider agencies (Appendix F, Referrals, Table 4.4).

Table 33: Reach of Referral Networks of Year 2 Organizations and Facilities Offering Residential Mental Health Treatment

Reach	% Receiving Referrals in Year 2	% Making Referrals in Year 2
Statewide Summary	n=18	n=18
Within their region	78%	61%
Outside of their region	50%	33%
Outside of WV	33%	11%

There was a 21% decrease in the percentage of providers who received referrals from organizations that offered RMHT in Year 2 compared to Baseline, as well as a 7% decrease in the percentage of providers who made referrals to organizations that offered RMHT in Year 2 compared to Baseline.

- 39% of providers received referrals from organizations that offered RMHT at Baseline and 44% made them.
- 18% of providers received referrals from organizations that offered RMHT in Year 2 and 37% made them.

All providers made referrals to or received referrals from organizations that offered RMHT in Year 2 (Appendix E, Referrals, Table 7.1). More information about coordination with community-based mental and behavioral health services as a part of discharge planning can be found in Section 8.1.

There are some areas for opportunity around policies and procedures for following up after youth are referred to RMHT.

- Providers neither agreed nor disagreed at Baseline (3.2) and in Year 2 (2.8) that there are clear policies or procedures for following up with youth after a referral to RMHT has been made (Appendix E, Referral Policies, Table 8.4).
- Providers at Baseline and in Year 2 indicated that they “sometimes” follow up with youth after a referral to RMHT has been made (Appendix E, Referral Policies, Table 8.4).

Providers reported that the top three barriers to maximizing the potential efforts of providers’ referral network for youth referred to RMHT were as follows (Appendix E, Referrals, Table 7.5):

- Lack of qualified providers within their network or areas (72% at Baseline and 66% in Year 2)

- Lack of resources (ex. funding, staff; 72% at Baseline and 76% in Year 2)
- Lack of information about resources in the community (62% at Baseline and 71% in Year 2)

These findings were consistent across all provider types and regions. There were several providers who wrote in responses in Year 2 to include additional barriers such as a lack of time and having to rely on other providers to follow through.

As reported in Section 5.3 above, during Round 2 of the case series interviews, some caregivers and youth described RMHTF as "holding places" while youth wait for additional services. Referrals were not specifically discussed during Round 3 case series interviews, although several spoke about discharge planning and the need for more intensive transition services after RMHT (see Section 8.1 below for more details).

Further, throughout each round of case series interviews, some caregivers perceived that they had to rely on the court/legal system as the only means to facilitate placement in RMHT. Specifically, caregivers indicated that by filing incorrigibility they were ultimately able to access services; however, it can strain the caregiver-youth relationship, and communication and engagement suffered as a result.

7.3.4.8 Children's Crisis and Referral Line (CCRL)

The 2023 DHHR Semi-Annual report describes the CCRL as a central access point to connect families and youth with immediate services such as Children's Mobile Crisis Response and Stabilization and/or CSED Waiver Mobile Response, as well as interim and longer-term services via the Assessment Pathway and Wraparound. Data from the CCRL were not captured in the Year 2 Organization and Facility Survey, but provider perspectives were captured. Findings indicate a slight increase in the percentage of providers who made referrals to the Children's Crisis and Referral Line compared to Baseline.

- 12% of providers received referrals from the CCRL at Baseline and 29% made them.
- 9% of providers received referrals from the CCRL in Year 2 and 36% made them (Appendix E, Referrals, Table 7.1).

All provider types except for RMHT staff and RMHT social workers reported exchanging referrals with the CCRL.

7.3.5 Following Up After Referrals Are Made

Providers neither agreed nor disagreed that there are clear policies and procedures for following up after youth are referred to RMHT. Similarly, mental and behavioral health and healthcare providers at Baseline and in Year 2 indicated that their policies for following up with youth or their families after a referral to community-based mental and behavioral health services has been made, or with a new provider, are sometimes clear (Appendix E, Referral Policies, Table 8.2). A new item was added to the Year 2 Provider Survey to also capture referral follow ups by probation officers. Fifty nine percent of probation officers regularly follow up with organizations that they

send referrals to, and 34% regularly follow up with youth and/or families after referrals are sent (Appendix E, Social Services & Probation, Table 13.4).

7.3.6 Recommendations

Recommendation: Consider ways to expand and/or reinforce policies for following up after a referral has been made to RMHT or community-based mental and behavioral health services. It is possible that technology plays a role here too, in that provider organizations with electronic health records or other computer-based systems might have an easier time tracking and following up on referrals than those making referrals by phone or fax.

Recommendation: Explore reasons why none of the organizations that responded to the Year 2 survey reported that they exchanged referrals with the CCRL. Administrative data showed greater use of the CCRL than what is reflected in the referral data from the surveys. One explanation is that organizations and providers might not be referring youth to the CCRL the same way that they might refer youth to other community-based programs such as Wraparound. For example, caregivers and youth might be encouraged to call 844-HELP4WV whereas referrals to Wraparound would be processed through the Assessment Pathway or other referral mechanisms.

8 Evaluation Results: Caregiver and Youth Experiences with Services and Discharge Planning

8.1 Finding: Caregivers and their youth in RMHT generally reported moderate to high levels of engagement, but also expressed the desire for greater involvement

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How engaged are WV families in the mental health treatment services for their children?
- How has family engagement with mental health services changed after PBS intervention?
- Has the proportion of youth (ages 18–21) referred for ACT services (at residential mental health treatment facilities or Psychiatric Residential Treatment Facilities discharge) increased?
- How has family engagement throughout the period of placement in residential mental health treatment facility changed?
- How engaged are WV families in wraparound treatment?
- How has family engagement in aftercare planning as part of discharge planning changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

8.1.1 Summary

Providers value family engagement, and caregivers and youth notice and appreciate it. Youth generally felt more engaged than their caregivers. For the most part, youth reported higher levels of engagement and involvement in decisions to change their levels of care, and in discharge planning, than their caregivers. Nevertheless, **most caregivers reported moderate to high levels of participation in their youth's care**, and little variation was observed over time.

Providers, caregivers, and youth described similar barriers to engagement, such as lack of regular communication which can be exacerbated by scheduling conflicts for meetings and appointments, and lack of services and resources available for youth and families. Caregivers and youth identified additional barriers including turnover at DHHR and provider organizations, changes in service availability, and their preferences being given little weight during decisions around treatment planning and discharges. Facilitators of engagement included regularly scheduled meetings and appointments, navigators and/or advocates to help caregivers stay informed and to connect youth with needed services and keeping youth close to home when possible. **Most caregivers in the case series reported positive changes over time related to engagement throughout the treatment process during Round 3 interviews.** Caregivers and youth also cited both successes and challenges with discharge planning and transitioning youth out of RMHT.

8.1.2 Provider Perceptions of Family Engagement

Providers indicated that they value family and caregiver involvement in youth's treatment (Appendix E, Out-of-Home Placements, Table 9.3). Providers were asked to rate their level of agreement with the series of statements displayed in Table 34. Levels of agreement to the statements in Table 34 were captured on scales anchored by 1 (Disagree) and 5 (Agree).

Table 34: Provider Perceptions of Family Engagement by Year

Survey Item	Level of Agreement at Baseline	Level of Agreement in Year 2
Families/caregivers are an essential part of the planning of mental and behavioral health services for their youth	4.8	4.8
Families/caregivers are asked to provide input for setting youth treatment goals	4.6	4.5
Family/caregiver opinions are considered during treatment planning for their youth	4.6	4.6
Family/caregiver opinions are considered in the delivery of mental and behavioral health services for their youth	4.6	4.6
Families/caregivers help with the delivery of mental and behavioral health services for their youth	4.4	4.3
Families/caregivers are involved in decisions to move youth to higher or more intensive levels of care	4.4	4.5

Providers also somewhat agreed at Baseline (4.4) and in Year 2 (4.0) that they maintain regular communication with caregivers about their youth's progress/status as part of their delivery of services.

8.1.3 Caregiver Treatment Participation Scale Findings

The Caregiver-Treatment Participation Scale measures the extent to which caregivers felt included in service planning and the delivery of care. As shown in Table 35, **most caregivers felt moderate to high levels of participation in the treatment of their youth in RMHTFs, and little variation was observed over time**.

Table 35: Caregiver Treatment Participation Scale Findings by Year

Score	Caregivers at Baseline	Caregivers in Year 2
Low	28%	29%
Moderate	42%	48%
High	30%	22%

During the case series interviews caregivers described attempts to stay in regular communication with their youth's care team but would like more involvement and for their opinions and preferences to be given more weight in decisions about their youth's treatment and care.

8.1.4 Service-Specific Engagement with Caregivers

Caregivers' perceived involvement, inclusion, and agreement with treatment goals for community-based services varied by service. The survey captured whether caregivers perceived that they were included in creating care plans for their youth in RMHT who also received Assertive Community Treatment, Behavioral Support Services (including PBS), and/or Wraparound in the last 12 months. Due to low utilization of Assertive Community Treatment, only findings for Wraparound and Behavioral Support Services (including PBS) are reported here (see more below for information about the role of Assertive Community Treatment and Wraparound in discharge planning). Level of agreement with the treatment goals set for each service were captured on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). **Comparisons across services indicate that caregivers generally felt more involved in creating care plans for Wraparound but reported slightly higher agreement with treatment goals set for Behavioral Support Services (including PBS).**

8.1.4.1 Wraparound

Caregivers felt included in the creation of care plans for Wraparound and agreed with the treatment goals at Baseline and in Year 2.

- Caregivers of youth in RMHT agreed that they were included when creating a care plan for Wraparound (at Baseline (3.9) and in Year 2 (3.6); Appendix C, Experiences w Mental Health Ser, Table 3.6).
- When asked if they agreed with their youth's treatment goals, caregivers of youth in RMHT indicated that they agreed with the treatment goals for CMHW (at Baseline (4.0) and in Year 2 (3.6); Appendix C, Experiences w Mental Health Ser, Table 3.6).

8.1.4.2 Behavioral Support Services (including PBS)

More caregivers of youth in RMHT in Year 2 agreed with the treatment goals set for Behavioral Support Services (including PBS) compared to Baseline.

- Caregivers of youth in RMHT neither agreed nor disagreed that they were included when creating a care plan for Behavioral Support Services (including PBS; at Baseline (2.6) and in Year 2 (3.3); Appendix C, Experiences w Mental Health Ser, Table 3.4).
- When asked if they agreed with their youth's treatment goals for PBS, caregivers of youth in RMHT at Baseline neither agreed nor disagreed (3.1). Caregivers of youth in RMHT in Year 2 agreed with the treatment goals for Behavioral Support Services (including PBS; 3.7; Appendix C, Experiences w Mental Health Ser, Table 3.4).

8.1.4.3 Residential Mental Health Treatment (RMHT)

Caregivers neither agreed nor disagreed that they were included in creating treatment plans, and neither agreed nor disagreed with the treatment goals for RMHT.

- Caregivers of youth in RMHT at Baseline and in Year 2 neither agreed nor disagreed that they were included when creating a care plan for RMHT (2.7 respectively; Appendix C, Experiences w Mental Health Ser, Table 3.5).
- Caregivers of youth in RMHT at Baseline and caregivers of youth in RMHT in Year 2 neither agreed nor disagreed with the treatment goals for RMHT (3.2 and 3.5, respectively; Appendix C, Experiences w Mental Health Ser, Table 3.5).

8.1.5 Youth Engagement

Survey findings indicate that youth in RMHT felt engaged in their treatment. Youth were asked to rate their level of agreement on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of statements. While youth in RMHT neither agreed nor disagreed that they helped choose their mental and behavioral health services (3.4 at Baseline and 3.3 in Year 2), they generally agreed that they:

- Helped choose their treatment goals (3.7 at Baseline and 3.8 in Year 2; Appendix D, Experiences with Mental Health, Table 2.2)
- Participated in their own treatment (4.1 at Baseline and 4.2 in Year 2; Appendix D, Experiences with Mental Health, Table 2.2).

8.1.6 Caregiver and Youth Treatment Engagement and Respect Scale Findings

As displayed in Table 36, **both caregivers and youth felt like staff treated them with respect and generally engaged them in care delivery**. Most caregivers and youth reported moderate to high levels of treatment engagement and respect from staff. The greatest percentage of caregivers fell into the moderate range of the treatment engagement and respect scale, and the greatest percentage of their youth in RMHT fell into the high range of the scale and little variation was observed over time.

Table 36: Caregiver and Youth Engagement and Respect Scale Findings by Year

Score	Caregivers at Baseline	Caregivers in Year 2	Youth at Baseline	Youth in Year 2
Low	13%	14%	4%	1%
Moderate	51%	51%	26%	27%
High	36%	36%	70%	73%

8.1.7 Opportunities to Enhance Caregiver and Youth Engagement

Providers reported a number of factors that affect caregiver and family engagement in treatment planning. The Year 2 survey listed six barriers and prompted providers to select all that apply. Findings were as follows:

- 75% of providers reported that caregivers miss appointments.
- 59% of providers reported that caregivers do not answer their phones when providers call to discuss treatment plans for their youth.
- 55% of providers reported that caregivers are too busy.
- 47% of providers reported that caregivers were uninterested in participating in decisions about their youth's care.
- 16% of providers reported that their caseloads prevent them from having time to talk to caregivers about treatment.
- 5% of providers reported that their organizations do not have policies for including caregivers in treatment decisions.

Of note, nearly half of providers reported that caregivers seem uninterested in participating in decisions about their youth's care, and yet many caregivers who participated in this Evaluation reported being somewhat involved and wanting more. Granted, selection effects are such that caregivers who participated in the surveys and/or case series interviews might be more involved than the average caregiver. Findings on barriers to caregiver engagement varied by provider type but are difficult to compare given some of the small cell sizes (see Appendix E, Out-of-Home Placements, Table 9.5 for more information). Fourteen providers (16%) also indicated that there were "other" barriers that aligned with caregiver and youth experiences:

- Difficulties navigating the mental and behavioral health system
    - As reported in Section 3.2, there is some room for improvement in caregiver and youth awareness of mental and behavioral health services, and case series participants also spoke to the complexity of the system. Together the data indicate that perhaps patient navigators might be helpful in this regard (see more below).

- Scheduling conflicts
    - Survey and interview data also indicated that services are not always offered at times that work best for caregivers and youth.
- Transportation barriers
    - This was a barrier reported by caregivers at Baseline but was less of an issue in Year 2, which could be related to resources provided by DHHR for transportation. Phone and video calls also allowed caregivers to participate more in treatments (e.g., family therapy) and MDT meetings. Several caregivers mentioned recent use of DHHR travel assistance, regretting that they were not informed of the service earlier as it would have facilitated engagement with youth during placement.
- Limited services and resources available to families
    - Case series participants also agreed that this is a significant barrier to engagement. They indicated that the specialized (often high intensity) community-based services needed for their youth were far away from home, difficult to access, and/or were not available in WV (see more below).
- Caregiver/family-related issues, such as caregiver mental health and caregiver substance use
    - When asked about barriers to accessing services, one youth wrote in that their parents had substance use issues that affected the youth's ability to get needed services. This was also a theme in the judge interviews at Baseline; judge perspectives will be captured again as part of Year 3 data collection and will be included in next year's report.

A great deal of information on engagement emerged from interviews with caregivers and youth participating in the case series, including other factors that reduced or prevented engagement (see Table 37). Importantly, perceptions of communication and engagement seem to go hand in hand for caregivers. Several caregivers reported both positive and negative experiences with engagement in their youth's treatment; this seemed largely dependent on the level of communication they had with RMHTF and DHHR staff. Youth engagement in treatment, coupled with frequent staff and provider communication, facilitated caregiver involvement in their youth's treatment. Caregivers described examples of a particular therapist or DHHR worker who was especially informative and responsive, but these appeared to be short-lived amid turnover and waitlists among facilities, services, providers and DHHR; these factors were continually discussed as impeding family communication and engagement in treatment as well as youth placement and service access.

Table 37: Barriers to Engagement Reported by Caregivers during Case Series Interviews

Barrier	Description	Example Quotations
Lack of Communication*	Several caregivers reported having to contact facilities and providers multiple times through various means (e.g., phone, text, voicemail, supervisors and higher administration, family attorney, judges) to elicit a response for any updates on youth's status, treatment, and changes. This difficulty reaching people who can provide updates on youth progress made them feel like their voices were not being adequately heard.	▪ "Nobody ever asks me any questions…I just set [sic] there…I just listen to what's being said by the team. I feel like I can't say anything unless they ask me." (Caregiver, Grandmother) ▪ "I don't think the communication [with RMHTF] is good. I don't feel like that we understand the processes. And - I don't think it's explained well, and I understand that the system – they're bogged down, probably with more important things than my kid. But he's my kid, and I feel like I have to stay like the hub of all of this stuff and try to keep these people going." (Caregiver, Mother) ▪ "Left three or four messages. No calls back. It's crazy trying to get information. They don't even call um, the [DHHR] worker. You know they haven't. There's no communication...As far as communication goes, it's just family therapy. Nothing outside of that." (Caregiver, Grandmother, Adoptive Mother)
Staff Turnover	Turnover among facilities, services, providers and DHHR staff that continue to impede family communication and engagement in treatment as well as youth placement and access to mental and behavioral health services.	▪ "It's one of those things he's been passed on over and over, and you know, how in the world do you get any kind of treatment done when he's got to get used to a different therapist each time, so he's starting over four different times?" (Caregiver, Grandmother, Adoptive Mother) ▪ "The DHHR people are not doing their job so she's [counselor] having to do some of their job so, I'm not happy with that. And we have had – I think this will be our sixth DHHR worker since we started, I mean, we are having them like a month at a time and there's just such a high turnover. It's crazy." (Caregiver, Adoptive Mother)
Service Availability	Lack of continuum and stability among services, facilities, and DHHR amid the lack of stable local options are major challenges expressed by both caregivers and youth as interrupting treatment process and progress and undermining the youths' sense of trust, security, and stability both in residential and in the community.	▪ "I would have loved for him to stay in West Virginia. Those are the really the big sticking points right there is being so far away, even in West Virginia, you know. Being so far away to any of the facilities that he was at. And now, of course, out of state, that's pretty much impossible for me to get out of state…That just made it even harder [to engage]." (Caregiver, Grandmother, Adoptive Mother) ▪ "No, no, [I wasn't involved in the services] because it was like a five-hour drive, and you know I got reports, but I wasn't part of anything that was going on." (Caregiver, Grandmother)

Barrier	Description	Example Quotations
	Distance was a barrier to engagement in placements and services both in and out of WV to varying degrees across all rounds of interviews.	
Lack of Youth Participation in Treatment**	Some youth are resistant to community-based treatments, which in at least one case led to readmission to RMHT. Lack of youth buy-in also affected caregivers' ability to engage in RMHT. For example, caregivers are unable to engage when youth choose not to go to therapy or participate in and/or attend meetings. Caregivers also discussed that often the youth's incorrigibility status results in RMHTF's not involving the caregivers.	▪ "The only reason he's in a [RMHTF] placement like that is because the judge says he was incorrigible.…I don't have any say so in what goes on." (Caregiver, Grandmother, Adoptive Mother) ▪ "I don't know [how to become more involved]. I think a lot of it has to come from him. He just has to show improvement….He doesn't like family [therapy]…he doesn't like going to therapy, because he says he don't have nothing to say, nothing to talk about. (Caregiver, Grandmother) ▪ "No [I am not engaged in youth's care]. I mean even if I tried to talk to [therapist or counselor] about what's going on with [Youth], she wouldn't be able to tell me." (Caregiver, Grandmother)
* These experiences were reflected in the survey data when caregivers and youth were asked about barriers to starting and continuing services (see Section 5.2 for more), including lack of responsiveness and not receiving calls back, and for approximately half of caregivers this was the biggest barrier to starting and continuing services for their youth in Year 2. ** Survey and interview data indicate that some services are not providing expected benefits, which affects youth interest and engagement in treatment.		

While caregivers and youth expressed increased engagement and involvement over time, they still desire more. Caregivers in particular discussed facilitators, preferences, and priorities related to engagement in their youth's treatment. Table 38 displays the facilitators and preferences caregivers mentioned when asked about factors that can increase engagement.

Table 38: Facilitators and Preferences for Engagement Reported by Caregivers in Case Series Interviews

Facilitators and Preferences	Description	Example Quotations
Communication via frequent updates about youth progress	Caregivers want better communication with those who can provide updates on their youth's treatment and status. They desire regularly scheduled meetings and appointments to make sure they are on the "same page" about their youth's care.	▪ "Communication. That's number one. Yeah, the last two DHHR workers have been awesome…Only one actually came to my house in the past two years….I have to know what's going on all the time, you know, even if there's nothing going on, I want to know….The last therapist before this one, she would really communicate with me a lot. She would call me outside of the family therapy meetings and stuff, and let me know concerns, or if [youth] didn't want to participate in the family therapy, she would call me, and me and her would do family therapy. But she was the only one that did that... "(Caregiver, Grandmother, Adoptive Mother) ▪ "We want the best for him….The most important factor, I guess, probably would be more along the lines of explaining what is happening in terms that I'm going to understand and what should be happening and what will be happening. So that you can understand, because I used the example several times that I've never experienced this." (Caregiver, Mother)
Shared Decision Making	Caregivers and youth have been and want to be included in treatment decisions, especially when it comes to youth placements in RMHT. Caregivers desired opportunities for discussions and shared decision making about youth's treatment to feel like their voices were being heard.	▪ "If everybody was on the same page and more interaction with me as [youth's] parent, that would be sweet, you know, because if you take your kid to the pediatrician or your family doctor, you know you can talk to them, and if you have any questions, then you know you can ask them or whatever. But yeah, that's not the case in these facilities, even the ones in West Virginia." (Caregiver, Grandmother, Adoptive Mother) ▪ "I think having us all talk together and discuss things together. There's an involvement that I think should take place more often….Hearing that he's doing well in school. He doesn't have any write-ups, he hasn't been aggressive…To tell me that he's on track, He's doing good - you know. I'm satisfied when I hear that…hearing the same thing from him... like to have the communication. Yes." (Caregiver, Grandmother)
Navigators and Advocates	Some caregivers found that securing personal support or an advocate helped them become more engaged in their youth's treatment. They appreciated that navigators or advocates that were well connected	▪ "And then I was having a few issues with his therapist... And I finally had started having my ex-husband come… So over the last, like six months, it's like progressed that way. And so I started having [ex-husband] come with me to the visit so that way it was less difficult." (Caregiver, Mother) ▪ "Yeah, it's [support and engagement] better since I have more people on board. Yeah." (Caregiver, Adoptive Mother)

	within the system could provide them with consistent updates.	
Youth Receiving Care in WV	Some caregivers feel the tension between wanting their youth to stay in state but also wanting to make sure they have access to the right level of care. Communication and in-person visits with their youth in RMHT, are a priority for many; thus, they preferred their youth to stay in WV. Distance between home and RMHT affected several families, but youth moving to placements in WV allowed for regular and more engagement in treatment though.	▪ "Well [new RMHTF is] an hour away, which is much better than six hours away….I never got to visit because of the transportation problem. [Now] I can go and see him, and he could have home visits now. I guess, I mean, I'm getting to see him more. I get a talk to him regularly. We can talk every night if we choose to." (Caregiver, Grandmother) ▪ Going out of state. That just made [engagement] even harder….in Tennessee that's a six-hour drive, and money-wise it's hard to do. In West Virginia, you know, it'd be easier." (Caregiver, Grandmother, Adoptive Mother)

8.1.8 Improvements in Engagement Over Time

In Round 2 interviews, most caregivers reported being involved during placement via family therapy and MDT meetings via video or phone calls, with a few reporting seasonal and sporadic in-person meetings. The seven caregivers interviewed in Round 3 perceived **more engagement throughout the treatment process.** They reported inclusion and participation in treatment and treatment meetings, and, to some extent, planning and decision making. One caregiver described advocating for herself to become more involved, stating, "I don't think I was involved in very many of them [MDT meetings] in the beginning. But after a while, whenever I realized what was happening, I was like, 'I need to be invited to these." She continued discussing the engagement between her and RMHTF staff:

> I do like the [RMHTF] therapist that we have now. I do appreciate that the staff that are with him day to day are able to talk to me and tell me how he's doing whenever I go for a visit. . . I think that the staff are actually taking me seriously whenever I tell them something. That's worked well because it hasn't in the beginning. . . So they're good at explaining things. (Caregiver, Mother)

Some barriers mentioned throughout the case series interviews improved by Round 3. Specifically, caregivers reported being able to reach and communicate with their youth's therapists and DHHR workers when needed; and some felt more involved in treatment team meetings. It should be noted that although caregivers felt more updated and informed, this was usually in the sense of passively receiving information versus influencing treatment. They at times felt that others involved in treatment team meetings (e.g., DHHR workers, attorneys, insurance agents, therapists) seemingly talked more among themselves than communicating with the caregivers and family.

Caregivers with youth in RMHT expressed that their DHHR workers were more communicative and supportive over time and helped advocate for their youth and family's treatment needs, thereby strengthening family engagement. While some caregivers felt that DHHR and other supportive services were "cut off" upon discharge from RMHT, others reported that their DHHR workers remained engaged and in frequent contact:

> As far as the DHHR, the last couple of workers have been awesome keeping me in the loop. This last one. . . she gave me her personal cell phone number and we communicate/text that way. . . . She's great. [Youth]'s had five [DHHR workers]. . . but the first three I never met or spoke to or anything. I had to get their emails and introduce myself and all that. But the last two they were great. . . communicated with me, you know, all the time would let me know if anything was going on. . . They just kept me informed (Caregiver, Grandmother/Adoptive Mother).

The caregiver explained that this DHHR worker's prior experience with CPS made her more knowledgeable about children and more understanding about what both children and parents are going through during RMHT, resulting in better communication and engagement.

8.1.9 Involvement in Decisions to Change Youth's Level of Care and Discharge Planning

Youth reported more involvement in decisions to change their levels of care and more engagement in discharge planning than their caregivers. Caregivers and youth were asked to rate their level of agreement on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree) to a series of statements.

- **Youth in RMHT agreed that they were included in planning for changes in their care**; the mean at Baseline was 3.6 and in Year 2 was 3.7 (Appendix D, Experiences with Mental Health, Table 2.2). However, their caregivers neither agreed nor disagreed. The average agreement among caregivers of youth in RMTH at Baseline was 2.8 and the average among caregivers of youth in RMHT in Year 2 was 2.7 (Appendix C, Experiences w Mental Health Ser, Table 3.5).
- Caregivers and their youth in RMHT neither agreed nor disagreed that they were involved in discharge planning. The average level of agreement among caregivers of youth in RMHT 2.9 at Baseline and in Year 2 respectively (Appendix C, Experiences w Mental Health Ser, Table 3.5). The average for youth in RMHT at Baseline was 3.4, and for youth in RMHT in Year 2 it was 3.6 (Appendix D, Experiences with Mental Health, Table 2.2).

8.1.10 Use of Assertive Community Treatment and Wraparound to Plan for Discharge from RMHT

DHHR is promoting the use of community-based services to help with discharge planning and transitioning youth back into their homes and communities after RMHT through provider training and policy updates. For example, DHHR is updating policies to require that Assertive Community Treatment or Wraparound is offered as part of discharge planning for all youth in RMHT, with implementation beginning in 2023. Providers who offered RMHT at Baseline disagreed that their organization routinely screen for eligibility in Assertive Community Treatment and neither agreed nor disagreed that their organization routinely collaborates with Wraparound services to plan to discharge clients. This finding varied by provider type and region with psychiatrists agreeing and psychologist disagreeing, and Regions 1 and 2 in more agreement than Regions 3-6. Similar items in the Year 2 survey captured responses in Yes/No format rather than in levels of agreement (Appendix E, Out-of-Home Placements, Table 9.4); findings were as follows:

- 15% of Year 2 providers routinely screen for Assertive Community Treatment as a part of discharge planning.
- 31% of Year 2 providers routinely screen for Wraparound as a part of discharge planning.

As previously mentioned, the target age of Assertive Community Treatment is older than the population of interest for this Evaluation, and the program is still being developed. Wraparound, on the other hand, has several funding streams and more providers throughout the state, so it was somewhat expected that more providers screened youth in RMHT for eligibility for Wraparound as part of discharge planning than for Assertive Community Treatment. The only noteworthy regional variation in Year 2 was with Wraparound, in that a slightly higher percentage

(approximately half) of the providers in Regions 1, 3, and 5 screen for Wraparound eligibility as part of discharge planning. Percentages that screen for Assertive Community Treatment and Wraparound are expected to increase in Year 3 given that implementation efforts of updated policies requiring screening for Assertive Community Treatment and Wraparound are already underway. For example, in the most recent case series interviews, two caregivers had already had discussions with the care team about CSED Waiver services that can help the youth after discharge.

8.1.11 Case Series Participants' Experiences with Discharge Planning and Transitioning Youth Back into Their Communities

The goal is to ensure that there are sufficient mental and behavioral health services and supports needed to transition youth back home and communities. Case series participants shared their experiences with discharge planning and transitions out of RMHT. Several themes emerged.

Lack of treatment engagement can lead to longer stays and transfers between RMHTFs. If youth do not engage and/or do not perceive that they need services, it can lead to transfers or delayed discharge from RMHT. Caregivers acknowledged that youth engagement in treatment impacts outcomes and the ability to transition back home. Caregivers also recognized that youth with more advanced and/or intensive needs likely require more supports, and wanted providers to find ways to engage youth, even when youth were unwilling to participate in their care, rather than transferring them to another facility.

Lack of available community-based services can lead to longer stays in and readmissions after discharge from RMHT. In general, caregivers and youth perceived there were not enough high-intensity service options in West Virginia for youth with advanced mental and behavioral health needs to remain in their homes. The following two quotes by caregivers demonstrate this perception:

> The services aren't there. Yeah, there's no services. . . That's one thing that people have talked about is they wish there were more facilities closer that could handle the extreme behaviors, because then the families could be a little bit more involved in treatment than maybe they can be in places like Arkansas. . . What kind of help he needs, I don't know, because I don't know what's fully available. I know what help he has gotten hasn't helped. (Caregiver, Grandmother)

> They were wanting to place her in a group home closer to us first before she got to come home, you know, to transition her slowly, instead of just sticking her home with us and send her to public school and everything that she's not used to there. . . There's just nothing in West Virginia. (Caregiver, Adoptive Mother)

Youth behavior during and after RMHT can result in early discharge, transfers between RMHTFs and readmissions. While some youth reported having their discharge dates delayed due to a lack of viable alternatives (e.g., RMHTF, group home, foster home), others' discharges were delayed due to poor behavior within the facilities or during home visits. Caregivers agreed

this was evidence that these youth were not ready to come home. A 15-year-old youth shared his journey through multiple residential placements:

> They brought me to the courthouse and I got adjudicated. . . and then I sat in a hotel room for like at least a week, maybe two. Then, after that, they had brought me to River Park. Then after that, I sat in River Park for a month, and after that I thought I was going home. Didn't go home. I went to the Hall. Sat up there for six months, and then I came down here because I knew as soon as I went to the Hall I knew I wasn't going home. (Youth)

Other caregivers discussed how placements (e.g., RMHTF, foster homes) were unable to manage the youth's behavior, resulting in transition or early discharge. For example, one caregiver stated that her 16-year-old youth was in foster care and the person that took her into foster care gave up, saying "I can't do it" and that the caregiver took the youth back to her home (Caregiver, Grandmother). Another added, "Yeah, because his behavior was so out of whack, and he was bigger than the children there. Anyway, the facility could not handle his behavior because he continually broke things" (Caregiver, Grandmother/Adoptive Parent).

Furthermore, caregivers often observed how improvements in youth behaviors and functioning as a result of RMHT are temporary and diminish within a few weeks or months without consistent, intensive treatment and supportive services and structures in the community. Caregivers frequently observed their youth falling back into old behavioral patterns and habits, sometimes facilitated by returning to problematic social groups. These observations, coupled with caregivers' descriptions of lack of follow-up after RMHTF discharge, may contribute to caregivers' ongoing beliefs that RMHT was most beneficial for their youth. This regressive behavior that occurs after discharge further illustrates the importance of higher-level and more intensive post-residential care, such as step-down community-based services, as well as services for caregivers to help manage youth behavior at home.

Table 39: Example Quotations from Caregivers about Youth Regressive Behavior after RMHTF Discharge

Example Quotations
"When he came home from there, he was like somebody that been in the military. He got up early. He said he was going to do his hygiene, which meant, brush his teeth do his hair, wash his face. Then he'd make his bed. Then he had his shoes all lined up…He was like on top of things. So I was very pleased with all that performance....[Then] he had already got suspended once or twice within the matter a couple of weeks [after return home]...DHHR worker] said, because he's reverted back to the same - that you've been in two different facilities you haven't been home for but a short time, so I think that it's time you need to go back to placement because you're back to the same things that you were doing in the beginning." (Caregiver, Grandmother)
"She'll do good for I'd say, like, a month or two, and then she'll regress..." (Caregiver, Adoptive Mother)
"All I know is that they're supposed to be doing one on one for [youth], but once they leave he falls back right into his same routine." (Caregiver, Grandmother)
"Immediately after he seemed to be more sympathetic to how much money we spent on things, and you know we had let him get a job, and he realized how hard it was to make money…But then I noticed a change about a month afterward, and so I keep a journal of his behaviors so then I can pick up on when I think he's doing drugs. And it was about a month afterward that I started noticing a change in him, and then it got to the point where he quit his job and didn't get another job, and he ended up testing positive and then ran away, so. There was a slight change in the beginning, but it didn't last for very long." (Caregiver, Adoptive Mother)

During Round 3 case series interviews, three of nine youth had transitioned back home from RMHT and one transitioned to a WV foster family home. Two of these transitions back home were not initially regarded by caregivers as successful treatment outcomes. Several caregivers in Round 2 (and some to a lesser extent in Round 3) referred to a "revolving door" whereby they perceived that youth were passed between emergency shelters, hospitals, detention centers, foster homes, caregivers' homes and RMHTFs throughout their journey. **Half of the youth-caregiver pairs perceived that placements could not manage youths' behavioral needs and/or that they exhausted all viable treatment options. In these cases, youth were moved 1) to RMHTF placements in WV, 2) to RMHTF placements out of state, or 3) back home when no other options were available. In these instances, the move out of RMHT was dictated not by successful completion of treatment but due to the youth not engaging and/or the facility not effectively manage youth behavior.**

Caregivers with youth who had transitioned out of RMHT felt that the onus is put on the family to find services and on the youth to engage and actively pursue the services absent RMHT structure, particularly when youth are transitioning to adults. They described several types of interventions that can help youth transition out of RMHT, as several positive successes were seen among youth who had transitioned home from RMHT, including current or planned use of community-based services. One youth experienced markedly positive behavioral progress after discharge, including maintaining positive relationships with his caregivers and "parent-approved friends." He is

excelling in school and extracurricular activities, like baseball. In this instance, it appeared the youth was open to community-based services after residential placement when he previously declined therapy:

> [Youth] received a medication change [after Round 2] and placed on Haldol, and that brought about a rapid change in behavior for the better...Yes, we're more satisfied now than we have been in in a long time. . . . He's been able to rein in what normally would have caused, you know, extreme anger. Far less depressed than he normally was. . . . He now readily meets with [therapist]. Prior to that he turned her away. (Caregiver, Grandfather/Adoptive Parent)

8.1.12 Recommendations

Recommendation: Work with providers to identify additional opportunities to engage caregivers and youth in the initiation of mental and behavioral services, treatment planning, and discharge processes.

Recommendation: Continue to examine youth living situations prior to discharge. DHHR is working to expand home-like settings for difficult to place youth (e.g., those in their teens), including foster care and kinship care, to help ensure that youth have a safe place to transition to after RMHT. Related analyses might look at rates of admission, readmissions and underlying reasons such as living situation.

Recommendation: Consider how caregivers are involved in and/or communicated with about screenings and assessments.

8.2 Finding: Most caregiver and youth report moderate to high levels of satisfaction with mental and behavioral health services

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has family satisfaction with children's mental health treatments and supports changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

8.2.1 Summary

Most caregivers and youth report moderate to high levels of satisfaction with services. **There was a considerable increase in youth satisfaction compared to Baseline. Caregivers and youth also reported having strong natural support networks**. Case series participants' perceptions of satisfaction were mixed, with most caregivers reporting both positive and negative experiences with facilities, providers and DHHR case workers.

8.2.2 Satisfaction Scale Findings

Responses to the Access and Satisfaction Scale in the surveys indicated that **most of the caregivers and their youth in RMHT had moderate to high levels of satisfaction with mental and behavioral health services and accessibility**. The biggest changes over time included **a considerable increase in youth satisfaction compared to Baseline.** Table 40 displays the percentages of caregivers and youth in the low, moderate, or high ranges of the satisfaction scale over time.

Table 40: Caregiver and Youth Satisfaction by Year

Score	Caregivers at Baseline	Caregivers in Year 2	Youth at Baseline	Youth in Year 2
Low	24%	28%	26%	4%
Moderate	44%	50%	58%	40%
High	32%	22%	17%	56%

Youth survey data revealed several factors that might be contributing to their high levels of satisfaction (Appendix D, Experiences with Mental Health, Table 2.2). When asked to rate their level of agreement on scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree), youth agreed that they:

- Received services that were right for them (3.7 at Baseline and 3.8 in Year 2)
- Got the help they wanted (3.7 at Baseline and 3.8 in Year 2)
- Got as much help as they needed (3.8 at Baseline and 3.7 in Year 2)

Youth indicated that they got the services they wanted, yet caregivers neither agreed nor disagreed to similar items in the survey, and case series participants generally described challenges finding the right level of intensity of services that are a “good fit” for youth.

Factors contributing to satisfaction, including factors that increase or enhance satisfaction and barriers to satisfaction among caregivers and youth are presented in Table 41.

Table 41: Barriers and Facilitators Related to Satisfaction Identified in Case Series Interviews

Theme	Barriers to Satisfaction	Facilitators of Satisfaction
Communication	▪ Lack of consistent communication across the entire treatment spectrum (e.g., RMHTF team, DHHR, court system). ▪ Caregivers not receiving updates about treatment or medication(s).	▪ Responsive DHHR case workers, therapists, RMHTF staff, and advocates, attorneys, healthcare providers who communicate care and concern for the youth and family.
Engagement with Services	▪ Caregivers not feeling like a meaningful part of an inclusive, comprehensive treatment team. ▪ Youth ongoing inability or refusal to engage in services; inability to adequately engage resistant youth.	▪ Caregivers feeling informed, included, and involved in various aspects of youth's treatment from all members of the treatment team.
Availability of Resources	▪ Difficulties accessing services after discharge from RMHT creates challenges to sustaining the positive gains experienced as a part of RMHT. ▪ Lack of intensive, tailored treatment options in WV to meet the complexity and comorbidity of youths' diagnoses and behaviors, especially for younger youth. ▪ Lack of psychiatric medications, therapy, and facilities that can address severe issues such as suicidal ideation, self-harm, oppositional defiant disorder, severe physical, verbal, and sexual aggression.	▪ Safe at Home services were noted as exceptional in responsiveness and for help finding community-based resources. ▪ Access to family therapy and psychiatric treatment with knowledgeable providers who spend adequate time with youth/family.
Distance	▪ The further from home RMHT and community-based services are, the less caregivers can engage in treatment, resulting in lower satisfaction among both youth and caregivers. This is particularly true for services that are outside of West Virginia.	▪ DHHR travel assistance. ▪ System-level efforts to place youth within West Virginia and closer to home. ▪ Access to in-home community-based services not previously covered by Medicaid coverage due to living in a WV border county. ▪ Closer distance creates more opportunities for in-person visitation with youth, which fosters engagement and improves satisfaction.
Person-centered Care Continuum	▪ Dissatisfaction was high among caregivers who perceived that RMHTFs were trying to prematurely discharge youth home and/or transfer youth to another facility due to their complex needs.	▪ Efforts to connect youth/family with post-discharge programs to keep youth busy such as community service and mentoring programs. ▪ Providers who are willing to get to know youth and their families and address deep-rooted family issues and youth's complex needs and behaviors.

8.2.2.1 Improvements in Satisfaction Over Time

Most caregivers reported higher satisfaction with their youth's treatment and services over time. This was largely a reflection of improved communication and engagement across services and with providers and staff. This finding was also reflected in the survey data.

8.2.2.2 Satisfaction with RMHT

Of those caregivers who reported higher satisfaction over time, three had youth in RMHT during Round 3 interviews. They reported increased satisfaction with current RMHTF therapists and treatment teams; caregivers felt more engaged, involved, and informed throughout the entire process. One caregiver reported their youth's new therapist was more knowledgeable, another felt they had a greater say in the treatment process, and the third perceived that providers worked hard to accommodate her youth's needs. This caregiver expressed greater satisfaction with engagement and access since youth transferred from an out-of-state RMHTF (six hours away) to a West Virginia facility just one hour away, allowing for regular in-person visitation and telephone calls. On the other hand, one caregiver during Round 3 expressed continued dissatisfaction with placements both in West Virginia and out of state, stating, "none of it has worked" (Caregiver, Grandmother/Adoptive Mother). One caregiver did express satisfaction with the two most recent RMHTF therapists who "dove deep" into youth and family issues during treatment.

8.2.2.3 Satisfaction with DHHR

At Round 3, three of the caregivers with youth in RMHT expressed greater satisfaction with their DHHR workers, who they described as communicative and supported youth's and family's needs. One caregiver expressed more confidence in their DHHR worker, and another said they felt like there was more of a team supporting her, stating, "It's better since I have more people on board" (Caregiver, Adoptive Mother). This caregiver also said of her youth's DHHR worker, "Yeah, she's a very nice lady. . . So, yeah. I think that her caseworker, the DHHR, is trying a little bit more than before." Another caregiver described her satisfaction and youth's satisfaction with their DHHR care worker:

> She's been excellent. . . . She would find me the answers to whatever questions I had concerning his health, or his well-being. She's the one person that always reaches back to me the same day. I mean, she doesn't put me off. I don't have to keep calling, leaving messages and getting recordings. She's very prompt at getting back with me, and she's very thorough. I like her a lot. [Youth] likes her, too." (Caregiver, Grandmother)

One described their last two DHHR workers (out of a total of five) as "awesome" and responsive. Another caregiver was glad that her ex-husband was able to access a DHHR parenting coach but wishes he could also afford therapy.

8.2.2.4 Satisfaction with Community-Based Services

Of the three caregivers with youth at home during Round 3, one reported higher satisfaction with in-home services over time. They attributed this improvement in satisfaction to their interactions with a community-based provider who facilitated a medication change for the youth, which had a

positive impact on his behavior and engagement in services. This caregiver was also more satisfied because the family could now access higher level services through other Medicaid Waiver services. The other two caregivers interviewed during Round 3 who had youth living at home expressed that their satisfaction levels were not associated with service availability or access, but instead the youth's ongoing inability and resistance to engaging in treatment.

8.2.2.5 Youth Satisfaction

All three of the youth interviewed in Round 3 conveyed satisfaction with their current RMHTF, particularly with their therapists. One youth recently moved to a new RMHTF and felt more satisfied with his therapist, peers, and environment. He felt apathy and lack of agency to make positive changes at his previous facility. Another youth expressed liking his new therapist and appreciated the skills he was learning but was not satisfied with his psychiatrist. He expressed the desire for staff to have more training in de-escalation of mental and behavioral health issues as opposed to punishing youth. However, this youth was pleased that his RMHTF will provide the credits needed to return to public high school as a senior after his anticipated discharge. Another youth has consistently liked her therapist and RMHTF staff, though she desires to move closer to home and/or be discharged home. Lastly, one youth in RMHT during Round 3 did not participate in an interview, however, his caregiver reported that he was satisfied with his RMHTF therapist.

The three caregivers with youth living at home during Round 3 reported positive improvements in youth functioning. One caregiver reported their youth is happier and more engaged in services and another reported their youth is doing well and considering returning to community-based therapy. There was also one caregiver who reported that although their youth continues to excel in school and work, she continues to have behavioral challenges and resists engaging in supportive services.

8.2.3 Social Support

Caregivers and youth benefit from having social networks that can support them during challenging times. **Caregivers reported having strong social support systems** and little variation was observed over time. The Social Support Systems Scale was added to the Year 2 Youth Survey. **Youth in RMHT in Year 2 also reported having strong social support systems**. Table 42 displays the percentages of caregivers and youth in the low, moderate, or high ranges of the social support scale.

Table 42: Caregiver and Youth Social Support by Year

Social Support	Caregivers at Baseline (n=103)	Caregivers in Year 2 (n=173)	Youth in Year 2 (n=134)
Low	3%	4%	3%
Medium	23%	27%	17%
High	73%	69%	80%

8.2.4 Recommendations

Recommendation: Continue to identify factors that contribute to caregiver and youth satisfaction with mental and behavioral health services to ensure interventions continue to meet family expectations.

Recommendation: Encourage providers to leverage social supports to improve outcomes for youth and families. For example, Wraparound promotes the inclusion of youth's social support networks and other forms of natural supports as part of the care team.

9 Evaluation Results: Youth and Family Status

9.1 Finding: Mental and behavioral health services help improve youth functioning

This section will present results from Year 2 data collection that relate to the following evaluation questions, which were identified either as high, medium, or low priority, as noted in the Evaluation Plan:

- How has functioning changed for children receiving mental health services?
- How has child functioning among PBS participants changed?
- How has academic engagement among PBS participants changed?
- How has child functioning among ACT participants changed?
- How has quality of life changed for children and families following PBS intervention?
- How has child functioning among wraparound participants changed?
- How has child functioning among Mobile Crisis Service participants changed?
- How many children have entered the juvenile justice system when they would have been better served in the mental health system?

- How many juvenile justice petitions have been filed for children whose needs would have been better met by the mental health system?
- How has the number of petitions for juvenile justice in response to a crisis situation changed?
- How have referrals and orders to the criminal justice system changed for ACT eligible participants?
- How has involvement with the criminal justice system among ACT participants changed?

Indicators that were identified for each evaluation question are included for reference in Appendix H.

9.1.1 Summary

DHHR is implementing the Child and Adolescent Functional Assessment Scale (CAFAS) as part of the Assessment Pathway to determine appropriateness of RMHT based on youth functioning. The process is not yet fully implemented statewide, so CAFAS data were not available in time for inclusion in this report. According to the 2023 DHHR Semi-Annual Report, early indications suggest that many placements are appropriate.

A Youth Functioning Scale was developed for this Evaluation using topics and themes from the CAFAS and the Child and Adolescent Needs and Strengths (CANS) assessment. Survey findings indicated that youth functioning has remained largely the same in Year 2 as it was at Baseline. Analyses to compare the CAFAS and this Evaluation's Youth Functioning Scale will be conducted and included in future reporting.

Findings from the case series interviews offer mixed perspectives on how youth functioning has changed over time. Although caregivers at Baseline largely agreed that RMHT had a positive impact on youths' needs, approximately half of the caregivers pointed to a lack of sustained change in their youth by Round 2 interviews. In contrast, youth themselves described improved functioning in Round 2. Caregivers of youth at home in Round 3 all reported perceptible improvements. Regardless of perceived youth functioning, caregivers throughout all rounds of interviews indicated that RMHT was the right treatment option for their youth.

9.1.2 Youth Functioning

DHHR is promoting the use of valid tools to regularly screen and assess youth at-risk of and/or who are currently in RMHT. As mentioned, the Child and Adolescent Functional Assessment Scale (CAFAS) is being used determine eligibility for RMHT based youth functioning. DHHR is working to implement the CAFAS statewide, and data are still being developed. The 2023 DHHR Semi-Annual Report indicated that many youths with available CAFAS data demonstrated a need for RMHT. It is expected that functional scores will decrease over time as youth respond to treatment and become eligible for less intensive supports (i.e., are nearing or are ready for transition out of RMHT), so as more CAFAS data become available, future reports might consider whether and how the timing of assessments affect youth functional scores.

A Youth Functioning Scale was included in the Caregiver Surveys and Youth Surveys for the purposes of this Evaluation. The items in the Youth Functioning Scale capture similar domains as the CAFAS and the Child and Adolescent Needs and Strengths (CANS) assessment, for example youth's ability to handle daily life, and how youth are doing in school or at work. The Caregiver-Youth Functioning Scale includes seven survey items, and the Youth Functioning Scale (for youth self-reports) includes six items. Caregiver and youth responses to the survey items were captured on scales that were anchored by 1 (Strongly Disagree) and 5 (Strongly Agree). At Baseline, summed scores from the Youth Functioning Scale were categorized as low, moderate, and high. The low, moderate, and high cutoffs were created to evenly split the total (summed) scores on the Youth Functioning Scale. Higher scores indicate higher functioning. Table 43 describes how the Youth Functioning Scale scores were categorized at Baseline:

Table 43: Categorization of the Youth Functioning Scale Scores

Categorization	Caregiver-Reported Functioning	Youth Self-Reported Functioning
Low	0-9	0-8
Moderate	10-19	9-16
High	20-28	17-24

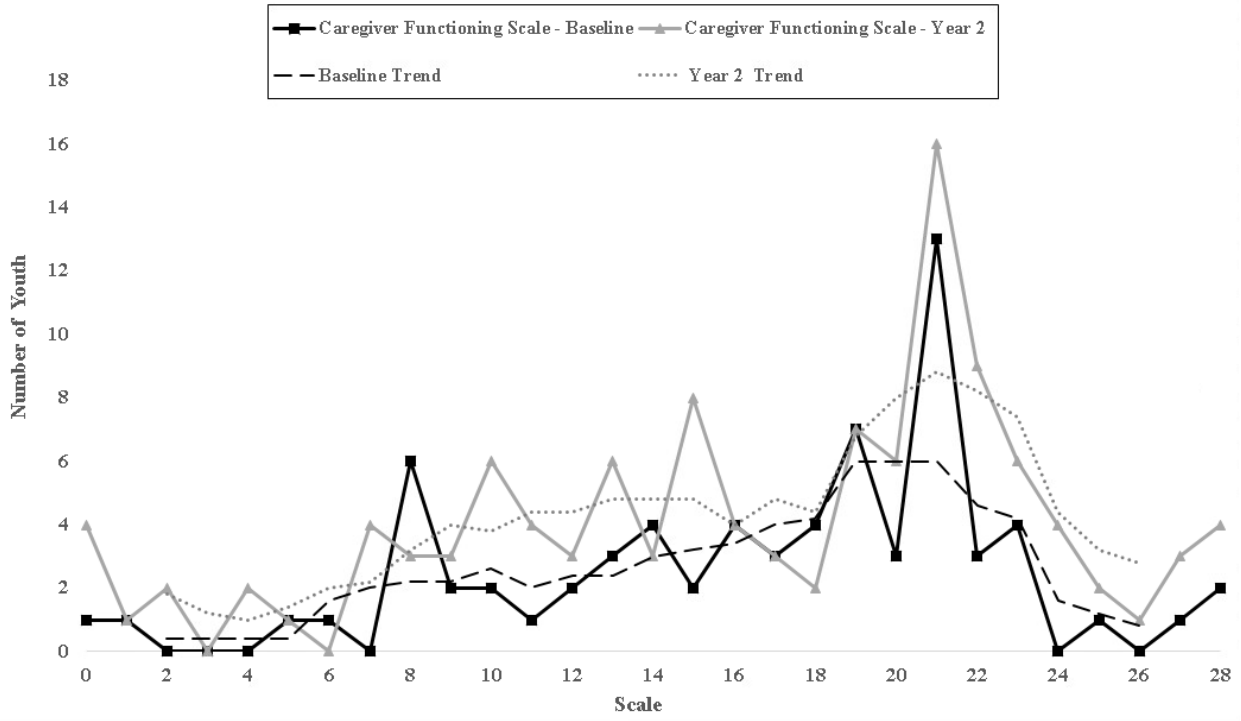
Table 44 provides a breakdown of the percentage of youth in RMHT who fell within the low, moderate, or high ranges of the scales across years. The percentages displayed in Table 44 suggest that youth functioning was higher in Year 2 than at Baseline.

Table 44: Youth Functioning Scale Results by Year

Functioning	Caregivers at Baseline (n=71)	Caregivers in Year 2 (n=117)	Youth at Baseline (n=103)	Youth in Year 2 (n=132)
Low	17%	17%	2%	2%
Medium	45%	39%	41%	32%
High	38%	44%	57%	66%

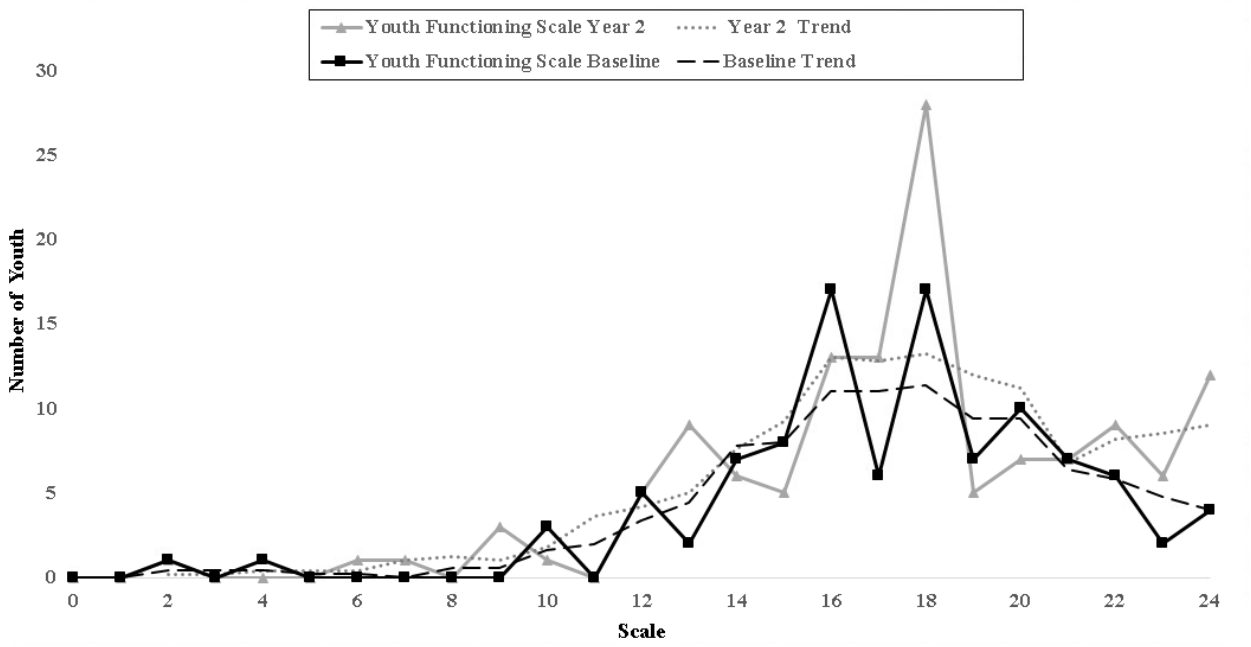
When comparing responses to the Youth Functioning Scale at Baseline to Year 2, a clearer picture emerged when the data were visualized with a line graph rather than the percentages of youth who fell within the low, moderate, and high ends of the scale. Figure 3 displays the caregiver-reported data for youth functioning by year and provides a trend line that demonstrates the overall trajectory of the data, which helps account for differences in the sample sizes. As can be seen in Figure 3, caregivers reported similar functioning among their youth in RMHT at Baseline and in Year 2, with the greatest number of youths falling between 19 and 23 on the scale.

Figure 3: Trends in Caregiver-Reported Youth Functioning by Year



Similarly, a line graph with a trend line was generated to compare self-reported functioning by youth in RMHT at Baseline and in Year 2 (see Figure 4). Youth self-reported slightly higher functioning than caregivers, but overall, their scores followed similar trajectories in that many fell between 15 and 19 on the scale consistently across years.

Figure 4: Trends in Youth Self-Reported Functioning by Year



Figures 3 and 4 provide snapshots of youth functioning as reported by caregivers and youth in RMHT at the time of Baseline and Year 2 data collection. Evaluation of the mean scale scores also indicate little change in reported youth functioning between Baseline and Year 2; data are displayed in Table 45.

Table 45: Average Youth Functioning by Year

Caregivers at Baseline (Range 0-28)	Caregivers in Year 2 (Range 0-28)	Youth at Baseline (Range 0-24)	Youth in Year 2 (Range 0-24)
16.6	16.4	17.2	17.6

There were several evaluation questions that asked about changes in youth functioning by service. Due to low utilization of community-based services during the data collection periods, there was not enough power to detect differences in youth functioning scores by service.

Case series interviews provide further insights into whether and how families' perceptions of youth functioning have changed over time.

9.1.2.1 Youth Functioning During Round 2 Case Series Interviews

During Round 2 interviews with caregivers, they largely agreed that RMHT had a positive impact on youths' needs and functioning. Some youth behavior remained unchanged after discharge, but most caregivers noticed improved functioning immediately following placement in RMHT; however, those improvements were not sustained. This was largely attributed to youth no longer having the structure and routine of RMHT, as well as the fact that youth received few, and in some cases, no community-based services post-discharge. Feelings of hopelessness emerged among some youth still in RMHT, triggering aggression and problematic behaviors related to the uncertainty of whether and when they would be able to return home.

Other youth who participated in Round 2 interviews described improved functioning over time. Most expressed wanting to improve their behaviors and outlook after placement and expressed hopes for the future such as obtaining education, employment, and having a family. Many were open to therapy, counseling, and other types of mental and behavioral health services both at home and in school. Several youth mentioned coping skills and tools for managing anger and depression that they learned during RMHT that they feel are helpful. Examples include deep breathing, bold and calming words, anti-anxiety and sensory fidget toys, as well as engaging in recreational activities such as drawing and basketball. One youth described learning how to remove himself from a situation once it escalated. In general, during Round 2, youth described their current and future functioning as positive, while caregivers focused on past and present difficulties with functioning and described logistical and service-related challenges they anticipated would impact youth's outcomes. Amid the lack of a continuum of community-based services and supports needed outside of RMHT, neither youth nor caregivers perceived they had the resources, tools, services and skills needed to sustain progress.

9.1.2.2 Youth Functioning During Round 3 Case Series Interviews

Three out of nine youth involved in the case series that were in RMHT at Round 2 had transitioned back home by the time Round 3 interviews were conducted. One youth transitioned to a West Virginia foster family home, and another returned home only to be placed in juvenile detention followed by another placement in RMHT. At least two of the transitions back home were not initially regarded by caregivers as successful outcomes during Round 2; however, one of these caregivers reported significant behavioral progress during Round 3 interviews and the other reported that their youth was excelling at school and employment, even though they were actively resisting participation in community-based services.

The caregivers of the three youth still in RMHTF at Round 3 have not seen sustained progress or changes in functioning over time, resulting in caregiver uncertainty about whether the youth will eventually return home and whether improved functioning is possible.

In terms of youth-caregiver relationships, some dyads discussed positive improvements during interviews, while others noted strained situations or being out of contact with their youth/caregiver. Participants discussed more positive youth behaviors at home, including helping around the house and decreases in frequency and severity of negative behaviors.

9.1.3 Encounters with Police

There are several indicators related to youth functioning, for example how often youth had interactions with the police and whether they were arrested or detained. As reported in Section 5.4, 33% of caregivers and 9% of their youth in RMHT reported calling the police for assistance with a mental and behavioral health emergency in Year 2. The surveys ask about police encounters as well—whether youth were arrested, hassled by police or taken by police to a shelter or crisis program. Little change was observed in the percentage of youth who had encounters with police at Baseline and in Year 2.

- Caregivers of 39% of youth at Baseline and caregivers of 42% of youth in RMHT in Year 2 indicated that their youths had experienced an encounter with the police in the last 12 months (Appendix C, Law Enforcement, Table 8.1).
- 35% of youth in RMHT at Baseline and 35% of youth in RMHT in Year 2 self-reported having encounters with police in the last 12 months (Appendix D, Health and Behavior Outcomes, Table 3.2).

Even though a similar percentage of caregivers and youth in RMHT reported having encounters with the police at Baseline and in Year 2, **approximately half indicated that youth had fewer police encounters in the last 12 months than in previous years** (Appendix C, Law Enforcement, Table 8.1; Appendix D, Health & Behavior Outcomes, Table 3.2). When asked about the frequency of police encounters, caregivers and youth reported the following:

Table 46: Frequency of Youth Encounters with Police by Year

Frequency of Police Encounters	Caregivers at Baseline (n=104)	Caregivers in Year 2 (n=180)	Youth at Baseline (n=115)	Youth in Year 2 (n=156)
Fewer police encounters in the last 12 months than in previous years	60%	46%	53%	53%
The same amount of police encounters in the last 12 months than in previous years	33%	43%	23%	37%
More police encounters in the last 12 months than in previous years	5%	8%	25%	8%

Compared to their caregivers, a greater percentage of youth in RMHT in Year 2 indicated that they were arrested in the last 12 months but fewer reported going to court because of it.

- Caregivers reported that 43% of their youth in RMHT at Baseline and 45% of their youth in RMHT Year 2 had been arrested in the last 12 months (Appendix C, Law Enforcement, Table 8.1).
    - Caregivers reported that 70% of their youth in RMHT in Year 2 went to court because an encounter with the police in the last 12 months (Appendix C, Law Enforcement, Table 8.1).
- 41% of youth in RMHT in Year 2 were reportedly arrested in the last 12 months.
    - 48% of the youth in RMHT in Year 2 who had an encounter with police in the last 12 months reported that they went to court because of it (Appendix D, Health & Behavior Outcomes, Table 3.2).

9.1.4 Activities of Daily Living

Many youth functional assessments capture activities of daily living such as school attendance and educational involvement. Most of the youth in RMHT attended school on campus at the facilities. **Approximately half of caregivers and their youth in RMHT in Year 2 noticed improvements in school attendance as a result of their youth receiving mental and behavioral health services, which represent increases compared to Baseline** (Appendix C, Law Enforcement, Table 8.2; Appendix C, Law Enforcement, Table 8.2). Changes in school attendance are reported in Table 47 below:

Table 47: Changes in School Attendance by Year

Changes in School Attendance	Caregivers at Baseline (n=104)	Caregivers in Year 2 (n=180)	Youth at Baseline (n=115)	Youth in Year 2 (n=156)
Youth attended more school since starting services	22%	43%	33%	51%
Youth attended the same amount of school since starting services	19%	36%	46%	37%
Youth attended less school since starting services	9%	12%	6%	5%

According to caregivers, less than 1% of youth in RMHT dropped out of school at Baseline or in Year 2 (Appendix C, Law Enforcement, Table 8.2). Lastly, suspensions and expulsions are a proxy for how well youth function in school settings. Approximately a third of youth were suspended in the last 12 months, and little variation was observed over time.

- Caregivers of 39% of youth in RMHT at Baseline and caregivers of 28% of youth in RMHT in Year 2 reported that their youth had been suspended or expelled in the last 12 months (Appendix C, Law Enforcement, Table 8.2).
- 34% of youth in RMHT at Baseline self-reported being suspended in the last 12 months, compared to 35% in Year 2 (Appendix D, Health & Behavior Outcomes, Table 3.3).

Approximately a third of youth had been suspended or expelled during the last 12 months, but case series participants noted improvements in school after receiving RMHT. Many caregivers noted consistent performance and/or positive improvements in school functioning during Round 3. These youth were either on track to graduate and/or were getting good grades. **Caregivers and their youth in RMHT also agreed that youth were doing better in school and/or work after receiving mental and behavioral health services**. When asked to indicate their level of agreement on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree), caregivers agreed at Baseline (3.6) and in Year 2 (3.6) that their youth were doing better in school or at work (Appendix C, Outcomes of MH Services, Table 6.1); the average agreement among youth in RMHT was 4.2 at Baseline and 4.1 in Year 2 (Appendix D, Health & Behavior Outcomes, Table 3.1).

Lastly, medication compliance is important indicator of daily functioning. Caregivers indicated their level of agreement that youth are better able to follow directions on how to take their medication on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

- Caregivers of youth in RMHT at Baseline agreed that youth are better able to follow directions on how to take their medication after receiving mental and behavioral health services (3.6). Caregivers of youth in RMHT in Year 2 neither agreed nor disagreed (3.4; Appendix C, Outcomes of MH Services, Table 6.1).

In Round 3 of the case series interviews, two caregivers discussed issues around medications. One discussed how medication led to negative side effects (e.g., increased aggression, suicidal ideation) and the other described difficulties finding medications to meet the intensity or severity of their youth's needs. Some of these challenges with medication were related to the youth's age and/or controlled substance restrictions, although there were also perceptions that providers were not listening to youths' needs. One of these caregivers also had a concern at Round 2 that a medication that had been prescribed was, in the caregiver's opinion, amplifying youth's self-harm and suicidal ideation. However, this was addressed by Round 3 with a medication change. Another caregiver reported a change in medication by Round 3 that had a significant positive effect on their youth.

Taken together, while overall youth functioning scores were similar at Baseline and in Year 2, there were several specific indicators of improvements, namely regarding fewer police encounters and improved performance in school or at work as a result of receiving RMHT.

10 Appendix A: Quantitative Data Collection Methods

10.1 Provider Survey Data Collection Methods

10.1.1 Overview of Sample

The Provider Survey was designed to better understand the perspectives of providers interacting with the youth mental and behavioral health system in WV. Data were collected by web and phone between November 9th, 2022, and March 7, 2023. There were 1,141 completed Provider Survey responses obtained from unique service providers and stakeholders involved in juvenile justice across the state of WV. This includes 173 law enforcement officers who completed an abbreviated version of the Provider Survey in Year 2[1]. All surveys were programed and administered with West Virginia University's HIPAA-compliant REDCap software in collaboration with Abt Associates (Abt); a research consulting firm. REDCap is a secure web application for building and managing online surveys and databases.

The sections that follow describe the samples, survey methods, data collection, and non-response analyses of providers and organizational leaders/administrators who were invited to participate in the survey. For a detailed account of the methods and non-response analyses for this survey, please refer to the report submitted in June 2023 entitled "Organization & Facility and Provider Methods and Non-Response Report."

10.1.2 Defining the Sample

The Provider Survey sample included 9,751 doctors, nurses, counselors, social workers, probation officers, attorneys, and other professions that regularly interact with youth with mental and behavioral health needs, whose contact information was obtained in collaboration with DHHR as well as through public information sources. No sampling took place as this represented a census for the population. Upon receiving the sample, Abt identified 33 pairs of duplicate records, which brought the total sample number to 9,718. Nearly all records (n=9,300) included a mailing address as part of their contact information and 2,201 included an email address.

In an effort to improve response rates, the WVU Health Affairs Institute conducted additional provider outreach in Year 2, including the use of snowball sampling techniques and outreach on social network websites. In all, 124 providers accessed the Year 2 Provider Survey through one of these methods, 10 of which were identified as already in the list sample, resulting in total of 114 potential "new" respondents.

10.1.3 Survey Development

The Provider Survey was developed by WVU Health Affairs Institute and was updated for Year 2 of data collection (during Phase 3) as part of the continuous quality improvement efforts

[1] The Law Enforcement Survey was drafted as a module in the Provider survey and administered as a separate, standalone survey. The Law Enforcement Officer Surveys were completed between December 22, 2022 and March 7, 2023

associated with the Evaluation. The Year 2 Provider Survey was slightly modified by removing and/or updating programs and services that were no longer relevant to the Evaluation and minor changes such as streamlined question wording and question order. The Provider Survey demographics section was also updated to be more inclusive. The survey was then reviewed by Abt prior to Year 2 data collection activities.

10.1.4 Content and Structure

The Provider Survey began with a screening question to confirm the respondent had interacted with “a youth who was experiencing a mental health crisis or had mental health difficulties in the last 12 months.” Providers who responded “No” were screened-out as ineligible after identifying their job category in the second question of the survey. The remainder of the survey contained over 250 items divided into modules that were specific to different provider types and the services that they offered (as reported by the respondent). Table 48 displays the types of providers who responded to each module.

Table 48: Populations Surveyed in Each Module of the Provider Survey

Module Name	Providers Who Received Each Module
Healthcare Provider	▪ Behavioral Analysts ▪ Registered Nurses (RN) or Licensed Practical Nurses (LPN) ▪ Nurse Practitioners (NP) or Physician Assistant (PA) ▪ Pediatricians or Primary Care Physicians (MD or DO) ▪ Family Medicine Practitioner ▪ General Medicine Practitioner ▪ Internal Medicine Practitioner ▪ Obstetrician or Gynecologist ▪ Neurologist ▪ Psychiatrists ▪ Psychologists ▪ Residential Direct Care Staff ▪ Residential Facility Workers
Attorney and Guardian ad Litem	▪ Attorneys and Guardians ad Litem
Law Enforcement Officers	▪ Law Enforcement Officers
Social Services	▪ Case Manager or Case Workers ▪ Counselor ▪ Licensed Social Worker ▪ School Counselor ▪ Educator
Probation Officer	▪ Probation Officers

There were three service-specific modules in the Year 2 Provider Survey:

- The module for Behavioral Support Services (including PBS) asked about utilization of PBS principles as part of providers' care delivery, and experiences with the certification process.
- The Wraparound Module asked about providers' understanding of the National Wraparound Initiative, and use of Wraparound principles and tools as part of their delivery of care to WV youth.
- The Assertive Community Treatment Module asked about providers' understanding of the evidence behind Assertive Community Treatment and whether they had the skills to deliver this service.

Demographic questions, such as age, gender identity, race, ethnicity, education, and West Virginia service area(s) were asked of all respondents at the end of the survey, except for law enforcement officers who were only asked about their jurisdictions.

10.1.5 Provider Survey Administration

The Year 2 Provider Survey was launched November 9th, 2022. Invitations were sent to 9,832 providers (9,718 from the original sample frame and 114 from the snowball sample), excluding law enforcement officers (see more below).

The Provider Survey was in the field for 16 weeks. Abt sent out invitation letters to any providers with a mailing address and sent an invitation email to any providers with an email address. Providers who had a postal and electronic mailing address received invitations from both modalities. Three reminder emails and one reminder letter were sent during the data collection period. Table 49 displays the dates that reminders were sent out.

Table 49: Dates of Respondent Outreach for the Provider Survey

Task	Date
Advance notification letter and email invitations	11/9/2022
Reminder email #1	12/12/2022
Reminder Letter #1	1/6/2023
Reminder email #2	1/11/2023
Reminder email #3	1/25/2023
Final email reminder (not part of original communication plan)	2/7/2023

Outreach communications were drafted by Abt at Baseline and were updated by the WVU Health Affairs Institute for Year 2 of data collection. Email invitations and reminders were sent from a

WVU email address by using the native REDCap software feature. WVU Health Affairs Institute staff forwarded Abt any emails with provider requests to be removed from the sample. Some providers asking to be removed also provided an updated contact that would be appropriate for the Provider Survey. These contacts were sent to Abt to include in the sample frame.

10.1.5.1 Law Enforcement Officers

The abbreviated Provider Survey for law enforcement officers was launched on January 3, 2023. Outreach to law enforcement officers was conducted by WVU Health Affairs Institute staff. Law enforcement agencies were contacted by phone and were asked to share the survey link with their officers. In lieu of an ID number, a question indicating the department or agency was added to the beginning of the law enforcement survey instrument to help track completion rates by department/agency.

Between early January 2023 and late February 2023, WVU Health Affairs Institute conducted survey outreach to all WV county Sheriff's Offices (55) and local law enforcement detachments (167) across the state. Of the 55 county sheriff's departments contacted, 26 counties (47.3%) agreed to disseminate the survey to their respective departments. Of the 167 local police departments contacted, 46 departments (27.5%) agreed to disseminate and participate.

10.1.6 Outreach Outcomes

A survey was "complete" if at least 70% of the questions in their respective modules were answered. Overall, 905 (9%) of the 9,718 sampled providers completed the Provider Survey either fully (n=875) or partially (n=30). An additional 63 respondents completed the survey after receiving an invitation from a colleague through the snowball sample approach, which resulted in 58 fully completed surveys and 5 partially completed surveys. There were 136 surveys that were minimally completed and did not provide sufficient data for analysis ("partial incomplete") and 149 that screened out due to ineligibility. Table 50 shows the survey completion rate for each provider type and sample group.

Table 50: Survey Completion Rate by Provider Type and Sample Group

	TOTAL SAMPLE		
PROVIDER TYPE	**TOTAL SAMPLE**	**CASES COMPLETED***	**COMPLETION RATE**
Community-Based Provider[1]	5,802	725	12%
Juvenile Justice Partner[2]	680	100	17%
Residential Mental Health Treatment Provider[3]	1	1	100%
Traditional Healthcare Provider[4]	3,235	79	2%
List Sample Subtotal	*9,718*	*905*	*10%*

Snowball Sample[5]	*114*	*63*	*55%*
Total Sample	**9,832**	**968**	**10%**

[1]Behavioral Analyst; Case Manager, Case Worker, or other Social Service Provider; Counselor; Licensed Social Worker; Psychiatrist; Psychologist; School Counselor

[2]Attorney; BJS Treatment Staff; Probation Officer

[3]Residential Direct Care Staff

[4]Family Medicine Practitioner; Internal Medicine Practitioner; General Medical Practitioner; Pediatrician, Physician Assistant, or Primary Care Physician; Nurse Practitioner, Registered Nurse, or Licensed Practical Nurse

[5]Snowball sample numbers in this table are after duplicates from the list sample have been removed.

*A completed survey is defined as an eligible participant who answered 70% or more of the questions asked.

A total of 293 law enforcement officers logged into the survey, 173 of whom were eligible and completed the survey. An additional 72 officers were classified as ineligible because they did not work with youth in a mental health crisis in the past 12 months. There were also 39 officers who started the survey but did not complete it and another 9 who accessed the survey but did not respond to any of the survey items.

10.1.6.1 Response Rates

Using the American Association of Public Opinion Research's (AAPOR) standard definitions[2], Abt calculated an overall response rate (AAPOR RR3) for the Year 2 Provider Survey of 16.1%.

10.1.6.2 Sample Characteristics

There were 1,141 completed Year 2 Provider Surveys. Social workers represent the largest provider type in the sample frame (18%), but they represent about a quarter (25%) of all Year 2 Provider Survey respondents. Case workers are also over-represented among survey respondents (15%) compared to the sample frame (4%). In contrast, physicians classified as Family Medicine, General Medicine, and Internal Medicine Practitioners make up 17% of the sample frame population, but account for only two percent of survey respondents. Providers from Region 5 also made up 30% of the sample frame but were under-represented among those who actually responded (23%). It is worth noting, though, that regional information was missing more frequently in the snowball sample than it was with providers in the original sampling frame. The higher representation of respondents with an unknown region in the snowball sample is likely

[2] https://aapor.org/standards-and-ethics/standard-definitions/

because address information was more readily available as part of the contact information obtained for the original list of providers in the sampling frame.

10.2 Organization and Facility Survey Data Collection Methods

10.2.1 Overview of Sample

Phase 3 of the West Virginia Children's In-Home and Community-Based Services Improvement Evaluation Project focuses on primary data collection. The Organization and Facility Survey was designed to better understand the perspectives administrators of organizations and facilities that offer the services and mental and behavioral health interventions of interest to this Evaluation.

Data were collected by web and phone between November 9th, 2022, and March 7, 2023. There were 52 completed Organization and Facility Surveys obtained from administrators across the state of WV. All surveys were programed and administered with West Virginia University's HIPAA-compliant REDCap software in collaboration with Abt Associates (Abt), a research consulting firm.

The sections that follow briefly describe the Organization and Facility sampling frame, survey methods, data collection, and non-response analyses. For a more detailed account of the methods and non-response analyses for this survey, please refer to the report submitted in June 2023 entitled "Organization & Facility and Provider Methods and Non-Response Report."

10.2.2 Defining the Sample

WVU Health Affairs Institute collaborated with DHHR to identify appropriate organizations for participation in the Year 2 Organization and Facility Survey. The final list contained 85 unique organizations and facilities (hereafter referred to as "organizations"), and one administrator was asked to complete a survey at each organization. As noted in the introduction, the sampling strategy was slightly modified in Year 2 to reduce the possible redundancies in responses by main campus and satellite locations within the same organizations.

The organizations included in the sampling frame included residential mental health treatment facilities, community-based mental and behavioral health service organizations, and hospital systems that offer inpatient youth psychiatric services. Contact information for the Organization and Facility Survey was very robust with nearly all organizations containing a mailing address, email address and/or phone number.

10.2.3 Survey Development

The Organization and Facility Survey was developed by WVU Health Affairs Institute and was updated for Year 2 of data collection (during Phase 3) as part of the continuous quality improvement efforts associated with the Evaluation. The major change to the Year 2 survey was that a "looped" module of repeat survey items was created to collect data based on specific services offered, as reported by the organizational administrator (see more below). Otherwise, minor modifications included removing and/or updating programs and services that were no longer relevant to the Evaluation and streamlining the wording of some of the survey items. The survey was then reviewed by Abt prior to Year 2 data collection activities.

10.2.4 Survey Content and Structure

The first question of the Organization and Facility Survey asked administrators to report which among 14 listed services are offered by their organization for youths between the ages of 0-25 years. The survey terminated and was flagged as ineligible if an organization only served adults 26 years of age or older. Administrators of organizations that met the eligibility criterion were then asked to indicate the type of organization they represent, their job title, and other details about the organization, for example how long it has delivered mental and behavioral health services to WV youth. Following that, the survey asked organizational administrators to respond to a series of items that were repeated for each service offered by each organization. Survey items in this repeating service-specific module captured information such as the county/counties in which services are offered, what resources are provided as part of each service, staffing and capacity, and service-specific referrals and coordination with other mental and behavioral health system stakeholders.

10.2.5 Organization and Facility Survey Administration

The Organization and Facility Survey was launched on November 16, 2022, and remained in the field for 14 weeks. Survey respondents were identified at Baseline through e-mail and telephone outreach with organizational leadership, including chief executive officers, executive directors, directors, presidents, and vice presidents. These organizational leaders identified appropriate administrators or volunteered to complete the survey themselves. In preparation for Year 2 data collection, WVU Health Affairs Institute called and emailed respondents from Baseline to confirm they would still be the appropriate person to complete this year's survey. Those who claimed they were not suitable to respond were asked to provide an alternative contact from their organization. In cases where there were multiple administrators, the organization's leadership was contacted to determine the most suitable administrator to complete the survey. When there were changes in administrator positions, the organization's leadership were asked to identify new contacts; in such cases, the WVU Health Affairs Institute team made phone calls to the new contacts, introduced them to the project, and verified their contact information.

10.2.6 Organization and Facility Survey Administration

Respondents received a survey invitation by both postal and electronic mail. Respondents also received four email reminders and two reminders in the mail. Table 51 details the outreach schedule for the Organization and Facility Survey.

Table 51: Dates of Respondent Outreach in Organization and Facility Survey

Task	Dates
Advance notification letter and email invitations	11/16/2022
Reminder email #1	12/12/2022
Phone Reminder #1	1/3/2023
Reminder Letter #1	1/3/2023
Reminder email #2	1/11/2023
Reminder Letter #2	1/31/2023
Reminder email #3	1/31/2023
Reminder email #4	2/21/2023

Surveys were considered "complete" if a response was provided for each item in the survey. If at least one service-specific module was completed, the survey was considered a partially completed response and included in the reporting total. Overall, 52 of 85 organizations fully or partially completed the Year 2 Organization and Facility Survey.

10.2.6.1 Response Rate

There were 52 out of 85 organizations that completed the Year 2 Organization and Facility Survey. Using the American Association of Public Opinion Research's (AAPOR) standard definitions[3], Abt calculated an overall response rate (AAPOR RR3) for the Year 2 Organization and Facility Survey of 76%.

10.2.6.2 Sample Characteristics

The 52 organizations provided mental and behavioral services to WV youth statewide. Based on the type of organizations selected by respondents, community mental health centers are under-represented among the responding sample (47%) compared to the sample frame (53%). Group homes and residential facilities appear to be slightly over-represented among responding organizations (23%) compared to their share of the sample frame (19%).

10.3 Caregiver Survey and Youth Survey Collection Methods

10.3.1 Overview of Samples

The Year 2 Youth Survey was sent to WV youth up to 21 years old who received RMHT (in-state or out-of-state) and the Year 2 Caregiver Survey was sent out to their parents or legal guardians

[3] https://aapor.org/standards-and-ethics/standard-definitions/

(unless the youth was a ward of the State; see more below). The Youth Survey was designed to better understand their experiences with mental and behavioral health services and functional wellbeing, while the Caregiver Survey was designed to better understand caregivers' experiences with youth mental and behavioral health services, as well as the caregiver's perception of the youth's behavioral changes due to services received.

The Year 2 sample frames included 605 caregivers of youth who were receiving RMHT on July 1, 2022. The sampling frame included 52 caregivers who had multiple youth in RMHT, and these caregivers were asked to fill out one survey for each respective eligible youth.

The original sampling frame was provided by WV DHHR and included 774 youth residing in RMHTFs, categorized by age as of July 1, 2022:

- Youth under 12 years of age (n=49)
- Youth between 12 and 17 years old (n=610)
- Youth 18 years of age or older (n=115)

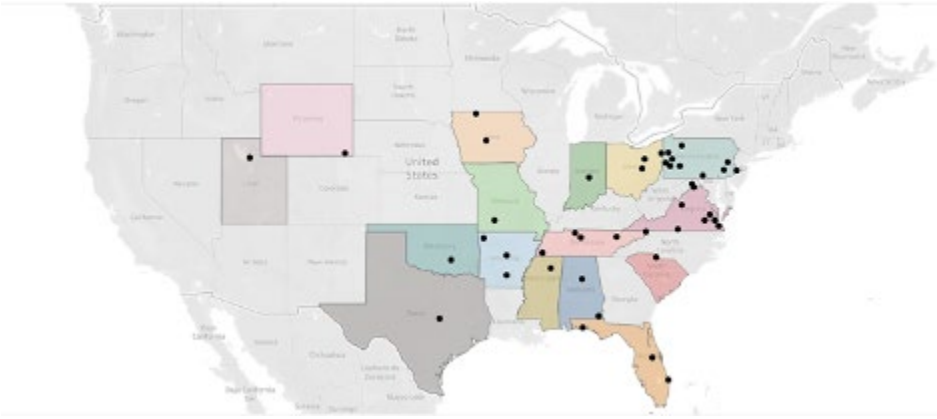
Youth in RMHT who were under the age of 12 were excluded from this part of the Evaluation because they were considered too young to provide informed answers to the survey questions.

The sections that follow describe the samples, survey methods, data collection, and non-response analyses of caregivers and their youth who were invited to participate in the survey. For complete details on survey methods and non-response calculations, please see the report submitted in June 2023 titled "Residential Mental Health Treatment Facility Caregiver and Youth Methods and Non-Response Report."

10.3.2 Defining the Samples

WVU Heath Affairs Institute received a list of youth in RMHT on July 1, 2022, from WV DHHR, who obtained the information from the Families and Children Tracking System (FACTS). The sampling frame included 774 youth in 80 RMHTFs. Among the 80 RMHTFs, 35 were in WV and 45 were in other states, including Virginia, Pennsylvania, Ohio, Florida, Iowa, Texas, Wyoming, and Utah among others. The map in Figure 5 shows the distribution of out-of-state RMHTFs.

Figure 5: Map of Youth in Out of State Facilities



The 774 youth in RMHT on July 1, 2022, included 149 youth who were classified as wards of the State. The sample frame for caregivers included 605 individuals whose contact information was provided by WV DHHR.

10.3.3 Development of the Surveys

The Caregiver Survey and the Youth Survey were developed by the WVU Health Affairs Institute and were updated for Year 2 (Phase 3) as part of the continuous quality improvement efforts associated with the Evaluation. The Year 2 surveys were slightly modified by removing programs and services that were no longer relevant to the Evaluation, adding a question that asks where they first learned about mental and behavioral health services, incorporating minor changes such as streamlined question wording and question order, and updating the demographics section to be more inclusive. The survey was then reviewed by Abt for clarity of wording to ensure smooth administration.

10.3.4 Caregiver Survey Content and Structure

The Caregiver Survey starts with an introduction that provides information about the Evaluation along with contact information for the WVU Institutional Review Board and the WVU Health Affairs Institute. Respondents were then presented with a screening question to confirm they were the parent, guardian, or legal caregiver of a specific youth within our RMHT sample for the data collection period. Caregivers who responded “No” were screened out as ineligible and no further questions were asked.

The main portion of the survey used a combination of Likert-type scales anchored by 1 (Strongly Disagree) and 5 (Strongly Agree), multiple choice, and open text responses on topics such as awareness of services, access and use of services, barriers to service use, and youth functioning. Several questions captured information about RMHT placement of the youth, including confirmation of the facility, length of placement, and number of previous stays in RMHTFs. Caregivers of youth in RMHT between the ages of 12 and 17 were asked to provide consent for their youth to be surveyed about their experiences with mental and behavioral health services.

The consent portion was skipped if the youth residing in a RMHTF while in their care was under the age of 12 or were between the ages of 18-21. If caregivers provided consent for a youth who had been discharged or transferred from the facility of record, respondents were asked to provide updated contact information for outreach to their youth.

10.3.5 Youth Survey Content and Structure

The Youth Survey starts with an introduction that provides information about the Evaluation and requests assent/consent to being surveyed. If youth agreed to participate, the survey administrators conducted a cognitive assessment that included questions about whether the youth knew of people they could turn to if they needed help. Survey administrators (who had backgrounds in social services) monitored youth answers to determine whether they seemed alert and able to respond to the survey questions. Any youth who refused to participate or was deemed not cognitively capable were ineligible to continue.

The main portion of the Youth Survey was similar to the Caregiver Survey. The survey used a combination of Likert-type scales anchored by 1 (Strongly Disagree) and 5 (Strongly Agree), multiple choice, and open text responses on topics such as awareness of services, access and use of services, barriers to service use, and youth functioning. There were several questions that subject matter experts from WVU identified as difficult to answer for youth under the age of 18, such as changes in the perceived value of mental and behavioral health services in the last 12 months; in such cases the survey items were only administered to youth between the ages of 18-21. The survey items with age restrictions are documented in the data tables and were noted in the write-ups in the main body of the report when applicable.

10.3.6 Caregiver Survey Administration

The Year 2 Caregiver Survey was launched on November 4, 2022. Baseline data collection was facilitated by a vendor. In Year 2, the WVU Health Affairs Institute transitioned to an in-house call center. The call center was staffed with WVU Health Affairs Institute personnel with extensive research and field experience, which enabled them to build connections with survey respondents. Survey administrators also received multiple trainings prior to taking calls. The project management software Monday.com was used to schedule survey administrators during call center hours and to track phone call attempts made by Zoom soft phones. Caregivers were given the option to take the survey online or over the phone with the survey administrator.

10.3.7 Youth Survey Administration

The Youth Survey launched on November 2, 2022. Outreach started with youth who were classified as wards of the State (for whom blanket consent was provided) and those who were between the ages of 18-21 years old and able to provide their own consent to participate. Consent from caregivers (collected as part of the Caregiver Survey) was needed before outreach could take place for youth in RMHT who were between the ages of 12-17; these youth were added to the scheduling process once caregiver consent was received. For each record where consent was collected, WVU Health Affairs Institute created a consent form which included the youth's name and facility, along with the name of the caregiver who provided consent and the date

consent was obtained. Files were password protected and stored in WVU's secure intranet environment.

WVU Health Affairs Institute staff established relationships with RMHTFs prior to scheduling youth survey sessions. For example, 49 RMHTFs were invited to attend one of two informational sessions prior to data collection activities, and representatives of 22 RMHTFs attended them. During these informational sessions, attendees were provided with an overview of the Evaluation, how the RMHTFs would be involved, the process for conducting surveys with youth at the facilities, and a brief description of the survey topics. The session facilitator also solicited feedback from the facilities for any potential obstacles to the process.

The contact protocol differed by RMHTF based on their preferred methods of communication. In general, WVU Health Affairs Institute survey administrators attempted to maintain a uniform process, which started with a phone call to the point of contact—typically a RMHTF administrator. If no contact was made on the initial attempt and the voicemail message confirmed the contact's identity and position, the survey administrator would leave a detailed message. After leaving the voicemail message, a follow-up email was sent referencing the phone call and including available times to conduct the survey. Survey administrators typically called back within the week (3-5 days between contact attempts) if there was no response. During follow-up calls, survey administrators staggered the times of day when attempting outreach. In some instances, RMHTF staff indicated that a youth was no longer in the facility; in these cases, WVU Health Affairs Institute inquired about reasons the youth left and where they went and recorded this information in a shared database. Due to differing policies at each facility, this information was not always provided. If youth were transferred to another facility, attempts were made to contact the new facility to complete the survey with the youth.

10.3.8 Caregiver Contact Protocol

The Year 2 Caregiver Survey was in the field for approximately 10 weeks. The WVU Health Affairs Institute sent out invitation letters to all caregivers with a mailing address and called all caregivers with a phone number. Prior to survey launch, the sample list was run through Lexis Nexis software to attempt to identify the best phone number to reach caregivers. Table 52 provides a summary of outreach methods and corresponding dates.

Table 52: Dates of Respondent Outreach for the Caregiver Survey

Initial Outreach Letter	Phone Outreach	Reminder Letter #1	Reminder Letter #2
11/4/2022	11/4/2022 - 01/09/2023	11/28/2022	12/21/2022

Outreach communications for traditional mail were drafted by WVU Health Affairs Institute and reviewed by WV DHHR Communications. These outreach materials introduced the purpose of the study, explained why they were selected to participate, outlined confidentiality of survey

responses, and informed participants that the survey takes about 35 to 40 minutes to complete. The outreach communications included a QR code so that caregivers could access the survey online, as well as contact information for the survey call center.

Phone outreach was prioritized over other forms of outreach. The goal was for survey administrators to establish rapport with caregivers, answer any questions or concerns caregivers had about the request for permission to contact their youth, and help increase caregivers' willingness to provide permission to contact their youth. Survey administrators called caregivers at various times on different days of the week with at least two days between each call to increase the likelihood of reaching them at times when they were willing and able to participate in the survey. To increase the probability of reaching participants, scripted voicemails were left indicating the option to participate either by phone or online, along with the information needed to access each method. Voicemails were left on the second attempt and shifted to every attempt starting in December as calls were being made about once a week to each caregiver. Up to eight attempts were made to reach each respondent. Requests for callbacks were honored, resulting in some caregivers receiving more than eight phone calls.

There were 157 youth who were between the ages of 12-17 who were not wards of the State and thus required caregiver consent prior to contacting their youth. Youth consent was asked of some caregivers who opted not to take the survey. As shown in Table 53, among the 157 caregivers who were asked to provide consent for their youth to be contacted, 123 (78.3%) provided consent while the remaining 34 (21.7%) declined to give consent.

Table 53: Consent Status by Survey Mode

	Survey Mode					
Consent Status	**Web**		**Phone**		**Overall**	
	n	**%**	**n**	**%**	**n**	**%**
Gave Consent	59	72.0	64	85.3	123	78.3
Declined Consent	23	28.0	11	14.7	34	21.7
Total	**82**	**100.0**	**75**	**100.0**	**157**	**100.0**
Two minimally completed (partial incompletes) who gave consent but did not complete 70% more of the questionnaire were included in this table.						

When a caregiver had completed the full survey, they were offered a $25 Visa gift card as a token of appreciation for their time. Visa gift cards were either electronic or mailed physical cards, determined by the preference of the respondent. Upon survey completion, caregivers were told they would receive mail or an e-mail within six weeks that included instructions on how to redeem their physical or electronic Visa gift card.

10.3.8.1 Caregiver Survey Response Rates

There were 174 caregivers who filled out surveys for 180 youth who were in RMHT on July 1st, 2022, which accounts for the fact that some caregivers had multiple youth in RMHT. Surveys were considered complete if caregivers responded to all survey items; partial completes were also included if at least 70% of the survey items had responses. Of the 605 sampled, the 180 caregiver records included 29.3% fully completed and 0.5% who partially completed the Year 2 Caregiver Survey. There were nine surveys identified as partial incompletes (because less than 70% of the survey was filled out).

There were 605 individuals in the sampling frame. There were 105 caregivers for whom valid contact information could not be obtained, and six caregivers who started the survey were determined to be ineligible during the survey screening questions because they were not the parent or legal guardian of youth in RMHT at the time of data collection. Therefore, the response rate calculations were based the remaining 494 individuals. The response rate after eliminating ineligible caregivers was 36.4%. The overall response rate for the Year 2 Caregiver Survey was 41.5% based on the AAPOR RR3 standard response rate definition, which is considerably higher than Baseline (30.9%). Table 54 presents completion rates among caregivers with varying amounts of contact information.

Table 54: Method of Completion by Contact Type

	Web Complete		Phone Complete		Total	
CONTACT TYPE	**n**	**%**	**n**	**%**	**n**	**%**
Phone Only	-	-	9	100.0	9	5.0
Mail Only	15	100.0	-	-	15	8.3
Phone and Mail	74	47.4	82	52.6	156	86.7
Total	**89**	**49.4**	**91**	**50.6**	**180**	**100.0%**

10.3.8.2 Caregiver Sample Characteristics

Table 57 provides a summary of the total number of caregivers, the total number of caregivers with viable contact information, and the percentage of caregivers who completed the survey on behalf of multiple youth in RMHT. Table 55 also provides a breakdown of caregivers by region, and age of their youth. Region 5 had the highest number of caregivers in the sample, and most of their youths were between the ages of 12-17 years old.

Table 55: Comparison of Sample Characteristics of Caregivers

	Total Caregiver Records in the Sample Frame		Caregiver Records with Viable Contact Information		Caregiver Records with Completed or Partially Completed Surveys	
	n	%	n	%	n	%
Responsible for Multiple Youth in Residential Mental Health Treatment						
Yes	52	8.6%	40	8.0%	15	8.3%
No	553	91.4%	460	92.0%	165	91.7%
Caregiver BBH Region of Residence*						
BBH Region 1	26	4.3%	24	4.8%	8	4.4%
BBH Region 2	56	9.3%	49	9.8%	21	11.7%
BBH Region 3	60	9.9%	55	11.0%	25	13.9%
BBH Region 4	108	17.8%	96	19.2%	28	15.6%
BBH Region 5	191	31.6%	179	35.8%	63	35.0%
BBH Region 6	62	10.2%	59	11.8%	22	12.2%
Outside of WV	29	4.8%	23	4.6%	8	4.4%
Unknown Location (No mailing Address)	73	12.1%	15	3.0%	5	2.8%
Age of Primary Youth in WV Residential Mental Health Treatment Facility						
Under 12 years	25	4.1%	16	3.2%	5	2.8%
12 to 17 years	484	80.0%	406	81.2%	154	85.5%
18 to 21 years	96	15.9%	78	15.6%	21	11.7%
Total Caregivers	605	100%	500	100%	180	100%

* BBH regions were defined by the initial sample contact information provided by DHHR before data collection occurred, since not all addresses were able to be confirmed.

10.3.9 Youth Contact Protocol

Among the 156 completed surveys, 118 (75.6%) were conducted via teleconference technology (i.e., “Zoom”) and 38 (24.4%) were conducted in-person at the RMHTFs. Facilities varied as to whether they required a staff member to be present during the survey session. If staff members were in the room, the youth was asked if they were comfortable talking with staff present, which they were most of the time. If youth were not comfortable with staff hearing the discussion, they were able to read the survey questions to themselves and communicate their answer to the survey administrators. In at least one instance, a youth asked to use hand signals to communicate their answer (e.g., one finger for the first option, two for the second, etc.).

The 38 in-person surveys were conducted at five facilities in close proximity to the WVU Health Affairs Institute office in Morgantown. The survey administrators were often able to use a private conference room to set up their equipment (i.e., a laptop) while the facility contact retrieved the youth. Upon completion of the survey, WVU Health Affairs Institute staff walked the youth to the office of the person of contact who then returned the youth to the appropriate area of campus.

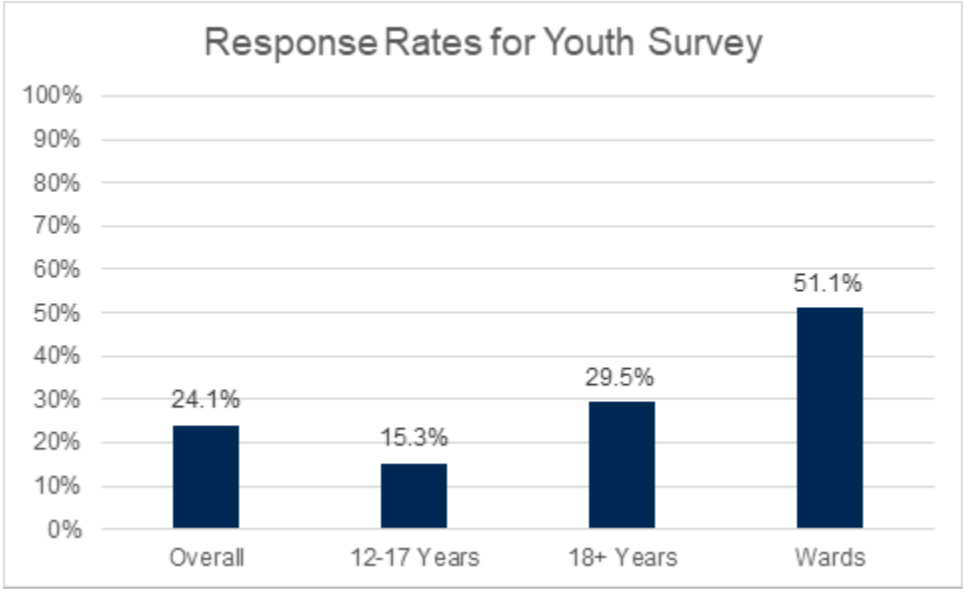
Survey length averaged between 30 to 40 minutes and varied depending on the demeanor of the youth and how talkative they were. Youth were offered a $10 Visa gift card for completing the survey to thank them for their participation in the Evaluation. As there was some concern about handing money directly to the youth while in RMHT, WVU Health Affairs Institute coordinated the mailing of incentives to the facilities to distribute among the youth upon their discharge.

10.3.9.1 Youth Response Rates

There were 520 youth (75.3%) for whom eligibility could not be determined because they refused to participate, were discharged or no longer at a RMHTF, or otherwise did not start the survey. This includes youths whose caregivers were not surveyed and/or did not yet provide consent. WVU Health Affairs Institute survey administrators also identified 11 youth (1.6%) who had cognitive impairments that prohibited them from participating in the survey. Three of these youth (0.4% of the total eligible youth) were flagged as such during the cognitive assessment built into the survey instrument, and eight (1.2%) were identified either during the survey introduction or by RMHTF staff before the survey process started.

Of the 774 youth in the sampling frame, there were 22.4% who fully completed the survey and 0.1% who partially completed the survey (i.e., they filled out 70% or more of the survey), resulting in an analytic sample of 156, compared to 115 at Baseline. According to the AAPOR RR3, the overall response rate was 24.1%. As shown in Figure 6, response rates were highest for wards of the State (51.1%).

Figure 6: Response Rates for the Youth Survey, Overall and by Category



10.3.9.2 Youth Sample Characteristics

Table 56 provides a breakdown of youth by age, ward status, and the sex assigned to youth at birth, as reported by their caregivers.

Table 56: Comparison of Sample Characteristics of Youth

	Total Youth in the Sampling Frame		Eligible Youth		Youth with Fully or Partially Completed Surveys	
	n	%	n	%	n	%
Age of Youth						
Under 12 years	49	6.3%	-	-	-	-
12 to 17 years	610	78.8%	569	83.7%	126	80.8%
18+ years	115	14.9%	111	16.3%	30	19.2%
Ward Status						
Ward of the state	149	19.3%	119	17.5%	58	37.2%
Not a Ward of the state	625	80.7%	561	82.5%	98	62.8%
Sex of Youth						
Female	270	34.9%	237	34.8%	53	34.0%
Male	496	64.1%	435	64.0%	101	64.7%
NA	8	1.0%	8	1.2%	2	1.3%
Total Youth	**774**	**100%**	**680**	**100%**	**156**	**100%**

In the sample frame, wards of the State comprised only 17.5% of the total population of youth ages 12 and older who were in RMHTFs on July 1, 2022. However, these youth accounted for 37.2% of all respondents to the Youth Survey. These differences are mainly due to obstacles related to contacting and gaining consent from caregivers of youth who were not wards of the State. Youth aged 18 years and older are slightly over-represented among survey respondents compared to their share in the total population of youth residing in RMHTFs.

11 Appendix B: Quantitative Data Analytic Methods

11.1 Analytic Methods

This section provides an overview of the analytic approaches utilized to generate the data tables for the Year 2 Organization and Facility Survey, the Provider Survey, the Caregiver Survey, and the Youth Survey. Frequencies (i.e., counts), valid percentages that account for missing data and "I don't know" or "not applicable" responses when relevant, and measures of central tendencies such as means, medians, and ranges made up most of the data presented in this Evaluation. Write-ins from open text responses in the surveys were qualitatively analyzed and incorporated into the findings. Analyses were primarily conducted using Statistical Analysis System[4] and R: A Language and Environment for Statistical Computing[5] data analytic software.

11.2 Provider Survey

The analytic sample for the Provider Survey included 968 providers and 173 law enforcement officers. Providers received different modules in the Provider Survey based on their self-selected professional role. These professional roles were also used to generate the “Provider Type” in the data tables. The regional variable described below was also applied similarly to providers, in that providers who delivered services in multiple regions were counted in each respective region.

11.3 Organization and Facility Survey

The analytic sample for the Organization and Facility Survey included 56 organizations that offered 91 services and 349 mental and behavioral health interventions across the state. The data tables were generated based on the information provided by respondents for services offered and counties served.

A variable was created to categorize organizations into 6 regions. Regions were defined by the Department of Health and Human Resources (WV DHHR) Bureau for Behavioral Health (BBH). The description of West Virginia counties included in each BBH region can be found in Table 57 below.

[4] SAS [Computer software]. Version 9.4. Cary, NC: SAS Institute Inc.; 2016
[5] R [Computer software]. Version 4.1.2. Vienna, Austria: R Core Team; 2017

Table 57: West Virginia Counties by Bureau for Behavioral Health Region

Region	Counties
Region 1	Hancock, Brooke, Ohio, Marshall, Wetzel
Region 2	Jefferson, Berkeley, Morgan, Hampshire, Mineral, Hardy, Grant, Pendleton
Region 3	Tyler, Ritchie, Calhoun, Roane, Jackson, Wirt, Wood, Pleasants
Region 4	Monongalia, Preston, Tucker, Randolph, Upshur, Lewis, Braxton, Gilmer, Doddridge, Harrison, Barbour, Taylor, Marion
Region 5	Mingo, Boone, Kanawha, Clay, Wayne, Lincoln, Putnam, Cabell, Mason, Logan
Region 6	McDowell, Wyoming, Raleigh, Fayette, Nicholas, Webster, Greenbrier, Monroe, Summers, Mercer, Pocahontas

Regions were assigned based on responses to the survey item that asked about the counties in which services were provided. In some cases, organizations provided services in multiple counties that spanned multiple regions. For example, an organization might reside in Pendleton County (Region 2), but also provide services to Tucker County (Region 4). For analytic purposes the data from that organization would be reported for both Region 2 and Region 4; therefore, the region variable is not mutually exclusive but allowed for a clearer picture of what services are provided where and by which organizations.

11.4 Caregiver and Youth Surveys

The analytic sample for the Year 2 Caregiver Survey includes 174 parents and/or legal guardians who completed surveys for 180 youth who were in RMHT on July 1, 2022. Many of the Caregiver Survey data tables use the number of youth (n=180) as the unit of measurement; the total number of caregivers (n=174) was used for survey questions were directly related to caregiver behaviors or experiences.

The analytic sample for the Year 2 Youth Survey included 156 youth up to age 21 who were in RMHT in WV or other states on July 1, 2022.

The next section describes the analyses used to obtain the findings reported for the five scales included in the Year 2 Caregiver Survey and the four scales included in the Year 2 Youth Survey.

11.4.1 Scale Analysis

Several scales were developed for the Caregiver Survey and the Youth Survey. Scale validity and reliability were established and reported at Baseline. The scale analyses described below were conducted on valid responses, meaning to be included in the analyses respondents had to provide responses to all of the items in the respective scales.

11.4.1.1 The Youth Functioning Scale

The Youth Functioning Scale was included in the Baseline and Year 2 Caregiver Surveys and in the Baseline and Year 2 Youth Surveys. There were seven items on the caregiver version of the Youth Functioning Scale, and there were six items in the version included in the Youth Survey. Responses to the survey items were captured on 5-point Likert-type scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). The responses to the Youth Functioning Scale were summed and then categorized as low, moderate, and high based on splitting the scale totals into three even categories, as described in the main body of this report. Caregiver-reported youth functioning ranged from 0-28. Youth self-reported functioning ranged from 0-24.

Year 2 analyses included examination of the distribution of responses to the Youth Functioning Scale. After reviewing the distributions at Baseline and Year 2, the data from the Youth Functioning Scale tells a much more nuanced story than can be portrayed by the categorization of scores as low, moderate, or high. To better understand the distributions and counts, scale scores were placed on graphs with trendlines that compare caregiver-reported youth functioning and youth self-reported functioning for Baseline and Year 2. Averages were also computed based on the total number of caregiver surveys (n=117) and youth surveys (n=132) that had complete responses to all scale items.

11.4.1.2 The Access and Satisfaction Scale

The Access and Satisfaction Scale was included in both the Caregiver Survey and the Youth Survey at Baseline and in Year 2. This scale includes seven items. The Likert-type scale items included five response options that ranged from "Strongly Disagree" to "Strongly Agree" and measured caregiver and youth perceptions of initiating and accessing mental and behavioral health services. To create the Access and Satisfaction Scale, the items were summed so that the scale ranged from 0-28. Scores were then categorized as follows: low (0-9), moderate (10-19) and high (20-28). In Year 2, there were 110 caregiver surveys and 104 youth surveys with responses to all of the items in the scale, and these totals were used to calculate the percentage of scores that fell in the respective low, moderate, and high ranges of the scale. Additional analyses revealed similar distributions of responses at Baseline and Year 2; therefore, it was determined that the low, moderate, and high categorizations of scale scores best suited the data.

11.4.1.3 The Social Support Scale

The Social Support Scale was included in the Baseline and Year 2 Caregiver Surveys; this scale was added to the Year 2 Youth Survey. The Social Support Scale includes four items. The Likert-type scale items included five response options that ranged from "Strongly Disagree" to "Strongly Agree" and measure perceptions of caregiver and youth support systems. To create the Social Support Systems Scale, the items were summed so that the scale ranged from 0-16. Scores were then categorized as follows: low (0-5), moderate (6-11) and high (12-16). In Year 2, there were 173 caregiver surveys and 134 youth surveys with responses to all of the items in the scale, and these totals were used to calculate the percentage of scores that fell in the respective low, moderate, and high ranges of the scale. Additional analyses revealed similar distributions of

responses at Baseline and Year 2; therefore, it was determined that the low, moderate, and high categorizations of scale scores best suited the data.

11.4.1.4 The Caregiver Treatment Participation Scale

The Caregiver Treatment Participation Scale was included in the Baseline and Year 2 Caregiver Surveys. This scale includes nine items. The Likert-type scale items included 5 response options that ranged from "Strongly Disagree" to "Strongly Agree" and measure caregiver's perceptions of their participation in their youth's treatment. To create the Caregiver Treatment Participation Scale, the items were summed so that the scale ranged from 0-36. Scores were then categorized as follows: low (0-12), moderate (13-24) and high (25-36). In Year 2, there were 116 caregiver surveys with responses to all of the items in the scale, and these totals were used to calculate the percentage of scores that fell in the respective low, moderate, and high ranges of the scale. Additional analyses revealed similar distributions of responses at Baseline and Year 2; therefore, it was determined that the low, moderate, and high categorizations of scale scores best suited the data.

11.4.1.5 The Engagement and Respect Scale

The Engagement and Respect Scale was included in both the Caregiver Survey and Youth Survey at Baseline and in Year 2. The Engagement and Respect Scale includes six items. The Likert-type scale items included five response options that ranged from "Strongly Disagree" to "Strongly Agree" and measure caregiver and youth perceptions of culturally sensitive practices used during the delivery of mental and behavioral health services. To create the Engagement and Respect Scale, the items were summed so that the scale ranged from 0-24. Scores were then categorized as follows: low (0-8), moderate {9-16) and high (17-24). In Year 2, there were 119 caregiver surveys and 117 youth surveys with responses to all of the items in the scale, and these totals were used to calculate the percentage of scores that fell in the respective low, moderate, and high ranges of the scale. Additional analyses revealed similar distributions of responses at Baseline and Year 2; therefore, it was determined that the low, moderate, and high categorizations of scale scores best suited the data.

11.5 National Syndromic Surveillance Program (NSSP) Data

The NSSP data were used to describe trends in emergency department (ED) utilization for access to mental and behavioral health services during the Evaluation timeframe (2019-2022). The NSSP data were restricted to youth 21 years of age or younger with a mental and/or behavioral health diagnosis. There were 40 ICD-10 codes were used for these analyses (see Table 58); these codes were identified with the help of subject matter experts.

Table 58: ICD Codes Used in the Evaluation

ICD-10 Codes	
F06 - Other mental disorders due to brain damage and dysfunction and to physical disease	F50 - Eating disorders
F20 - Schizophrenia	F54 - Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F21 - Schizotypal disorder	F60 - Specific personality disorders
F22 - Persistent delusional disorders	F63 - Habit and impulse disorders
F23 - Acute and transient psychotic disorders	F64 - Gender identity disorders
F24 - Induced delusional disorder	F65 - Disorders of sexual preference
F25 - schizoaffective disorders	F70 - Mild mental retardation
F30 - Manic episode	F71 - Moderate mental retardation
F31 - Bipolar affective disorder	F72 - Severe mental retardation
F32 - Depressive episode	F73 - Profound mental retardation
F33 - Recurrent depressive disorder	F78 - Other mental retardation
F34 - Persistent mood [affective] disorders	F79 - Unspecified mental retardation
F38 - Other mood [affective] disorders	F81 - Specific developmental disorders of scholastic skills
F39 - Unspecified mood [affective] disorder	F84 - Pervasive developmental disorders
F40 - Phobic anxiety disorders	F90 - Hyperkinetic disorders
F41 - Other anxiety disorders	F91 - Conduct disorders
F42 - Obsessive-compulsive disorder	F92 - Mixed disorders of conduct and emotions
F43 - Reaction to severe stress, and adjustment disorders	F93 - Emotional disorders with onset specific to childhood
F44 - Dissociative [conversion] disorders	F94 - Disorders of social functioning with onset specific to childhood and adolescence
F45 - Somatoform disorders	F95 - Tic disorders
F48 - Other neurotic disorders	F98 - Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence
Note: There has been a change in the codes available in the syndromic data system. As a result, codes F38 (Other mood [affective] disorders) and F92 (Mixed disorders of conduct and emotions) are no longer included in annual reports. Those codes did not yield results at Baseline, thus there is no perceived impact on the trends reported.	

The percentage of WV youth 21 years of age and younger with a documented mental or behavioral health diagnosis who visited the ED to access mental or behavioral health services was calculated in 6-month intervals; this data was displayed in Figure 2 in the main body of the report. The volume and quality of the data included in the NSSP dataset might vary over time, especially given the COVID-19 pandemic and subsequent changes in healthcare-seeking behavioral that could not be accounted for in these data at this time. Thus, caution should be taken when comparing statistics during the surge of the pandemic to other periods of time. Additionally, the analyses performed at Baseline were not able to be replicated, rather data were pulled for the entire Evaluation timeline to-date (from May 2019 – December 2022). A similar approach will be taken again for next year's report to continue to monitor trends in ED utilization.

11.6 Limitations

There were several limitations to the methods and analytics that are worth noting, which are listed below. We also enumerated below the mitigating measures to minimize the impact of the limitations on findings and results. Although the overall completion rate for the Caregiver Survey (41.5%) was acceptable according to standard conventions, the completion rate for the youth survey (24.1%) was lower than expected. The second limitation of the report is that regional trends could not be analyzed for caregivers or youth. The small numbers of survey respondents in some of the BBH regions prevent us from analyzing regional variations in the survey outcomes.

The completion rate for the Provider Survey was low overall, but it varied by provider type. Additionally, variations in service perspectives could be influenced by provider type and region of service provision. Therefore, the survey data were often stratified by provider type and region, as can be seen in the data tables. Different providers have different training, take on distinct roles and responsibilities for providing care, and therefore will have different perspectives on the youth mental and behavioral health system. Stratifying the data by provider role helps account for these expected differences. In a similar sense, the region is related to the ways in which resources are distributed across the state, thereby affecting important indicators of interest such as availability and capacity of services. When possible, data were stratified by provider type and region to account for these underlying differences, account for variations in completion rates, and facilitate comparisons. The limitations of stratifying the data were that it sometimes resulted in only a few data points in each category.

The quantitative findings were compared to qualitative data to gain greater insights into stakeholders' perspectives and experiences. The qualitative data were integrated into the quantitative findings to triangulate the data, meaning that multiple data sources and multiple data collection methods were used to enhance the validity and credibility of the findings.

12 Appendix C: Caregiver Survey Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_DEL_RMHTF_CaregiverDataTables_20230731

Demographics & Awareness

Table 1.1: Caregiver Reports of Youth Demographics and History in RMHT

Table 1.2: Demographic Characteristics of Caregivers of Youth in RMHT

Table 1.3.1: Awareness of Services Among Caregivers of Youth in RMHT

Table 1.3.2: Caregiver Reports of Youth in RMHT's Service/Program Use

Table 1.4: Frequency and Description of Other Mental Health Services Received

Table 1.5: How Caregivers Heard About Behavioral and Mental Health Services for Youth

Crisis Support and Access

Table 2.1: Caregiver Needs for Crisis Stabilization

Table 2.2: Caregiver Agreement Regarding Mental or Behavioral Health Services Received by Youth in RMHT

Table 2.3: Caregiver Understanding of How to Access Behavioral or Mental Health Services

Experiences with Mental Health Services

Table 3.1: Caregiver Experiences with Mental and Behavioral Health Services

Table 3.2: Caregiver Experiences with Staff Providing Mental and Behavioral Health Services to Youth

Table 3.3: Caregiver Experiences with ACT Services

Table 3.4: Caregiver Experiences Behavioral Support Services (including PBS)

Table 3.5: Caregiver Experiences with RMHT

Table 3.6: Caregiver Experiences with CMHW Services

Starting Service Barrier

Table 4.1: Caregiver Reported Challenges with Starting Mental and Behavioral Health Services for Youth

Table 4.2: "Other" Challenges with Starting Mental or Behavioral Health Services for Youth.

Table 4.3: Caregivers' Biggest Challenge to Starting Mental and Behavioral Health Services

Continuing Service Barriers

Outcomes of Mental Health Services

Future Service Needs

Law Enforcement

13 Appendix D: Youth Survey Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_DEL_RMHTF_YouthDataTables_20230731

Demographics and Service Awareness Tab

Table 1.1: Youth Demographics and History in RMHT, Statewide and by Status

Table 1.3.1: Youth Awareness of Services (Part 1: Service awareness)

Table 1.3.2: Use of Service Among Youth in RMHT (Part 2: Youth participation)

Table 1.4: Youth Reports of Other Mental Health Services Received

Table 1.5: How Youths Heard About Mental and Behavioral Health Services

Experiences with Mental Health Tab

Table 2.1: Youth Experiences with Mental and Behavioral Health Services

Table 2.2: Youth Experiences with Mental and Behavioral Health Treatment Engagement

Table 2.3: Youth Experiences with Support and Respect

Table 2.4: Youth Experiences with Care and Discharge Planning

Table 2.5: Youth Experiences with Seeking Help to Receive Mental or Behavioral Healthcare

Table 2.6: Youth Understanding of How to Access Behavioral or Mental Health Services

Table 2.7: Youth Outcomes with Receiving Treatments

Health and Behavior Outcomes Tab

Table 3.1: Youth Perceptions of Health Outcomes

Table 3.2: Youth Reports of Encounters with Law Enforcement in the Past 12 Months

Table 3.3: Youth Reports of School Experiences for the Past 12 Months

Starting Service Barriers Tab

Table 4.1: Youth Perspectives on Challenges with Starting Mental and Behavioral Health Services

Table 4.2: “Other” Challenges to Starting Mental and Behavioral Health Services

Table 4.3: Youth’s Perceived Biggest Challenge to Starting Mental and Behavioral Health Services

Continuing Service Barriers Tab

Future Service Needs Tab

14 Appendix E: Provider Survey Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_DEL_ProviderDataTables_20230731

Modules Tab

Table 1.1: Summary of Survey Responses by Provider Type and Survey Module: Healthcare Provider Module, Social Service Module, Probation Officer Module, Attorney & Guardian Ad Litem Module

Table 1.2 Summary of How Respondents Heard About the Survey by Provider Type and Survey Module: Healthcare Provider Module, Social Service Module, Probation Officer Module, Attorney & Guardian Ad Litem Module

Background Tab

Table 2.1: Demographics of Providers Surveyed: Healthcare Provider Module, Social Service Module, Probation Officer Module, and Attorney & Guardian Ad Litem Module

Table 2.1.1: Demographic Profile of Providers Surveyed by Provider Type: Healthcare Provider Module

Table 2.1.2: Demographic Profile of Providers Surveyed by Provider Type: Social Service Module

Table 2.1.3: Demographic Profile of Providers Surveyed by Provider Type: Attorney & Guardian Ad Litem Module

Table 2.1.4: Demographic Profile of Providers Surveyed by Provider Type: Probation Officer Module

Table 2.2: Organization or Facility Type Employing Providers by Region: Healthcare Provider Module and Social Service Module [1]

Table 2.3: Years Practicing in West Virginia And in Current Role by Provider Type: Healthcare Provider Module

Table 2.6.1: Respondents by Provider Type, County and Region: Healthcare Provider Module

Table 2.6.2: Respondents by Provider Type, County and Region: Social Service Module

Table 2.7: Demographics of Law Enforcement Officers [1]

Table 2.8: Law Enforcement Officers by Jurisdiction and Region [1]

Services and Programs Tab

Table 3.1.1: Screening Tools Used by Providers: Healthcare Provider Module

Table 3.1.2: Screening Tools Used by Providers: Social Service Module

Table 3.2.1: Services Offered by Providers: Healthcare Provider Module

Table 3.2.2: Provider Awareness of Services: Healthcare Provider Module, Social Service Module, and Probation Officer Module

Table 3.3: Provider Awareness and Beliefs About Service Benefits: Attorney & Guardian Ad Litem Module

Skillset & Training Tab

Table 4.1: Provider Service Delivery Training History and Training Needs by Provider Type: Healthcare Provider Module [1]

Table 4.2: Provider Beliefs on Training and Service Delivery by Provider Type: Healthcare Provider Module [1]

Table 4.3: Level of Agreement on PBS Training Quality and Sufficiency by Provider Type and Region: Healthcare Provider and Social Service Module [1]

Capacity & Resources Tab

Table 5.1: Intervention Provision and Capacity by Provider Type: Healthcare Provider Module[1]

Table 5.2: Intervention Provision and Capacity by Provider Type and BBH Region: Healthcare Provider Module [1]

Table 5.3: Providers' Weekly Caseload and Hours Worked by Provider Type and BBH Region: Healthcare Provider Module [1]

Plans

Table 6.1: Providers' Current Career Plans for the Foreseeable Future by Provider Type and State and Region: Healthcare Provider Module

Table 6.2: Providers' Current Career Plans for the Next 3 to 5 Years by Provider Type and State and Region: Healthcare Provider Module

Table 6.3: Providers' Current Career Plans for This Time Next Year by Provider Type and State and Region: Healthcare Provider Module

Referrals Tab

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16 Appendix G: Case Series

16.1 Overview

A longitudinal case series study is being conducted to gain an in-depth understanding of youth and caregivers' experiences with mental and behavioral health services over time. This mixed-methods design uses a combination of survey and interview data, which allows for diverse perspectives to be captured, as well as to explore any service-specific changes over time. Caregiver-youth pairs were invited to participate in the case series as part of the Baseline surveys. Each youth-caregiver pair, once identified, was invited to participate in separate one-on-one interviews that will occur every six months for the duration of the project. Interview questions for participants enrolled in the case series focus on awareness of and access to mental health services, service experiences, engagement in treatment, changes observed among youth and families as a result of receiving mental and behavioral health services, and satisfaction with services. Separate interview guides were developed for caregivers and youth. Each question was further tailored for two distinct groups: youth in RMHTFs matched with their caregivers, and youth utilizing community-based mental and behavioral health services who are at-risk of placement in RMHT and their matched caregivers. This report includes data collected from youth in RMHTFs and their caregivers from Round 1 (April 2022), Round 2 (November 2022), and Round 3 (April 2023) of case series interviews. The first round of interviews with youth utilizing community-based mental and behavioral health services and their caregivers has been completed and data are currently being analyzed for inclusion in the Fall 2023 report.

16.2 Methods

16.2.1 Sampling

WVU Health Affairs Institute aimed to enroll a diverse sample in terms of youth demographics, length of stay in residential treatment, and facility location for the case series study. Thus, the sampling plan included targeted recruitment of 10 youth from the following categories: youth who were wards of the State (n=1) at the time of data collection, minority youth (n=2), youth from each of the regions defined by the Centers of Medicare and Medicaid Services region (n=6), and WV youth who were placed out-of-state for RMHT (n=1). Those eligible to participate in the case series study included caregivers whose youth were 21 years of age or younger who were in RMHT either in or outside of WV on October 1, 2021.

Recruitment (in the Baseline surveys) began on October 28, 2021. Caregivers and youth who completed Baseline surveys between October 28, 2021, and February 17, 2022 and expressed willingness to participate in a series of follow-up interviews comprised the case series sampling frame. Youth who completed the Baseline Youth Survey who fell into one of the aforementioned categories were invited to participate once their corresponding caregiver provided informed consent to participate in the case series study. Only pairs of caregivers and corresponding youth with complete survey data who consented to be a part of this longitudinal case series study were invited to participate in the first round of interviews. In each subsequent round of data collection, some participants completed a survey and/or an interview. In total, nine pairs of caregivers and

youth were identified and interviewed. In order to gain the perspective of a youth who was a ward of the State, a tenth youth participant was interviewed, but there is no corresponding caregiver interview data for this participant (blanket consent to participate was provided by WV DHHR).

16.2.2 Data Collection

The longitudinal case series design provides insights into changes in participant experiences over time. One-on-one, semi-structured interviews were used to collect qualitative data from youth and their caregivers, allowing for an in-depth exploration of their unique experiences.

Data from youth and caregiver pairs from Rounds 1, 2, and 3 of case series interviews are included in this report to provide in-depth, contextual data about experiences with RMHT. Separate interview guides were developed for each data source based on the corresponding evaluation questions identified in the WV Children's In-Home and Community-Based Services Improvement Project Evaluation Plan (April 8, 2021). Semi-structured interview guides were drafted by the Principal Investigators and included four to six core questions with probes to be explored by interviewers. Feedback on the interview guides was solicited from WVU subject matter experts and incorporated into the interview guides. Corresponding note-taking forms that mirrored the interview guides were developed for each data source. All personnel involved in data collection and analysis received training in qualitative interviewing.

Youth were contacted via telephone to schedule their Round 1 interviews, after obtaining the youth's assent to participate. This process is repeated during each round of interviews. After Round 1, emails, text messages, and/or letters were sent to participants based on their preferred method of communication and availability of up-to-date contact information. Round 1 interviews were conducted between January 2022 and April 2022. Round 2 interviews took place between October 2022 and November 2022. Round 3 interviews were conducted between March 2023 and April 2023.

Caregivers and youth were interviewed separately. All interviews were conducted using HIPAA-compliant Zoom accounts. Each session included one facilitator, one note-taker, and on some occasions, one staff member to provide Zoom technology support to youth in RMHTFs. Informed consent was obtained by presenting each participant with information about the Evaluation, including the main objectives, data collection procedures, risks and benefits, voluntary participation, and confidentiality at the beginning of each session. All sessions were recorded using the Zoom recording feature (with participants' consent). Interviews ranged from 15 to 60 minutes. To show appreciation for their participation, participants received a thank you note and were offered a $25 Visa gift card.

16.2.3 Analysis

Audio recordings from interviews with youth and caregivers were automatically transcribed by Zoom Audio Transcription. Audio recordings, transcripts, and interview notes were securely stored in a HIPAA-compliant SharePoint folder. Each transcript was reviewed and compared with the original audio recording to ensure accuracy. Transcripts were de-identified in accordance with HIPAA privacy rules.

WVU Health Affairs Institute staff content analyzed the transcripts from all of the interviews conducted to date. Content analysis involves a subjective interpretation of the content of text data through a systematic classification process of coding transcripts and then identifying themes and patterns. ATLAS.ti qualitative data analysis software was used to facilitate all aspects of data management, classification, coding, and synthesis. Each transcript was independently coded by two coders via two phases of coding. After the first phase of coding, revisions to the codebook were identified, revisions were made to coding guidelines and the codebook, and the transcripts were re-coded in the subsequent phase. WVU Health Affairs Institute staff produced an ATLAS.ti data report that contained all quotes that were assigned to each code. Coders worked independently to read all data for each code, merge, collapse, or split codes into categories, synthesize and clean the quotes for each category, and then develop high-level summaries paired with illustrative quotes. Coders then inserted code summaries and relevant quotes into a data matrix that contained evaluation questions and outcome indicators. Youth and caregiver transcripts were coded and summarized separately, and then compared between and across pairs for each round of data collection as described below.

After the first phase of conventional content analysis was completed in Round 1, a case profile was created for each caregiver-youth pair (and the ward of the State). These case profiles contain a narrative summary of key individual-level themes that emerged from each interview, as well as a dyadic (i.e., paired) profile summarizing varied perceptions and relationship between the caregiver-youth pairs. Case series profiles from Round 1 provided a cross-sectional Baseline; data from subsequent rounds are added to develop a unique narrative over time, both within and between cases and dyads, to track patterns and changes in experiences over the course of the Evaluation. To facilitate mixed methods data integration, qualitative interview data from each youth-caregiver dyad were paired with their survey responses.

16.2.4 Trustworthiness

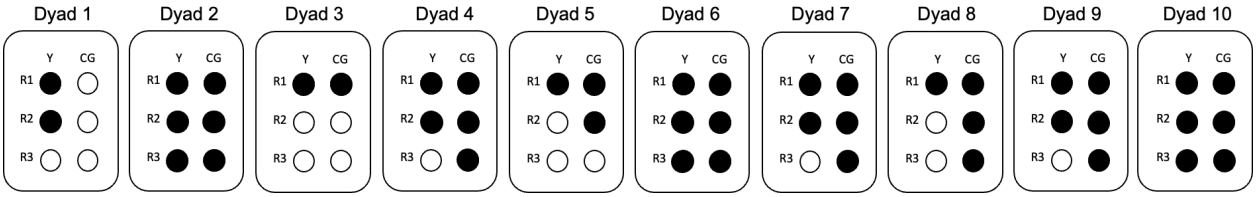
Trustworthiness is widely used as the criteria for evaluating qualitative research. WVU Health Affairs Institute has worked to ensure that the four constructs of trustworthiness outlined by Lincoln and Guba (i.e., credibility, transferability, dependability, and confirmability) were adhered to at each stage of data collection, analysis, and reporting. Credibility ensures that an accurate description and interpretation of participants' experiences has been captured. Data credibility was ensured via rigorous training for each staff member involved in data collection and analysis. Further, a variety of techniques were used to ensure credibility, including: data triangulation (i.e., including data from multiple sources using different methods); reflective memoing (i.e., taking details notes during all stages of the data collection and analysis process); frequent debriefing (i.e., in-depth discussions about the emerging findings and analysis process); review of all interview guides by subject matter experts to promote confidence in the qualitative evaluation design and findings. Transferability is the extent to which the findings can be transferred to similar situations. WVU Health Affairs Institute documented and described procedures for participant outreach and recruitment, data collection, and analysis in this report and within project records. These in-depth descriptions convey the methods used to conduct the Evaluation and may be useful for others conducting similar work. This detailed information about the research design,

data collection, and analytical process also aids in the Dependability of findings. Finally, Confirmability refers to the degree to which the research findings can be confirmed by others. During data analysis, each transcript was coded by at least two coders independently and in-depth debriefing sessions facilitated intercoder agreement and reliability. In addition, an audit trail was established to document the changes made during evaluation, lessons learned, and limitations.

16.3 Results

Results from the first round of case series interviews were presented in the Youth and Family-Level Evaluation Report dated July 29, 2002 (revised September 15, 2022). The current report details the findings from Rounds 1, 2, and 3 of data collection. Figure 7 displays caregiver, youth, and dyad participation across the three rounds of interviews. Filled in (black) dots represent participation, while empty (white) dots represent missing interview data for a given case.

Figure 7: Participation Across Three Rounds of Case Series Interviews



As can be seen in Figure 7, ten individual case series participants completed all three interview rounds, including three dyads (Groups 2, 6, 10) and four additional caregivers (Caregivers 4, 7, 8, and 9). Four other youth completed Rounds 1 and 2 (Youth 1, 4, 7, and 9), and the other three youth completed interview Round 1 only (Youth 3, 5, 8). Reasons for attrition included: caregivers' conflicting work schedule (Group 1); caregivers' phone number did not accept calls and messages and/or phone numbers no longer in service (Group 3); caregivers could not be reached to provide consent to contact youth (Youth 3 and Youth 5); caregivers did not attend the scheduled interview session and did not respond to follow-ups (Group 5 and Caregiver 1); caregiver requested that we not contact youth at this time (Group 9); youth was placed in juvenile detention at time of interview (Youth 4); youth did not respond to request and/or refused to participate (Youth 7 and Youth 8).

Table 59 contains in-depth demographic information and clinical characteristics of youth involved in the case series at Baseline (i.e., Round 1 interviews). Ages of youth ranged from 14 to 17 years and six reported their race as White. Five of the youth had caregivers who were a biological grandparent.

Table 59: Demographic and Clinical Characteristics of Case Series Youth at Baseline

ID	Demographics & Clinical Characteristics						
	Age [1]	Sex/ Gender [1]	Race [1]	Relationship [1]	Income [1]	Service History [1,2]	RMHT Status [1]
1	14	Female	White	N/A, Ward of State	N/A	CMCRS CMHW CSED CCRL BSS	WV RMHTF
2	13	Male	White, Native American/ Alaskan Native	Biological grandmother/ adopted mother	< $75k	CMCRS CMHW CSED BSS	Out-of-state RMHTF (TN)
3	16	Female	White, Black	Biological grandmother/ custodian	< $75k	CMCRS CMHW CSED	WV RMHTF
4	15	Male	White	Biological grandmother	< $75k	CMCRS CMHW CSED CCRL	Out-of-state RMHTF (VA)
5	15	Male	White, Black	Adopted mother	> $75k	CMCRS CSED	Out-of-state RMHTF (PA)
6	15	Male	White	Biological mother	> $75k	CMHW	WV RMHTF
7	17	Male	White	Adopted mother	< $75k	CMCRS CSED BSS	WV CG home

ID	Demographics & Clinical Characteristics						
	Age [1]	Sex/ Gender [1]	Race [1]	Relationship [1]	Income [1]	Service History [1,2]	RMHT Status [1]
8	15	Female	White	Biological grandmother	> $75k	CMCRS CMHW CSED	WV RMHTF
9	14	Male	White	Biological grandfather/ adopted father	< $75k	CMCRS CMHW CSED BSS	WV CG home
10	14	Female/ Male	Don't know	Adopted mother	> $75k	CMCRS CMHW CSED BSS	Out-of-state RMHTF (VA)

Note: BSS=Behavioral Support Services (including Positive Behavior Support); 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 Waiver services.
[1] Data were obtained from Baseline surveys.
[2] Some of the service use data were obtained from administrative data from 2018-2022.

16.4 Youth Placement in RMHT Over Time

Table 60 displays youth placement across the three rounds of interviews, as well as the total number of RMHT placements reported by youth or caregivers. Four youths were in out-of-state RMHTFs at Baseline, and total number of times youth have been in residential placement ranged from one to six.

Three of nine residential case series youth (Youth 7, 8, and 9) were at home from RMHTF at Round 2. Youth 4 had been placed in a WV RMHTF following a brief discharge home. Youth 5 was placed in a WV juvenile detention center following a brief discharge home from an out-of-state (PA) RMHTF. Youth 6 was in the same WV RMHTF as in Round 1, and Youth 10 was in the same out-of-state (VA) RMHTF as in Round 1.

In Round 3, three youth (Youth 7, 8, 9) were still at home with caregivers, and Youth 1 was placed with a WV foster family after discharge from a WV RMHTF that occurred after the Round 1 interview. Youth 2 has transitioned from out-of-state Level III RMHTF to new out-of-state Level III RMHTF after not completing their treatment plan. Youth 4 has transitioned from a WV RMHTF to a WV juvenile detention center. Youth 6 was at the same WV RMHTF as in Rounds 1 and 2, and Youth 10 was at the same out-of-state RMHTF as in Rounds 1 and 2. Groups 3 and 5 were unable to be contacted for interviews at Round 3.

Table 60: Youth Placement by Interview Round and Total Number of Placements

ID	Round 1	Round 2	Round 3	Number of Stays in RMHTFs (Source)
Youth 1	WV RMHTF	WV RMHTF*	WV foster family home	6 (Youth)
Youth 2	Out-of-state RMHTF (TN)	Out-of-state RMHTF (TN)*	Out-of-state RMHTF (TN)	4 (Caregiver)
Youth 3	WV RMHTF	Unknown	Unknown	1 (Caregiver)
Youth 4	Out-of-state RMHTF (VA)	WV Caregiver home/WV RMHTF	WV juvenile detention facility	4 (Caregiver)
Youth 5	Out-of-state RMHTF (PA)	WV Caregiver home/WV juvenile detention facility	Unknown	1 (Caregiver)
Youth 6	WV RMHTF	WV RMHTF*	WV RMHTF**	1 (Caregiver)
Youth 7	WV Caregiver home	WV Caregiver home*	WV Caregiver home**	2 (Caregiver)
Youth 8	WV RMHTF	WV Caregiver home	WV Caregiver home*	2 (Caregiver)
Youth 9	WV Caregiver home	WV Caregiver home*	WV Caregiver home**	3 (Caregiver)
Youth 10	Out-of-state RMHTF (VA)	Out-of-state RMHTF (VA)*	Out-of-state RMHTF (VA)**	4 (Caregiver)

*Note: placement marked with * indicates same placement as Round prior; ** indicates same placement as Rounds 1 and 2. RMHTF # indicates number of times Youth has ever been in RMHTF placement, in or out-of-state (Caregiver self-report, second survey, with exception of group 1, which has no paired caregiver).

Table 61 provides a breakdown of caregiver-reported youth functioning, as well as youth self-reported functioning, as reported in the Baseline and Year 2 surveys. The Youth Functioning Scale captures perceptions of youth functioning in daily social, school, and family settings.

Table 61: Youth Functioning Scale Scores by Year

Dyad	Participant	Baseline Survey	Year 2 Survey	Change
1	Y1	Moderate	Moderate	No change
2	Y2	Moderate	High*	Increase ^
	CG2	-	-	-
3	Y3	Moderate	-	-
	CG3	-	-	-
4	Y4	High	High	No change
	CG4	-	-	-
5	Y5	-	Low	-
	CG5	High	-	-
6	Y6	High	High	No change
	CG6	Low	Moderate*	Increase ^
7	Y7	-	High (EAF)	-
	CG7	Moderate	High (EAF)*	Increase ^
8	Y8	Low	-	-
	CG8	Low	Low	No change
9	Y9	Moderate	-	-
	CG9	High	Moderate**	Decrease v
10	Y10	High	High	No change
	CG10	High	Moderate**	Decrease v

Note: - indicates that the respondent did not complete the scale items and/or did not complete a survey; * indicates a higher score in their Year 2 survey; ** indicates a lower score in their Year 2 survey; EAF=early adult functioning.

Table 62 provides information on the status of youth and their caregivers at the time of Round 3 interviews.

Table 62: Youth and Caregiver Overall Status at the Time of Round 3 Interviews

Group	Status at Round 3 Interview
1	Youth 1 has transitioned to a WV foster family home from a WV RMHTF where she had resided since Round 1. Though unable to complete a Round 3 interview, **Youth 1 has consistently reported high/positive service engagement, life changes, and satisfaction in Rounds 1 and 2 and has achieved her stated discharge goal to find a foster family in Round 3.**
2	At Round 3, Youth 2 has transitioned to an out-of-state RMHTF from another out-of-state RMHTF (both Level IIIs) where he had resided since Round 1. Though the dyad's relationship has continued to deteriorate, **Youth 2 conveys higher engagement and satisfaction with services, and Caregiver 2 shares higher engagement, satisfaction, and support with DHHR** (though consistently low service engagement and satisfaction overall).
3	Group 3 has been out of contact since Round 1, at which time Youth 3 resided in a WV RMHTF. **At Round 1, the dyad reported higher engagement and satisfaction in services than prior experiences and was positively anticipating a discharge home.**
4	Youth 4 has transitioned to a WV juvenile detention facility following placement in a WV RMHTF and a brief discharge home in Round 2 and an out-of-state RMHTF in Round 1. Though Youth 4 was unable to complete a Round 3 interview, **Caregiver 4 conveys higher engagement and satisfaction with WV RMHTF placement, DHHR, and Youth 4's positive life changes.**
5	Group 5 is out of contact in Round 3. In Round 2, Youth 5 was in a juvenile detention facility following a brief discharge home for poor behavior from his out-of-state RMHTF at Round 1. Though the dyad's status at Round 3 is unknown, **Caregiver 5 reported consistently low service engagement and satisfaction in Round 2.**
6	Youth 6 is residing in the same WV RMHTF since Round 1. **The dyad conveys higher engagement and satisfaction with their WV RMHTF** (due to hiring an attorney advocate), particularly therapy, and higher intra-family engagement amid consistent Youth 6 behaviors.
7	Youth 7 is living at home in WV with Caregiver 7, where he has resided since Round 1 and prior discharge from WV RMHTF. Though Youth 7 was unable to complete a Round 3 interview and shows a consistent lack of service engagement since discharge home, **Caregiver 7 conveys a more positive outlook on service pursuit, support, and Youth 7's trajectory.**
8	Youth 8 was living at home in WV with Caregiver 8, where she has resided since her discharge from WV RMHTF following Round 1. **Caregiver 8 shares Youth 8's consistently low service engagement, behavior change, and intra-family engagement, though Youth 8 continues to excel in school and work.**
9	Youth 9 is living at home in WV with Caregiver 9, where he has resided since Round 1 and prior discharge from an out-of-state RMHTF. Though Youth 9 was unable to complete a Round 3 interview, **Caregiver 9 shares Youth 9's significantly positive behavior changes and higher engagement and satisfaction with services after a tumultuous few months of transition home in Round 2.**
10	Youth 10 is residing at the same out-of-state RMHTF since Round 1. **The dyad conveys consistently high engagement, satisfaction, and support with RMHTF services and consistent Youth 10 behaviors. Though distance and Youth 10's complex needs continue to be a major challenge to progress, Caregiver 10 reports higher engagement, satisfaction, and support with DHHR.**

16.5 Youth-Caregiver Case Profiles

Tables 63-72 below include summary profiles of each youth-caregiver pair across the three rounds of data collection, including changes observed over time. Some data fields (e.g., age, functioning) may differ from the demographics and clinical information contained in Table 59, as information has been updated to reflect the most recent data obtained for each participant. Some data were unavailable due to incomplete data or non-participation in surveys and/or interviews. Data on youth functioning is reported from the perspective of youth ('Y') and caregiver ('CG') where available.

Table 63: Dyad 1 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
15	Female	White	N/A (Ward of State)	—	CMCR CMHW CSED SCCRL BSS	WV foster family home	Moderate (Y)

Youth 1 is a ward of the State with no paired caregiver, as her biological parents lost custody many years ago. She has a history of anger and depression and prior in-state RMHTFs, hospitalizations, foster homes, and inpatient and outpatient therapy. During Rounds 1 and 2, Youth 1 reported attending weekly therapy and treatment meetings and shared positive experiences with service engagement, life changes over time, and satisfaction. She has continued to perform well in school, maintain good friendships, and utilize coping skills to help with ongoing behaviors and feelings.

At Round 2, Youth 1 stated, *"I'm really satisfied with [services], and it's really helpful that I'm using all these tools and techniques. That's really helping me out."* Though "kind of hard," services will "definitely" be helpful for her if she continues *"focusing on my dreams and hopes, […], what I'm doing right now, […] what will happen to me. And then I'll be fine."* Youth 1 reported being open to therapy and mental health support in the future and did not indicate a desire to change anything about her RMHTF services. She shared that staff are "*really kind and respectful to me, and they really, really care. [They're] really responsible, and they're just like, you know, like family to me."*

At Round 3, Youth 1 has transitioned to a WV foster family home from a WV RMHTF where she has resided since Round 1. In Round 2 she stated, *"What I want to achieve is like getting out of here and just going somewhere where I can be like, actually, really good, and like where they care about me. So I can know, like, oh, they're taking care of me, and so I can focus on the family instead of where else I will go*." **Despite not participating in an interview during Round 3, the Evaluation team learned that Youth 1 has achieved her stated discharge goal to find a WV foster family home.** This is Youth 1's fifth foster home placement, and she reported positive prior experiences with the family following a brief stay with them between Rounds 1 and 2.

Table 64: Dyad 2 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
14	Male	White, Native American/Alaskan Native	Biological grandmother/ adopted mother	< $75k	CMCR CMHW CSED BSS	Out-of-State RMHTF (TN)	High (Y)

Youth 2 has a history of severe child abuse and oppositional defiant disorder (ODD), attention-deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), anger, depression, violent behaviors, and criminal charges. He has prior in-state and out-of-state experiences with RMHTFs, hospitalizations, emergency shelters, counseling and therapy, and six foster homes before Caregiver 2 received custody several years ago.

At Round 3, Youth 2 has transitioned to a new out-of-state RMHTF from another out-of-state RMHTF (both Level IIIs) where he has resided since Round 1. The transition follows several months without services at his prior RMHTF, as Youth 2 refused family therapy and did not complete any treatment plans. However, at Round 3, Youth 2 is receiving individual, group, and family therapy and reports marked improvements in service engagement and satisfaction, noting positive changes in therapy, staff, peers, and overall environment. Youth 2 stated that therapy is going "really, really good," and "I just prefer to talk to [new therapist]. . . because she's more like, more knowledgeable about it." He describes current services as "the health I've been wanting [with] people who understand what my actual needs are." Following discharge, Youth 2 aims to move to independent living.

Caregiver 2 shares higher engagement and satisfaction with DHHR and social support in Round 3, amid persisting frustration with system communication and the "standard mold" and "revolving door" of treatment. She recounted the high turnover of Youth 2's five DHHR workers and five therapists impeding progress. However, Caregiver 2 reports that the last two DHHR workers have been "awesome" keeping her "in the loop" and *"informed [with] a lot of experience,"* understanding *"what the parent […] is going through with one of these kids and stuff like that."* Caregiver 2 relays that though his grades are steadily good, she hasn't seen positive behavior changes, as Youth 2 continues to get in trouble for bullying and predatory behaviors and is not forming bonds with others. The Dyad's relationship has deteriorated since Round 1. Other than one family therapy session at Youth 2's new RMHTF, the pair haven't spoken in several months nor physically seen one another in nearly two years. Youth 2 conveys that he wants as little caregiver involvement as possible. She plans to visit Youth 2 soon if he will permit it. Though she holds out hope, **Caregiver 2 feels that Youth 2's severe needs have been inadequately treated to the point beyond intervention, and Youth 2 will continue to rotate among RMHTFs until he ages out.**

Table 65: Dyad 3 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
17	Female	White, Black	Biological grandmother /custodian	< $75k	CMCR CMHW CSED	WV RMHTF*	Moderate (Y)

Youth 3 has a history of bipolar disorder and oppositional defiant disorder (ODD), violent and threatening behaviors, substance use, assault, theft and criminal charges, resulting in a prior placement in RMHT and use of community-based services such as Safe at Home. In Round 1, Youth 1 resided in a WV RMHTF, and neither she nor Caregiver 2 participated in interviews during Rounds 2 and 3. During Round 1, Youth 3 shared that experiences at prior RMHTFs were less "structured" and "horrible" but reported positive life changes, service engagement and satisfaction at her current RMHTF. In Round 1, Youth 3 stated, *"I like therapy. I like going to school. I like the teachers. I like the staff. […] I have other things to do [to] get my mind off stuff like outside of here."* She also reported an improved relationship with Caregiver 3, stating, *"I still get a little bit irritated at times, but I can control my anger."* Though Youth 3 had refused participation in Safe at Home services in the past, she desired such support upon discharge to help deter problematic behaviors and friendships to remain at home but was concerned that she would "go back to my old ways." Youth 3 hoped to graduate early and study nursing.

At Round 1, Caregiver 3 reported high engagement and participation in treatment and moderate satisfaction and support with services. She felt "proud" of Youth 3's improvements in school and grades and wanted her at home. However, since placement, Caregiver 3 had had limited visitation with Youth 3 due to ongoing distance and health barriers. **She had seen some reoccurring behavioral issues during home visits and was concerned that Youth 3's destructive behaviors would resume upon discharge. Caregiver 3's apprehension was exacerbated with the challenges she had faced in the years prior to accessing community-based services amid limited availability, frequent turnover, and poor communication.** She shared, "*I went to the courthouse so many times, I called the police so many times. It's like pulling teeth trying to get help."* Caregiver 3 reported that services received in WV had been helpful but ineffective in engaging Youth 3, stating, *"It's just her behavior. That's the thing. Trying to keep her, you know, away from the girls who do drugs and hang out in the streets."*

** At Round 1*

Table 66: Dyad 4 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
16	Male	White	Biological grandmother	< $75k	CMCR CMHW CSED SCCRL	WV juvenile detention facility	High (Y)

Youth 4 has a history of aggressive behaviors, medication, police encounters and legal issues and has experience with juvenile detention and RMHTF placements in WV and out-of-state. He continues in DHHR custody and probation. Following Round 1, Youth 4 was discharged home for two months, where he was *"...like somebody that been in the military,"* and she *"was very pleased with all that performance."* He then quickly "reverted back" to poor behavior and refused to participate Safe at Home therapy, though the worker was "great." Youth 4 was sent to a juvenile detention facility for one month awaiting his new in-state RMHTF. Needed therapy was not set up upon discharge home, but the judge advocated for the family's needs thereafter. Youth 4 was placed at an in-state RMHTF during Round 2. Due to challenges with prior out-of-state placement (e.g., distance, expense, and inadequate communication, Caregiver 4 was hopeful yet apprehensive that this placement would be better.

At Round 2, Youth 4 seemed more engaged and satisfied at his new WV RMHTF than he had in prior placements. He had weekly individual therapy, and "really liked" his therapist and knew that he needed help with coping, aggression, and self-management skills. He was also learning more in school and liked the extracurriculars, such as basketball. He reported less physical aggression and fighting and improved relationships with peers but making friends was an ongoing challenge. He would rather be home, but liked his WV RMHTF better than prior placements (staff were younger/more relatable and facility was closer to home/family). He shared that Caregiver 4 had been engaged with him and his treatment.

At Round 3, Caregiver 4 conveys higher engagement, confidence, and satisfaction with services and Youth 4's positive strides. Communication improved at the new WV RMHTF, and she can reach both staff and Youth 4 daily by phone and multiple visits per week. Still, she desires more family therapy and a team approach, saying, *"I think that having us all talk together and discuss things together. There's an involvement that I think should take place more often....I'm satisfied when I […] have the communication."* The family experienced a setback when Youth 4 and his brother (who is in a different RMHTF) violated the conditions of their home visit, suspending visitation privileges. Yet, Caregiver 4 reports that Youth 4 is "improving" overall in behavior and school, with less aggression and fighting. She is uncertain which services are needed, sharing, "*I think a lot of it has to come from [Youth]. He just has to show improvement."* She has little social support and hopes for her sons' discharge home soon. Caregiver 4 has briefly discussed CSED with RMHTF staff and desires more information on community-based service options for discharge home.

Youth 4 did not complete a Round 3 interview due to placement in juvenile detention from the WV RMHTF in the weeks following Caregiver 4's Round 3 interview.

Table 67: Dyad 5 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
16	Male	White, Black	Adopted mother	> $75k	CMCR CSED	WV juvenile detention facility*	Low (Y) High (CG)

Youth 5 has a history of anger, aggression, and substance use and experiences with RMHTF placement, juvenile detention, probation, and community-based individual, family, and substance use therapy. In Round 1, Youth 5 shared that while he had shown little interest in services prior, he felt he was engaged and satisfied with his current out-of-state RMHTF. Though Youth 5 did not want therapy because it made him "mad," staff were "encouraging," and he'd gained "perspective" on his actions and their consequences for those around him. He reported that he was making positive progress with physical and behavioral changes as well as relationships with his peers, staff, and family. Youth 5 was unable to complete a Round 2 interview due to placement in juvenile detention.

At Round 2, Caregiver 5 reported feeling satisfied with Youth 5's RMHTF services until he was abruptly released due to poor behavior without discharge notice or planning. Youth 5 returned home on probation with family and substance use therapy through a Youth Reporting Center. Youth 5 continued to display problematic behaviors and refused to cooperate with court-mandated service conditions. His school performance and attendance continued to decline along with his engagement in therapy. Youth 5 ran away after failing a probation check and entered detention thereafter. Caregiver 5 conveyed that the court and treatment processes have been stressful for the family without an intermediary, and their relationship with Youth 5 had deteriorated throughout. Youth 5's refusal to engage or invest in services had been a major barrier to progress, exacerbated by long waitlists and limited availability for community-based therapy, including provider referrals who would not accept Medicaid. Caregiver 5 shared, *"I'm trying to think of what other services we've used. I mean, a lot of them I didn't know were out there. [...] But he's willing to talk to a psychiatrist now, but getting in to see somebody, I don't know. But no there isn't, I don't know what other services are out there. I mean, we've tried all different kinds."* Engagement and communication also continued to be challenges, as Caregiver 5 reported not receiving treatment or process updates or follow-up across DHHR, providers, or the school. She relayed that the school system was "broken" for their lack of involvement and frustrated that services weren't secured for discharge. **Caregiver 5 conveyed that the family was not comfortable with Youth 5 returning home due to ongoing substance use and safety concerns.**

Neither Youth 5 nor Caregiver 5 could be contacted for interviews during Round 3, thus the Dyad's status at Round 3 is unknown. In Round 2, Youth 5 was in a juvenile detention facility following a brief discharge home after his out-of-state RMHTF at Round 1. **Overall, Caregiver 5 reported consistently low service engagement and satisfaction in Rounds 1 and 2.**

**At Round 2*

Table 68: Dyad 6 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
16	Male	White	Biological mother	> $75k	CMHW	WV RMHTF	High (Y) Moderate (CG)

Youth 6 has a history of anger, depression, criminal charges, suicidal ideation and self-harm, and prior experience in a WV RMHTF, emergency shelters, inpatient and community-based therapy. His discharge was postponed after Round 1 due to failing a substance use test following a home visit. Youth 6's behaviors then spiraled, affecting the Dyad's service engagement and satisfaction in Round 2. Caregiver 6 felt the RMHTF team had reacted inappropriately, isolating Youth 6 from therapy, support, and medication changes during a time of escalated need. She felt the team was "blaming" her and leaving her out of "secret" MDT meetings and communication. She hired attorney, as she said, "*I just couldn't believe that this was what was really happening."*

At Round 3, Youth 6 resides in the same WV RMHTF since Round 1. The Dyad conveys higher involvement and satisfaction with his therapy and placement, despite Youth 6's variable behaviors. Both Youth and Caregiver 6 are pleased to have more say in court and treatment processes and credit their attorney advocate. Youth 6 continues to receive weekly individual and group therapy focused on substance use and life skills and occasional psychiatry. The Dyad reports higher satisfaction with his new therapist, who Youth 6 states, is "really supportive" and "easier to talk to." She continues, *"The most important factor" [of satisfaction], probably would be more along the lines of explaining what is happening in terms that I'm going to understand and what should [and] will be happening [because] I've never experienced this."*

Engagement among the family continues to grow stronger. Caregiver 6 is highly involved in monthly family therapy, weekly in-person visits, and brief daily phone calls. She now has her own therapist and Youth 6's father is now in both family therapy and has DHHR parenting coach. Discharge was postponed a second time following Round 2. Caregiver 6 wants more information and education on discharge planning and services. At times, Caregiver 6 has felt that, *"[RMHTF staff] want him to go home. They want to wipe their hands of him."* Though the Dyad has generally been satisfied with the RMHTF placement, Caregiver 6 does not feel satisfied with the services received due to the lack of sustained positive outcomes.

At Round 3, Youth 6 reports that he is working on his anger and aggression, communication, and coping skills. He continues to struggle with self-harm, running off, and peer fighting but feels he is improving. Youth 6 thinks that RMHT has helped a lot, stating, *"I'm happy with what I've learned in therapy now. I've learned some new ways to talk to [others and] understand myself."* He wishes staff had more specialized training to get to the root issues of his behaviors. He feels "scared" to return to the public-school setting where he skipped class and fought with peers. **Upon discharge, he anticipates probation, volunteer work, and employment as well as CSED in-home therapy, behavioral therapy, and Safe at Home. He looks forward to finishing high school, getting his driver's license, and pursuing welding and vocational training through the WV Workforce Empower program.**

Table 69: Dyad 7 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
18	Male	White	Adopted mother	< $75k	CMCR CSED BSS	WV CG home	High (Y) High (CG)

Youth 7 has a history of ADHD, depression, substance use, suicidal ideation, anger and aggression and prior experiences with RMHTFs and community-based services such as counseling, therapy, and psychiatry. Services facilitated positive changes previously, but the Dyad had lower service engagement and satisfaction in Round 2. Following RMHTF discharge in Round 1, Youth 7 briefly attended outpatient individual and group counseling but reported not engaging and feeling judged and overwhelmed. After three visits, the facility cancelled an appointment and failed to follow-up. Though he saw value in the RMHT he had resisted. Youth 7 determined services were not useful or needed for him at Round 2. He stated, *"I just don't, I don't know, want to do it anymore I guess. I got a little older, prefer to work most of the time, and then one day I can step back and deal with it a little bit later."* Caregiver 7 disagreed, feeling that Youth 7 needed structured services, particularly in light of his "self-medicating" substance use. Though Caregiver 7 continued to support Youth 7, this was a big stressor on their relationship. Now an adult, Youth 7 thinks his way is best, and Caregiver 7 felt she had little say or agency in his services or daily life.

In Round 2, the Dyad reported that Youth 7 is more mature and better able to control his anger and behaviors at home, where he has resided since RMHTF discharge in Round 1. Youth 7 continues to focus on work and high school graduation. A senior in high school, his school attendance has been irregular, but he had really liked his carpentry class and teacher and met with the school counselor sometimes. He reported working nearly full-time but does not like the job much. He has few friends but preferred it that way. He was looking forward to graduating and pursuing construction work or possibly military training. Caregiver 7 was hopeful that the military could offer the authority and structure needed for Youth 7 to become a well-functioning adult. Having aged out of the system, she "worried" about Youth 7's future, his ongoing substance use, late outings, and inconsistent school attendance. She felt like a "recluse," "judged" and "isolated" from formal and informal support. She didn't know where to look for adult services and desired service information and outreach.

Though Youth 7 was unable to complete a Round 3 interview, **Caregiver 7 conveys a more confident and positive outlook on Youth 7's trajectory and the services, referrals, and support available to him when he's ready. Youth 7 is still living at home with her in WV, and on course to graduate high school and obtain his driver's license. He maintains the same job, to which he is always accountable.** In addition to a major recent breakup, Youth 7 has had a serious altercation with his oldest brother (biological son of Caregiver 7) that has created a rift in the family and stress for both Youth and Caregiver 7. Nevertheless, Youth 7 seems to have coped and rebounded well. Though his continual resistance to services and her involvement is difficult, Youth 7 recently expressed interest in pursuing community-based counseling again, and she listens and offers advice at times.

Table 70: Dyad 8 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
16	Female	White	Biological grandmother	> $75k	CMCR CMHW CSED	WV CG home	Low (Y) Low (CG)

Youth 8 has a history of ODD, anger, and assault charges and experiences with in-state RMHTF, outpatient therapy and counseling, and community-based services like Safe at Home. Though Youth 8 was unable to complete a Round 2 or 3 interview, Caregiver 8 has participated in all three to date. Caregiver 8 reports that Youth 8 continues to live with her at home in WV, where she has resided since her discharge from a WV RMHTF following Round 1. Youth 8 continues to attend mandated biweekly counseling and probation services post-RMHTF, meeting with her probation officer once a month and DHHR case worker every two to three months.

While Caregiver 8 seemed optimistic about securing community-based services upon discharge in Round 1, service engagement and satisfaction seemed to decline in Round 2. Since returning home, Youth 8 has aggressively resisted services and Caregiver 8's involvement, including in family therapy. The Dyad's relationship continues tenuously. At Round 2, Caregiver 8 largely avoided Youth 8 at home due to regular conflict and does not discuss or participate in her services. Caregiver 8 attends some MDTs, which provide helpful information, but she does not feel she has a real voice or say. She states, *"I mean, I just set there [in MDT meetings], no one asks me questions or anything. So I just you know I just listen to what's being said by the team. I feel like I can't say anything unless they ask me."* Caregiver 8 was also caring for Youth 8's first child while Youth 8 was at work, which was a stressor. She felt like she was at a loss to which services could effectively engage and benefit Youth 8.

In Round 3, Caregiver 8 shares that Youth 8 is pregnant with her second child and a senior in high school, set to graduate and give birth in the coming months. She continues to excel in school though her attendance is poor. She works the same job diligently but rarely participates in extracurriculars and has sporadic friends. Similar to Round 2, Caregiver 8 states that Youth 8 continues to behave aggressively towards her and their family and does not listen to or like anyone. Though Caregiver 8 believes the need is great and growing as her family expands, Youth 8 continues to refuse services and the formal and informal support offered to her. Caregiver 8 is frustrated, as she presumes that Youth 8 will discontinue all mandated services once she completes probation in the near future. Caregiver 8 does not have much social support, and friends and family advise her to quit helping Youth 8. She also has a disability and is physically unable to leave home and feels she does not have formal support. **When asked about service satisfaction, she responds, *"I don't know how to answer that question because [services are] there and she can use them, but she chooses not to. […] I'm sure there's things out there, but like I said, she won't do any, and I can't do it for her.*** *[…] She doesn't want anybody's help. She needs the help, but she doesn't want it."*

Table 71: Dyad 9 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
15	Male	White	Biological grandfather / adopted father	< $75k	CMCR CMHW CSED BSS	WV CG home	Moderate (Y) Moderate (CG)

Youth 9 has a history of reactive attachment disorder (RAD), ODD, anger, and violence and experiences with in and out-of-state RMHTFs and community-based therapy, psychiatry, case management, and services such as CMCRS and Safe at Home. At Round 2, Youth 9 received weekly, in-home family therapy, psychiatric, and case management services and monthly individual therapy with his security officer. He felt "9 out of 10" satisfied with his current therapy and moderate satisfaction with prior services. Youth 9 acknowledged anger and aggression issues and was utilizing some coping skills and avoiding upsetting situations. Services were "helpful sometimes," and he was working on communication with his Caregivers (his grandparents). Friendships were not going well, and he did not want to discuss school. He was in Scouts and interested in martial arts and weapons.

Both Caregivers have been highly engaged throughout Youth 9's treatment journey. At Round 2, one stated that current services were convenient but ineffective. Though family therapy was a helpful outlet for Caregivers, Youth 9 would "act" and not engage, was frequently angry and deceptive, and returned to troubling behaviors. Caregiver 9 felt "afraid" of Youth 9 for his frequent aggression and destructive behaviors, growing physicality, and fixation on weapons and violent games. Residing in a WV border county, service challenges persisted due to their remote location. Several providers would not accept Youth 9 due to his complex history and needs. CMCRS was helpful but located an hour away. Prior services had not resulted in positive change, and his caregiver felt he was worse off than when in RMHT. She wanted more training and support services but felt they had exhausted their options. She was apprehensive about Youth 9's trajectory.

Although Youth 9 did not complete a Round 3 interview, Caregiver 9 shared that his psychiatric team introduced a new medication that fit and "brought about a rapid change in behavior for the better" and improved family engagement and satisfaction. Youth 9 continues with family therapy, psychiatric, and case management services, as well as more frequent individual therapy every week at home. Youth 9 has *"been able to rein in what normally would have caused, you know, extreme anger."* He's "*far less depressed, […] now readily meets with [therapist, and] much better than he was."* Youth 9 is learning and utilizing coping and communication skills. He is more engaged in therapy as well as with Caregivers, peers, school, and extracurriculars. The family is getting along better, and school performance is improving. Youth 9 has "parent-approved friends" and is involved in junior varsity baseball, aiding his "social and emotional state." Caregiver 9 hopes that he will continue the upward momentum and stay busy and focused over the summer with Scouts and positive peers. Caregivers are "more satisfied than we have been in a long time" with services and Youth 9's overall improvement.

Table 72: Dyad 10 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
15	Female/Male	Don't know	Adopted mother	> $75k	CMCR CMHW CSED BSS	Out-of-State RMHTF	High (Y) Moderate (CG)

Youth 10 has a history of multiple mental health diagnoses, lower cognitive functioning, aggression, and communication challenges and experiences with community-based services. At Round 3, Youth 10 resides at the same out-of-state RMHTF where she has lived since Round 1. The Dyad conveys consistently high engagement, satisfaction, and support with RMHTF services. Though distance and Youth 10's complex needs continue to be major barriers, Caregiver 10 reports higher engagement, satisfaction, and support with DHHR sharing, *"I think that her caseworker at the DHHR is trying a little bit more than you know before. […] Yeah, it's better since I have more people on board."*

At Round 3, Youth 10 continues to receive individual therapy three times per week and virtual family counseling, as well as some field trips and extracurricular activities that she enjoys. She consistently reports engagement and satisfaction with her RMHTF placement and services, which are going well and helpful for her attitude and behaviors. Youth 10 is learning coping and anger management skills, though has some ongoing conflict with peers and a "love/hate" relationship with staff who help calm her down but also discipline. Youth 10 is currently under closer supervision and not permitted day passes or home visits due to two runaway attempts since Round 2, one in which she was hit by a car and admitted to the hospital. Since Round 1, Caregiver 10 has been working with the treatment team and DHHR to find a closer group home setting in WV that will accept Youth 10's complex needs that cannot be met at home. Youth 10 has previously expressed a sense of hopelessness at missing her family and "real school" and wishing to return home. However, at Round 3, she acknowledges the plan to find another placement and states it will be good for her and the family. Youth 10 calls her Caregivers nearly every night and is working to get day passes again to visit with them. She misses her family and understands that distance impedes Caregiver 10's engagement.

Caregiver 10 reports little change at Round 3. **Youth 10 continues to have good and bad weeks, and her comprehension and communication issues are sustaining challenges to treatment progress along with distance to her out-of-state RMHTF.** Though Caregiver 10 cannot attend monthly MDTs due to work conflicts, she receives updates from the treatment team. Contact and engagement with DHHR has been more frequent since Round 2, as the Dyad now has a second DHHR worker who is "very nice" and assigned to help secure the desired new placement. Caregiver 10 has also connected with Disability Rights of WV for support. **Though Caregiver 10 seems somewhat resigned because she has not seen substantial or lasting change with Youth 10, she is satisfied with the RMHTF placement and services provided.** She cannot think of another service that may help. She states, *"[RMHTF is] good. It's good. I mean, you know, [Youth 10's] been there almost 5 years. […] They've accommodated what she needed. "*

16.6 Case Series Interview Summary Data Tables

Longitudinal case series interviews with youth and caregivers focused on the following domains: 1) service history and experiences, 2) engagement in treatment, 3) changes in youth and family functioning over time, and 4) satisfaction with mental health services. In addition to using these data to answer relevant evaluation questions, summaries of youth and caregiver experiences for each of the domains have been compiled and are presented in tables below, along with illustrative quotes for each theme.

16.6.1 Service History and Experiences

When asked about mental and behavioral health services, caregivers and youth discussed their service needs, awareness of services, barriers to obtaining services, and hopes for future services. Table 73 contains summaries of most themes under the Service History and Experience domain, along with a description and illustrative quotes. Caregivers and youth also talked about a few specific services such as Safe at Home and Wraparound, though not often and usually without using the formal names of services or being able to describe what each service provided. There was no discussion of Assertive Community Treatment or Behavioral Support Services (including Positive Behavior Support) during case series interviews in Rounds 1, 2, or 3. A recurring theme was the positive impacts made, including securing services, when families were connected with an effective advocate.

Table 73: Service History and Experiences

Theme & Summary	Representative Quotes
Needs. Caregivers talked at length about their youth having specialized needs requiring a higher level of care than most community-based services can provide. Thus, most caregivers discussed needing more services after RMHTF discharge that provided some structure, routine, and accountability as well as specialization to address youth's unique and intense needs.	"I've been told by different people a lot of it has to do with [youth's] IQ, her eloping, her anger issues. So there's a few, you know, roadblocks there that a lot of the facilities won't accept children with these problems." **(Caregiver #10, Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)** "Well, the only challenges so far is he needs a more intense therapy because he's smarter than what people give him credit for, and he can manipulate situations very easily and he needed—a long time ago—more intense than what he was getting in the Level 2 [facility]....he's not getting the therapy that he needs...And he's getting more violent, and you know more sexually...I don't know...honing in on smaller children more, and you know, becoming more predatory behavior and stuff like that..." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)** "Maybe he needs another program, or he would need, you know, an escalation, you know, another, a higher-level program. And I said you know I know that there are no programs in the State that you know

Theme & Summary	Representative Quotes
	specifically work with kids with conduct disorder." **(Caregiver #6, Mother, Youth in WV RMHTF, Round 3)**
Awareness. Most case series participants were uncertain and unaware of which community-based mental and behavioral health services were available to sustainably benefit their youths' unique needs, and/or they didn't know where to begin looking for services. In comparison with Round 1, participants in Rounds 2 and 3 mentioned specific programs less, perhaps because subsequent interviews were focused on experiences during the previous six months, during which most youth were in RMHTFs. Service awareness was low for youth as they return home from RMHT, and particularly as they age into adulthood. However, during Round 3, some youth were more familiar with services available to them upon discharge, and one caregiver stated that she felt more confident finding resources for youth due to her "excellent" DHHR case worker.	"They were going to try to set up something called CSED, or something. I don't really understand. I don't know anything about it. I think it's just more in-home services for family therapy. But nothing has transpired." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)*** "But see, I don't know what CSED is. Nobody has…I mean, I know it's a service....it's not clear for me. I feel like I need a little more detail..." **(Caregiver #6, Mother, Youth in WV RMHTF, Round 3)** "Actually, I don't know if I received Wraparound. I just heard my grandma—she always talked about something about—Wraparound this, Wraparound that. So, I thought I received it..." **(Youth #4, Male, Age 15, in WV RMHTF, Round 2)** "There's a DHHR case worker and she's been excellent… She would find me the answers to whatever questions I had concerning his health, or his well-being. She's the one person that always reaches back to me the same day. I mean, she doesn't put me off. I don't have to keep calling, leaving messages and getting recordings. She's very prompt at getting back with me, and she's very thorough. I like her a lot. [Youth] likes her, too." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)**
Barriers. In all rounds of interviews, caregivers discussed the critical need for community-based services between and after discharges, and all caregivers were open to post-residential services. However, caregivers noted these services—which should be intensive, consistent, and tailored to youth's unique situations—are far from home, difficult to access, and often	"The services aren't there. Yeah, there's no services... That's one thing that people have talked about is they wish there were more facilities closer that could handle the extreme behaviors…I don't know it's, you know, what's fully available. I know what help he has gotten hasn't helped." (**Caregiver #9, Grandmother & Adoptive Mother/Custodian, Youth at Home, Round 2)** "It has to go through weeks and weeks before you get an appointment." **(Caregiver #4, Grandmother, Youth in WV RMHTF, Round 2)** "[Some RMHTF therapists] didn't want to delve too much into anything… and I think it's because there's so many kids and they just, you know, so many hours in the day, and they just try to hurry up and get through it. And

Theme & Summary	Representative Quotes
unavailable outside of residential treatment. Waiting times for services were also a big concern in Rounds 1 and 2, with some improvements reported in Round 3. Workforce capacity was seen as a barrier to provider time with youth.	you know, a lot of them do bare minimum…and not really do a deep dive into any issues, and just let it go as smooth as possible without any outbursts or argument, or anything like that. And it's 'go on to the next.'" **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)**
Hopes for Future Services. Caregivers and youth were clear about the types of services they would ideally like for their youth after RMHT. Desired services included more individual and family therapy, community service and activities to "keep busy", vocational training, and group home and pre-independent living as youth transition to adults. Also mentioned were more intensive support and structure to stay on track and continue gains made during residential treatment.	"You're discharging him, and it's, you know the end of [month in spring)], and he's going to be, you know I still have to work, so I mean he's going to be home by himself all day long, so - Can we have some community service, or is there something that we could do to keep him busy?" **(Caregiver #6, Mother, Youth in WV RMHTF, Round 3)** "You know, go to a therapist and have some outside activities around - away from home activities for him to do something to keep him occupied...what I thought would help him the most and keep an active is something that he does need. He doesn't have a male figure per se in his life. I think that if they had something like the Boys Club or the big brother, or something like that, where a man can take him and do things with him." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)**
*Note: *Youth 4 was transferred to WV juvenile detention facility in the weeks following Caregiver 4's Round 3 interview, at which time he was in a WV RMHTF.*	

16.6.2 Engagement

When asked about engagement, caregivers and youth discussed several issues related to their engagement in youth's treatment. They mentioned how communication with treatment teams, staff, and DHHR workers can foster engagement, and they desired not only to be passively involved but to have their voices heard. Several caregivers reported not receiving timely updates and/or being listened to regarding treatment and medication changes. In some cases, caregivers worked with advocates, such as health providers, DHHR workers, and attorneys, to facilitate better engagement. Youth generally described more engagement in their treatment than their caregivers, but some discussed wanting more involvement in decision making. Youth engagement in treatment was also a large factor in caregiver engagement; if youth refused to participate in services, it limited the extent to which caregivers could engage. Finally, across all rounds of interviews, the distance between the family's home and RMHTF and services related

to level of engagement. Many caregivers were unable to engage if the RMHTF was outside of West Virginia or several hours away. While some improvements were seen during Round 3 interviews, caregivers and youth generally desired more engagement, though in some cases youth resisted engagement by their caregivers. Table 74 provides illustrative quotes related to the theme of Engagement.

Table 74: Youth and Caregiver Engagement in Treatment

Theme and Summary	Representative Quotes
Communication: Inclusivity and Being Heard. Families generally perceived that they were being more included in their youth's treatment planning by Round 3 interviews but would prefer to have more communication with staff and providers. Even though some caregivers were attending more MDT meetings over time, several felt they had little influence, and their voices and perspectives were not heard in the meetings. In two instances, caregivers described not being heard when expressing concerns about side effects of their youth's medication.	"…having us all talk together and discuss things together. There's an involvement that I think should take place more often….Hearing that he's doing well in school. He doesn't have any write-ups, he hasn't been aggressive…To tell me that he's on track, He's doing good - you know. I'm satisfied when I hear that…hearing the same thing from him... I like to have the communication." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)** "I mean, I just set there [in MDT meetings], no one asks me questions or anything. So I just, you know, I just listen to what's being said by the team. I feel like I can't say anything unless they ask me." **(Caregiver #8, Grandmother, Youth at Home, Round 3)** "And I said, 'what about this medicine, because the medicine can make you more aggressive and maybe that's what's doing it.' And she's like 'no it's not. But we'll have the psychiatrist review it.'... Now [RMHTF team is] kind of - they're dismissive of me." **(Caregiver 6, Mother, WV RMHTF, Round 2)**
Advocacy. Some caregivers found that securing personal support or an advocate helped them become more engaged in their youth's treatment. Several caregivers with youth currently in RMHT expressed improved communication with DHHR in Round 3, which helped improve engagement in their youth's treatment.	"I called this attorney and asked her if I could go ahead and just hire her because I had reached out to her after that last MDT meeting because…[treatment team is] acting like children….And so finally that [new attorney] started talking more like, 'OK, we need to worry about [Youth]'s rights.' and I was like, "That's right. That's about right. Yeah, that's about time." **(Caregiver #6, Mother, Youth in WV RMHTF, Round 2)** "As far as the DHHR, the last couple of workers have been awesome keeping me in the loop. They don't have to, but you know I've got this last one, she gave me her personal cell phone number and we communicate, text that way….She's great. [Youth]'s had five… but the first three I never met or spoke to or anything" **(Caregiver #2, Grandmother & Adoptive Mother, Round 3)**
Youth Engagement. Some youth described their participation in treatment as more passive, and they had varied perceptions of whether they had a voice or a say	"My prosecutor was talking to my judge about me having a discharge, and she was a little worried about what I was going to do when I went home. I got to speak about what I planned on doing when I got home so they had let me at least talk. They usually don't

Theme and Summary	Representative Quotes
in treatment planning, goals, discharge, and decision making. During Round 3, the three youth interviewed felt they had a say in various aspects of their care. However, across Rounds 2 and 3, caregivers discussed how youth's buy-in and engagement with treatment dictated or limited the caregiver's ability to engage (i.e., if the youth doesn't want to participate in a meeting or call the caregiver when permitted then the caregiver feels less included, involved, and/or informed). Therefore, some of the youth both in RMHT and at home who did not engage in services also had caregivers who felt less engaged.	let me talk in court and stuff, help with any of our discharge stuff, but I get to help plan what I'm gonna do when I come home." **(Youth #6, Male, Age 16, Round 3)** "I think they do [treatment team meetings] like once a month that all staff do but like, I don't get involved in that because they're my treatment team...MDT's I get invited. When I get court, I sometimes get invited. But in court, you don't really get to talk that much. It kind of annoys me because I don't get to voice my opinion." **(Youth #6, Male, Age 15, Round 2)** "The only time I would talk to him is during family therapy, which was once a week, if he wanted to participate." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 2)** "…they said visitations only on the weekend… and then [Youth] has to be agreeable to it, which he's usually not agreeable to much of anything unless he wants something… I don't see him wanting to see me anyway soon." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)**
Distance. Distance was a barrier to engagement in placements and services both in and outside of West Virginia, to varying degrees, across all rounds of interviews.	"No, no, [I was not involved in the services] because it was like a five-hour drive, and you know I got reports, but I wasn't part of anything that was going on.... Naturally, I would have wanted to have been there to participate. But you know the travel time and stuff, I just couldn't do it." **(Caregiver #8, Grandmother, Youth at Home, Round 2)** "I would have loved for him to stay in West Virginia. Those are the really the big sticking points right there is being so far away, even in West Virginia…. And now, of course, out of state, that's pretty much impossible for me to get out of state." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)** "Well it's an hour away, which is much better than six hours away. Whatever [travel time to previous facility] was, I never got to visit him there because of the transportation problem." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)**

16.6.3 Changes in Youth and Family Functioning

When asked about changes in youth's functioning, caregivers and youth discussed five key issues. Specifically, they mentioned youth progress in RMHT, progress during or after discharge from RMHT, and youth hopes for the future upon leaving RMHT. They also discussed school performance, and changes in relationships between youth and their caregivers. Youth still in RMHT seemed more optimistic about their futures than their respective caregivers, who were more skeptical of positive changes occurring in the near future. Illustrative quotes about Changes in Youth and Family Functioning are provided in Table 75.

Table 75: Changes in Youth and Family Functioning

Theme and Summary	Representative Quotes
Youth Progress in RMHT. Caregivers were mixed in their views on their youths' progress in RMHT. Some saw improvement, but others saw little to no changes while their youth was in RMHT. Youth were generally more positive about their progress and discussed skills they had learned to help manage their behavior.	"But he will throw things when he gets aggregated at the staff. He will cuss at the staff, you know, he will argue with the staff. He has no respect for authority whatsoever. He knows he can pretty much get away with whatever he wants to, because…they can't do a lot of things as far as punishment goes." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 2)** "It's really helpful that I'm using all these tools and techniques. That's really helping me out…" **(Youth #1, Female, Age 14, in WV RMHTF, Round 2)** "…it helps teach like learn like coping skills and things like that for reducing your anger, and it works....It's like helped with difficult conversations, how to deal with being told no." **(Youth #6, Male, Age 15, in WV RMHTF, Round 2)**
Youth Progress on Leaving RMHT. Although caregivers at Baseline largely agreed that residential placement had a positive impact on youths' needs, about half of the caregivers in Round 2 discussed a lack of sustained positive changes in youth after they returned home. In some cases, transitions or discharges home were postponed or readmissions occurred due to negative behaviors that occurred during home visits or upon discharge. In at least two cases, postponed or cancelled discharges resulted in a sense of hopelessness and youth resuming negative past behaviors.	"Within the matter of a couple of weeks [after discharge, youth got into trouble]. [Judge] said because he's reverted back to the same - that 'You've been in two different facilities you haven't been home for but a short time, so I think that it's time you need to go back to placement because you're back to the same things that you were doing in the beginning.'" **(Caregiver #4, Grandmother, Youth in WV RMHTF after a period home, Round 2)** [Youth returned to RMHTF following home visit and was] "getting along well with his peers. He's helping with the counselors, you know, and he's doing so well, and I think he's going to come home [for discharge]...Well, he tested positive for alcohol and nicotine... [Youth] is acting out aggressively, and...he told me on Tuesday he lost his discharge date...He didn't know when it was going to be, and he was furious...So then, the next week, when I come back, I figure out that [therapist] had sent him away. He sent him away from group. He sent him away. He didn't want to talk to him." **(Caregiver #6, Mother, Youth in WV RMHTF, Round 2)**

Theme and Summary	Representative Quotes
School Performance. School performance at Round 3 was positive and encouraging with almost all of the caregivers stating their youth is either on track to graduate and/or performing well in school with grades no lower than a B. Youth are improving or consistently performing in school regardless of mental or behavioral health issues.	"…he's doing well in school. He doesn't have any write-ups, he hasn't been aggressive." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)** "He's involved in Junior Varsity baseball, and that is going very well for him…He's got all Bs…He had one C at the beginning of the marking period, and he's brought it up." **(Caregiver #9, Grandfather & Adoptive Father/Custodian, Youth at Home, Round 3)**
Youth Hopes About Returning Home. Most youth expressed wanting to improve their behaviors and outlook once outside of placement, sharing hopes of future education, occupations, and family, and were open to therapy, counseling and other support systems at home and in school to stay on track.	"What I want to achieve is like getting out of here and just going somewhere where I can be like, actually, really good, and like where they care about me. So I can know, like, oh, they're taking care of me, and so I can focus on the family instead of where else I will go." **(Youth #1, Female, Age 14, in WV RMHTF, Round 2)** "…he does know he has to get off of his, the addiction he's got which is marijuana, because they all require drug screening and the military and the apprenticeship require a diploma. He knows this, and he tells me not to worry he's got it covered." **(Caregiver #7, Adoptive mother, Youth at Home, Round 2)**
Youth and Caregiver Relationships. Relationships between some youth and their caregivers improved by Round 3; however, a few caregivers and youth had tenuous relationships. Youth moving closer to home from an out-of-state or far away RMHTF improved caregiver-youth relationships.	"I'm thinking [caregiver is] involved enough…but I don't want her to…I just like, at this moment, I wouldn't advise it…Yeah, I don't call her at all here. [She still can't visit RMHTF] and I'm glad that's a problem, because I'm not ready for it yet…I mean, I haven't talked to her in months…Mostly 'cause I don't want her in it…I'd rather be able to focus on my problems than create more problems because I just can't do it with [Caregiver]. She has done too much to me, some things I can't forget." **(Youth #2, Male, Age 14, in Out-of-State RMHTF, Round 3)** [New WV RMHTF is] "an hour away, which is much better than six hours away [and] the transportation problem. I can go and see him, they get to get home on a pretty regular basis for home visits [and RMHT helps with transport]...I'm getting to see him more. I get to talk to him regularly. We can talk every night if we choose to…I think it keeps him knowing that he's connected with home, that we still miss him and want him. And you know things like that. I think that's important." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)**

16.6.4 Satisfaction with Mental and Behavioral Health Services

When asked about satisfaction with mental health services, caregivers and youth specifically discussed their satisfaction with RMHT, DHHR, and with community-based services. Communication and engagement were often key to satisfaction (or lack thereof). Service availability continues to be a major factor associated with satisfaction; often caregivers were skeptical that they would obtain access to needed services. Caregivers continued to call for more specialized, tailored, and structured treatment options (in-home and community-based services as well as RMHT) in West Virginia and closer to home to meet specialized needs, diagnoses, and behaviors and promote family involvement. Table 76 provides illustrative quotes related to Satisfaction with Mental and Behavioral Health Services.

Table 76: Satisfaction with Mental and Behavioral Health Services

Theme and Summary	Representative Quotes
Satisfaction with RMHTFs . Five of the seven caregivers interviewed in Round 3, including three of the four with youth still in RMHT, seemed generally more satisfied with treatment and services, largely reflective of improved engagement and communication. All three of the youth interviewed in round 3 conveyed satisfaction with their current RMHTF, particularly their therapy. One of these had moved to a new RMHTF where he was much more satisfied with his therapist, peers, and environment. Another was really liking his new therapist and the skills he had learned but continues to not like his psychiatrist. The third youth has consistently liked her therapist and staff and wouldn't change anything about services, though continues to desire discharge home and/or placement closer to home.	"I do like the therapist that we have now. I do appreciate that the staff that are with him day to day are able to talk to me and tell me how he's doing whenever I go for a visit." **(Caregiver #6, Mother, Youth in WV RMHTF, Round 3)** "[My therapy session] went really, really good…I just prefer to talk to her about it because she's more like, more knowledgeable about it…I feel like, it's just been the help I've been wanting…People who understand what my actual needs are." **(Youth #2, Male, Age 14, in Out-of-State RMHTF, Round 3)** "[My therapist is] really supportive and stuff, and he helps me talk about it. It's easier to talk to him about it than [the last therapist]…but I've also been I'm happy with what I've learned in the therapy now, I've learned some, new ways to talk to - to understand myself." **(Youth #6, Male, Age 16, in WV RMHTF, Round 3)**
Satisfaction with DHHR. At Round 3, three of the caregivers with youth in RMHT were more satisfied with their DHHR workers, who they indicated are more communicative and supportive and advocate for youth and family needs in treatment and information. One of these caregivers had more confidence in the worker. Another feels like she has more of a team supporting her. One caregiver stated that her current and former DHHR case workers (of five total) have been "awesome."	"As far as the DHHR - The last couple of workers have been awesome keeping me in the loop…She gave me her personal cell phone number and we communicate, text that way….She's great." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3)** "There's a DHHR case worker and she's been excellent…She would find me the answers to whatever questions I had concerning his health, or his well-being. She's the one person that always reaches back to me the

Theme and Summary	Representative Quotes
Another caregiver was happy that her ex-husband has access to a DHHR parenting coach.	same day." **(Caregiver #4, Grandmother, Youth in WV Detention Facility, Round 3)**
Satisfaction with Community-Based Services. Of the three caregivers with youth at home interviewed in Round 3, one was much more satisfied with the in-home community-based therapy and services youth was receiving. The other two caregivers with youth at home were struggling with their youth's ongoing resistance to engage in services, and, in turn, the services' inability to effectively engage the youth. Across all rounds of interviews, caregivers and youth wanted additional services, including more consistent individual and family therapy both in RMHT and in the community, as well as therapy and educational resources for caregivers in addition to DHHR parent coaches.	Youth 9 has "been able to rein in what normally would have caused, you know, extreme anger. Far less depressed than he normally was.…He now readily meets with [therapist]. Prior to that he turned her away…He's not yet perfect, but...yeah, much better than he was....Yes, we're more satisfied now than we have been in a long time." **(Caregiver #9, Grandfather & Adoptive Father/Custodian, Youth at Home, Round 3)** "I'm sure he's not [invested in his therapy]...In his mind, his state of mind is, 'I'm not going to talk about any of my problems or anything that's going wrong with me, because it gets back to the court and gets me in more trouble'….He has never thought of counseling as something that helps him." **(Caregiver #5, Adoptive Mother, Youth in WV Detention Facility, Round 2)** "He can't be forced to participate. He can't be forced to take his meds. He can't be forced to…do any of the therapies…if he doesn't want to…if he decides to throw a temper tantrum and throw a book or something…You know he's not going to get in trouble for it." **(Caregiver #2, Grandmother & Adoptive Mother, Youth in Out-of-State RMHTF, Round 3).**

17 Appendix H: Evaluation Questions and Indicators

Tables 77-85 include Initiative-level and component-specific evaluation questions, and the corresponding primary and secondary data sources that were proposed in the most recent Evaluation Plan (March 2023). References to "DHHR records" as the proposed data source were based on the assumption that these data will be captured by WV DHHR and made available to the WVU Health Affairs Institute. If these data are not currently available, WV DHHR and the WVU Health Affairs Institute project team may develop different strategies, data sources, and/or remove/revise the affected evaluation question(s) to reflect the available data. References to "DHHR reports" include staffing information, number of children served, outreach efforts to increase program awareness, and other information to help contextualize efforts related to continuous quality improvement. References to "DHHR implementation data" represent information that was collected in collaboration with BerryDunn and reported in DHHR Semi-Annual Reports, and data published from Marshall University's fidelity monitoring of Wraparound services. The (*) in the Priority column indicates that the workgroup did not provide a prioritization for the item(s).

Table 77: Initiative-Level Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicator	Priority
What proportion of children with serious MH conditions who had been placed in RMHTF/ PRTFs by May 14, 2019, were transitioned back to family homes?	▪ FACTS (PATH as of 1/2023) ▪ Medicaid ▪ KEPRO ▪ DHHR records	▪ Number of youth who left RMHTF for a permanent reason, and did not return within 14 days[6]	▪ High
How has length of stay in RMHTFs and PRTF changed since the agreement?	▪ FACTS (PATH as of 1/2023) ▪ Medicaid ▪ KEPRO ▪ DHHR records	▪ Number of days in RMHTFs[7] ▪ Number of days in PRTF	▪ High

[6] This indicator will be captured in the Child Welfare Data Store as a part of Phase 1a measures and is based on a count of children experiencing an RMHTF placement including at least one day in the analysis month who exit during the analysis month to permanent reunification with their family

[7] This indicator will be captured in the Child Welfare Data Store as a part of Phase 1a measures and is based on the number of days between placement entry date and placement exit date, where client exit date is less than or equal to the last date of the analysis period; or the number of days between placement entry date and the last date of the analysis period, otherwise divided by the total number of RMHTF placements (n) including at least one day in the analysis month (m) =

$$\frac{\sum_{m}^{n}(\text{exit date} - \text{entry date})}{n}$$

Were fewer children with serious MH conditions needlessly removed from their family homes (after the Agreement)?	▪ FACTS (PATH as of 1/2023) ▪ Medicaid ▪ KEPRO ▪ DHHR records	▪ Number of youth in RMHTF over time, since the Agreement effect date ▪ Number of youth in RMHTF with no previous Medicaid claims with MH related diagnosis codes since the agreement	▪ High
Can WV families with children who need MH services access those services in a reasonable period of time?	▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series ▪ Provider Focus Groups ▪ Key informant interviews ▪ Organization and Facility Survey	▪ Length of time to service receipt (after identification or referral of service needs) ▪ Caregiver agreement on reasonableness of wait time ▪ Barriers to access within and across regions	▪ High
How has the length of time to access services changed?	▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Case Series ▪ Organization and Facility Survey	▪ Length of time to service receipt (after identification or referral of service needs) ▪ Caregiver agreement on reasonableness of wait time	▪ High
Can WV families with children who need MH services access those services in their communities?	▪ DHHR reports ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series	▪ Available providers by region ▪ Caregiver agreement with convenient location ▪ Youth 18 – 21 agreement on convenient location	▪ High

	▪ Surveillance Data	▪ Caregiver and Youth perceptions of availability and/or use of Telehealth ▪ Use of WV emergency department for MH related ICD-10 codes	
How has awareness of MH services for children changed among (families, MH providers, medical providers, partner organizations)?[8]	▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key informant Interviews ▪ System-level focus groups ▪ Surveillance Data	▪ Change in level of awareness of available MH services ▪ Awareness of newly available MH services (crisis line, mobile crisis) and processes for access ▪ Use of WV emergency department for MH related ICD-10 codes ▪ Volume of calls to law enforcement related to juvenile cases	▪ Medium
How has functioning changed for children receiving MH services?	▪ DHHR records (Juvenile Justice, criminal justice, education) ▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ Caregiver Survey ▪ Caregiver Interviews	▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning (self-report by Caregivers and Youth) ▪ Educational involvement ▪ Hospitalizations and PRTF stays	▪ High

[8] This question is at the child- provider- and system-levels. It was rated medium as a child-level, and low as a provider-level. This was not rated at the system-level.

	▪ Youth Survey ▪ Case Series ▪ Surveillance Data ▪ WV CANS	▪ Use of WV emergency department for MH related ICD-10 codes	
How has the use of community-based MH services changed?	▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Organization and Facility Survey ▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ System-level focus groups ▪ Surveillance data	▪ Number and type of services accessed ▪ Change in referral pathways ▪ Use of WV emergency department for MH related ICD-10 odes	▪ High
Did fewer children with serious MH conditions unnecessarily enter RMHTF (after the agreement)? [44]	▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups ▪ System-Level Focus Groups	▪ Number of children in RMHTF ▪ Previous MH-related diagnoses ▪ Use of a validated and timely assessment ▪ Attitudes/philosophy toward referrals for RMHTF	▪ High
How engaged are WV families in the MH treatment services for their children?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey	▪ Caregiver and youth self-reported involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported	▪ Medium

		barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery	
How has family satisfaction with children's MH treatments and supports changed?	▪ Caregiver Survey ▪ Case Series ▪ Youth Survey	▪ Caregiver and youth satisfaction with treatment ▪ Caregiver and youth experience with service delivery	▪ Medium
What proportion of children were appropriately assessed and placed in RMHTF or PRTF?	▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ DHHR records	▪ Number of youth in RMHTF/PRTF ▪ Number of youth with placement assessments ▪ Length of time between referral and assessment	▪ Medium
How many children have entered the juvenile justice system when they would have been better served in the MH system?	▪ DHHR records	▪ Number of DHHR youth entering juvenile and criminal justice system(s) ▪ Number of DHHR youth with petitions ▪ Number of youth in Juvenile Services with previous Medicaid claims with MH related diagnosis codes	▪ Medium
How has the philosophy/attitude toward use of community-based services changed among youth/caregivers, providers,	▪ Caregiver Survey ▪ Case Series ▪ Provider Survey	▪ Agreement with prioritization of in-home and community-based service	▪ High

and partner organizations?[9] (understanding the continuum of services)	▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System- Level Focus Groups	▪ Perception of conditions for necessary residential placement	
How well-integrated are MH services with community healthcare organizations?	▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System-Level Focus Groups	▪ Referral pathways ▪ Proportion of referral completed ▪ Awareness of referrals across agencies ▪ Engagement of multidisciplinary team ▪ Barriers to integration ▪ Level of communication among organizations ▪ Number of MH provider organizations with processes for data sharing	▪ Medium
How have referral pathways changed?[10]	▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System-Level Focus Groups	▪ Number of youth referred to community-based programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types	▪ Low

[9] This question is at the child- provider- and system-levels. This question was rated high as a provider-level but medium as a system-level.
[10] This question is at the provider- and system-level. It was rated low as a provider-level outcome but medium as a system-level.

How has capacity of the MH workforce changed?	▪ DHHR reports ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System-Level Focus Groups	▪ Number in current MH workforce ▪ Number and type of certifications ▪ Number of MH providers by educational level and training specialty ▪ Number of providers by type of licensure ▪ Number of providers who are able to meet need for MH services (self-report) ▪ Provider perception of workforce capacity to meet population MH needs	▪ High
Are the community-based programs associated with the Initiative meeting their desired outcomes?[11]	▪ DHHR Reporting ▪ FACTS ▪ Provider Focus Groups	▪ Number of youth referred to RMHTF or PRTF from community-based programs ▪ Barriers and facilitators to meeting desired outcomes	▪ Medium
How have waiting periods changed for MH services?[12]	▪ DHHR reporting ▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Organizational service capacity ▪ Workforce capacity ▪ Length of time to service receipt	▪ High

[11] This question is at the provider- and system-level. It was rated medium as a provider- and system-level.
[12] This question is at the provider- and system-level. It was rated high as a provider- and system-level.

How have referral pathways changed between traditional and MH providers?	▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Number of youth referred by provider type ▪ Referral patterns by organization type ▪ Referral follow up practices by provider type	▪ Low
How have communication and working relationships between MH and traditional healthcare providers changed?	▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ System-Level Focus Groups	▪ Level of MH provider agreement on existence of communication with traditional providers ▪ Level of coordination for treatment planning and delivery ▪ Barriers and facilitators for effective communication	▪ Low
How have the quality and timeliness of MH assessments/screenings changed?[13]	▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups	▪ Assessment tool fidelity ▪ Number of assessments ▪ Length of time between assessments ▪ Barriers and facilitators to timely assessments and screenings ▪ Number of screenings ▪ Length of time between screenings ▪ Barriers and facilitators to timely screenings	▪ High

[13] This question is at the provider- and system-levels. It was rated high as a provider- and system-level.

How has the capacity of the MH service system workforce changed?	▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey	▪ Number and location of providers ▪ Number and location of organizations ▪ Number of years of service provider experience	▪ High
Are all planned services available in each region?	▪ DHHR records	▪ Number and type of service provider organizations	▪ High
How have coordination and communication among agencies and bureaus changed?	▪ Provider Survey ▪ Provider Focus Groups ▪ System-Level Focus Groups	▪ Level of provider and professional stakeholder agreement on existence of communication among service organizations ▪ Level of provider agreement on existence of coordination for treatment planning and delivery	▪ Low
How have crisis response times changed?	▪ DHHR records ▪ KEPRO	▪ Mobile crisis response time	▪ High
How have standards changed for MH services?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System-Level Focus Groups ▪ DHHR records	▪ Certification requirements ▪ Training requirements ▪ Barriers to achieving desired standards	▪ Low
How engaged are stakeholders with DHHR bureaus and MH programs?	▪ Key Informant Interviews ▪ Provider Focus Groups ▪ System-Level Focus Groups	▪ Level of stakeholder engagement ▪ Level of stakeholder active participation	▪ Medium

Table 78: Wraparound-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How engaged are WV families in Wraparound treatment?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Provider Focus Groups	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery	▪ *
How has awareness of Wraparound services among West Virginians whose children are receiving MH services changed?	▪ Caregiver Survey ▪ Caregiver Interviews ▪ Case Series	▪ Change in level of awareness of available Wraparound services ▪ Awareness of processes for access to Wraparound services	▪ High
How did receiving Wraparound services contribute to children's ability to remain at home?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ DHHR records (juvenile justice, criminal justice, education)	▪ Caregiver and youth agreement with treatment outcomes ▪ Caregiver and youth agreement with functional outcomes ▪ Caregiver and youth rating of Wraparound's contribution	▪ High

		▪ Number of youth enrolled in wraparound with involvement in juvenile services	
How has the length of stay for inpatient hospitalizations changed among Wraparound participants?	▪ KEPRO ▪ FACTS (PATH as of 1/2023)	▪ Length of stay	▪ Low
How has child functioning among Wraparound participants changed?	▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey	▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning (self-report caregiver and youth)	▪ *
How has the use of Wraparound services changed?	▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ KEPRO	▪ Number of wraparound services utilized ▪ Number of unique individuals receiving Wraparound services ▪ Number of referrals to Wraparound programs	▪ *
How have Wraparound providers' knowledge and skills changed?	▪ DHHR Implementation Data ▪ Provider Survey ▪ Provider Focus Groups ▪	▪ Level of provider knowledge of NWI ▪ Level of Wraparound skills	▪ High
How has coordination/communication between Wraparound providers and non-	▪ Provider Survey ▪ Provider Focus Groups	▪ Level of provider agreement on existence of communication among wraparound providers	▪ *

Wraparound providers changed?		▪ Level of provider agreement on existence of coordination for treatment planning among wraparound and other MH providers	
How has the length of time to access Wraparound services changed?	▪ KEPRO ▪ Organization and Facility Survey	▪ Length of time to service receipt from referral	▪ *
How has capacity of the Wraparound workforce changed?	▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Number of qualified providers ▪ Number of providers who are able to meet need for MH services (self-report) ▪ Provider perception of workforce capacity to meet population MH needs	▪ *
Can WV families with children who need MH services access Wraparound services in their communities?	▪ DHHR records ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey	▪ Caregiver agreement with service access and availability ▪ Barriers to access to preferred locations or services ▪ Available providers by region ▪ Caregiver agreement with convenient location ▪ Youth 18-21 agreement on convenient location	▪ *
How has fidelity to the NWI model changed?	▪ DHHR Implementation Data	▪ Fidelity adherence	▪ *
How has coordination/communication	▪ DHHR records	▪ Level of coordination	▪ *

between the two Wraparound programs changed?	▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ Provider Survey	▪ Number of referrals	
How has the availability of Wraparound services changed?	▪ DHHR Implementation Data ▪ DHHR records	▪ Number of NWI trained providers	▪ *
How has the quality and timeliness of CANS assessment for the Wraparound program changed?	▪ DHHR implementation data ▪ DHHR records ▪ KEPRO ▪ WV CANS	▪ Length of time to first assessment ▪ Length of time between assessments ▪ Number of assessments completed by an independent trained person	▪ *
How has knowledge of the NWI model among Wraparound providers changed?	▪ DHHR implementation data ▪ Provider Survey ▪ Provider Focus Groups	▪ Level of knowledge of NWI model	▪ *
How has awareness among professional stakeholders related to eligibility/accessibility of Wraparound services changed?	▪ DHHR implementation data ▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Level of knowledge of eligibility ▪ Level of awareness of available wraparound services ▪ Level of awareness of processes for wraparound referrals and access	▪ High

Table 79: Mobile Crisis-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How did receiving Mobile Crisis services contribute to children's ability to remain at home?	▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Youth Surveys ▪ Caregiver Interview ▪ Case Series ▪ DHHR records (juvenile justice, criminal justice, education)	▪ Number of children in RMHTF or PRTF ▪ Caregiver perception of crisis hotline effectiveness ▪ Caregiver perception of Mobile Crisis effectiveness ▪ Caregiver and youth agreement with treatment outcomes ▪ Number of youth who received mobile crisis services with involvement in juvenile services	▪ High
How has child functioning among Mobile Crisis Service participants changed?	▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Interview ▪ Surveillance data	▪ Level of short-term functioning (e.g., stabilization, ability to remain at home)	▪ *
What proportion of families contact the crisis line more than once?	▪ DHHR records ▪ Case series	▪ Number of repeat crisis line contacts	▪ Low
How satisfied are families with the Mobile Crisis services received?	▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series	▪ Caregiver level of satisfaction with service receipt ▪ Level of youth satisfaction with service receipt ▪ Caregiver and youth experience	▪ High

		with service delivery	
How accessible are mobile crisis services to families?	▪ DHHR records ▪ Caregiver Interview ▪ Case Series ▪ Organization and Facility Survey ▪ Surveillance Data	▪ Caregiver agreement with service access and availability ▪ Available providers by region ▪ Caregiver and youth perceptions of availability and/or use of crisis call services	▪ *
How engaged are WV families in children mobile crisis treatment?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Surveillance data	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery ▪ Use of WV emergency department for MH related ICD-10 codes	▪ *
How has the number of petitions for juvenile justice in response to a crisis situation changed?	▪ DHHR records	▪ Number of Juvenile Justice petitions ▪ Number of children entering Juvenile Justice system	▪ Low

What is the frequency of Mobile Crisis usage and how has this changed over time?	▪ DHHR reports	▪ Number of calls to Crisis hotline	▪ Low
How has awareness among West Virginians related to availability of mobile crisis services/the mobile crisis hotline changed?	▪ Caregiver Survey ▪ Youth Survey ▪ Case Series	▪ Level of awareness of crisis hotline ▪ Level of awareness of mobile crisis services ▪ Self-reported use of Mobile Crisis services ▪ Self-reported use of Crisis hotline	▪ High
How well-integrated are Mobile Crisis services with community healthcare organizations?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Level of provider agreement on existence of coordination between Mobile Crisis teams and community healthcare organizations	▪ *
How are the working relationships between Mobile Crisis services and traditional medical providers?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Level of provider agreement on existence of communication among traditional medical providers and Mobile Crisis Teams ▪ Level of coordination between traditional medical providers and mobile crisis response in treatment planning and delivery	▪ *
How is the coordination and communication between Mobile Crisis and community-based organizations?	▪ Provider Survey ▪ Provider Focus Groups	▪ Barriers and facilitators to coordination and communication	▪ *

	▪ Organization and Facility Survey ▪ Key Informant Interview ▪ System-Level Focus groups	between Mobile Crisis Teams and community-based organizations	
How have the hotline staff changed?	▪ DHHR reports ▪ Provider Survey	▪ Number of adequately trained workforce ▪ Number of providers who are able to meet need for MH services (self-report)	▪ *
How well do Mobile Crisis services communicate with traditional medical providers?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Provider level of agreement about communication with traditional providers	▪ *
What are the referral pathways between Mobile Crisis and other service providers?	▪ Provider survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ DHHR reports	▪ Number and type of referrals to Mobile Crisis Response services ▪ Number of children referred to community-based programs by Mobile Crisis providers ▪ Barriers to referrals to community-based programs	▪ Medium
How routinely are standardized and approved assessments used by Mobile Crisis services?	▪ DHHR reports ▪ KEPRO ▪ Provider Survey	▪ Type of assessment ▪ Length of time between assessments	▪ *
How have the mobile crisis teams changed?	▪ DHHR reports ▪ Provider Survey	▪ Number of adequately trained workforce	▪ *

	▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ Provider Focus Groups	▪ Number of providers who are able to meet need for MH services (self-report) ▪ Provider perception of workforce capacity to meet population MH needs	
How has the length of time to respond to a child crisis situation changed?	▪ DHHR reports ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Length of Mobile Crisis response time	▪ High
How have QA/PI processes improved CMCR services?	▪ DHHR Implementation data ▪ DHHR records	▪ Use of QA/PI data	▪ High
How has the availability of Mobile Crisis services changed?	▪ DHHR Implementation Data ▪ DHHR records ▪ Organization and Facility Survey	▪ Number of provider organizations and service area location ▪ Number of trained workforce and service area location	▪ *
How has the average response time for crisis response services changed?	▪ DHHR Records ▪ DHHR implementation data	▪ Response time	▪ Low
How engaged are stakeholders with Mobile Crisis services?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey	▪ Level of stakeholder engagement with service providers ▪ Level of capacity to engage services independently	▪ *

Table 80: Positive Behavior Support-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How has child functioning among PBS participants changed?	▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ DHHR records ▪ WV CANS ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series	▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning ▪ Hospitalizations and PRTF stays ▪ Educational involvement ▪ Caregiver and youth (self-report) of changes in functioning	▪ High
How has academic engagement among PBS participants changed?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey	▪ Educational involvement ▪ Self-report educational experiences	▪ Medium to High
How has quality of life changed for children and families following PBS intervention?	▪ ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series ▪ DHHR records ▪ KEPRO ▪ FACTS ▪ WV CANS	▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning ▪ Caregiver and youth satisfaction with care ▪ Hospitalizations and PRTF stays ▪ Educational involvement	▪ Medium
Can WV families with children who need MH crisis services access PBS services within their community?	▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series	▪ Caregiver agreement with service access and availability ▪ Available providers by region ▪ Caregiver and Youth perceptions of	▪ High

	▪ Surveillance Data	availability and/or use of PBS services ▪ Use of WV emergency department for MH related ICD-10 codes	
How have family/caregiver knowledge and skills changed to meet youth behaviors and needs?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪	▪ Caregiver knowledge ▪ Provider perception of barriers to improved knowledge and skills ▪ Number of providers trained	▪ Medium
How has family engagement with MH services changed after PBS intervention?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators	▪ High
How has the quality and timeliness of CANS screenings for PBS participants changed?	▪ DHHR implementation data	▪ Fidelity of tool delivery ▪ Length of time to reassessment	▪ Medium
How has the capacity to provide PBS services changed at the region and state levels?	▪ DHHR Implementation Data ▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey	▪ Number of trained PBS providers ▪ Reduced dependence on WVU CED to assist PBS service delivery ▪ Improved performance of WVU CED relative to identified performance metrics	▪ Medium

		▪ Sustained delivery of PBS services to meet needs statewide ▪ Expanded workforce and system capacity to provide PBS ser ices statewide	
How has the availability of PBS services changed?	▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey	▪ Number of trained PBS providers	▪ High
How has coordination/communication between PBS providers and child serving agencies changed?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Level of provider agreement on existence of communication among PBS providers and partner agencies ▪ Increased coordination/comm unication across child-serving agencies ▪ Increased referral pathways across child-serving MH programs and bureaus	▪ Medium to High
How has ability and knowledge among Wraparound facilitators and mobile crisis team members to independently deliver and incorporate PBS services into their care delivery changed?	▪ Provider Survey	▪ Level of PBS skills ▪ Experience with PBS	▪ High
How has fidelity of PBS service delivery related to standards of practice changed?	▪ DHHR implementation data	▪ PBS fidelity adherence	▪ High

How has the use of PBS services changed?	▪ KEPRO ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey	▪ PBS service utilization	▪ *
How has the length of time to access PBS services changed?	▪ KEPRO ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Organization and Facility Survey	▪ Length of time to service receipt	▪ High

Table 81: Assertive Community Treatment-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
Has the proportion of youth (ages 18–21) referred for ACT services (at RMHTF or PRTF discharge) increased?	▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ DHHR records	▪ Number of ACT referrals	▪ Medium to high priority – tied to policy change
How has involvement with the criminal justice system among ACT participants changed?	▪ DHHR records	▪ Criminal justice encounters among ACT enrolled individuals	▪ Low to medium
How have referrals and orders to the criminal justice system changed for ACT eligible participants?	▪ DHHR records	▪ Criminal justice encounters among ACT enrolled individuals	▪ Low to Medium
How has the length of stay for inpatient hospitalizations due to a primary MH condition changed among ACT participants?	▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ DHHR records	▪ Length of stay	▪ Medium
How has child functioning among ACT participants changed?	▪ KEPRO ▪ FACTS (PATH as of 1/2023)	▪ Level of clinical functioning (CANS, CAFAS)	▪ Medium

	▪ DHHR records ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Surveillance data	▪ Level of overall functioning ▪ Hospitalizations and RMHFT stays ▪ Educational involvement	
How has the acceptance of community-based MH treatment (for ACT) as an alternative to RMHTF placement changed?	▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups	▪ Number of children in RMHTF ▪ Perception of criteria for placement in RMHTF	▪ High, due to DOJ order
How has awareness of MH services and supports among child-serving MH professionals changed, including of ACT eligibility? (e.g., primary care physicians, juvenile judges and probation, emergency room staff, foster care parents)	▪ Provider Survey ▪ Provider Focus Groups	▪ Level of provider knowledge of eligibility ▪ Level of provider awareness of available ACT services ▪ Level of awareness of processes for ACT referrals and access	▪ High
How has the availability of ACT services changed?	▪ DHHR records ▪ DHHR Implementation Data ▪ Organization and Facility Survey	▪ Number of ACT provider organizations ▪ Number of counties/regions with available ACT services ▪ Number of qualified ACT team members	▪ High – need to demonstrate statewide coverage
How has the use of ACT services changed?	▪ DHHR records ▪ DHHR implementation data ▪ KEPRO	▪ ACT team caseload ▪ Utilization volume of ACT services per enrolled individual	▪ Medium, because somewhat contingent on eligibility

		▪ Total number of unique individuals being served by ACT programs	
How many ACT team members met all of the model fidelity factors?	▪ DHHR records ▪ KEPRO	▪ Statewide access to children's MH prevention and treatment services	▪ *

Table 82: Mental Health Screening Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
What percentage of Medicaid children not presenting with a MH issues, received a MH screening annually? [14]	▪ KEPRO	▪ Length of time to screening ▪ Number of children being screened	▪ High
Can WV families with children who need MH services access those services in their communities?	▪ KEPRO ▪ DHHR records ▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series	▪ Length of time to service receipt (after identification or referral of service needs) ▪ Decreased involvement with Juvenile Justice ▪ Caregiver agreement on reasonableness of wait time ▪ Barriers to access ▪ All youth are appropriately assessed and placed in RMHTFs	▪ High
How has awareness of MH services for children changed among (families, MH providers,	▪ Caregiver Survey ▪ Caregiver Interview	▪ Change in level of awareness of available MH services	▪ Medium

[14] The first question included in this table (What % of Medicaid children received a mental health screening at the appropriate visit/interval?) is workgroup specific. The other Evaluation Questions for the Screening workgroup are at the Initiative-level but are indicated within the workgroup specific logic model.

medical providers, partner organizations)?	▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey ▪ DHHR records ▪ Surveillance data	▪ Awareness of newly available MH services (crisis line, mobile crisis) and processes for access ▪ Use of WV emergency department for MH related ICD-10 codes ▪ Volume of calls to law enforcement related to juvenile cases ▪ Increased referrals	
How engaged are WV families in the MH treatment services for their children?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth self-reported barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery	▪ High
How well-integrated are MH services with community healthcare organizations?	▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Referral pathways ▪ Proportion of referral completed ▪ Awareness of referrals across agencies ▪ Engagement of multidisciplinary team	▪ Medium

	▪ System Focus Groups ▪ KEPRO ▪ DHHR records	▪ Barriers to integration ▪ Level of communication among organizations ▪ Number of MH provider organizations with processes for data sharing	
How have referral pathways changed?	▪ KEPRO ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System Focus Groups	▪ Number of children referred to community-based programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types	▪ Low
How have referral pathways changed between traditional and MH providers?	▪ KEPRO ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews	▪ Number of children referred by provider type ▪ Referral patterns by organization type ▪ Referral follow-up practices by provider type	▪ Low
How have the quality and timeliness of MH assessments/screenings changed?	▪ DHHR implementation data ▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups	▪ Assessment tool fidelity ▪ Number of assessments ▪ Length of time between assessments ▪ Barriers and facilitators to timely assessments and screenings ▪ Number of screenings	▪ High

		▪ Length of time between screenings ▪ Barriers and facilitators to timely screenings	
How have coordination and communication among agencies and bureaus changed?	▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey	▪ Level of provider and professional stakeholder agreement on existence of communication among service organizations ▪ Level of provider agreement on existence of coordination for treatment planning and delivery	▪ High

Table 83: Workforce-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question[15]	Data Source	Indicators	Priority
How many MH providers are available to treat children in WV?	▪ DHHR records	▪ Number of MH providers statewide	▪ High
Can WV families with children who need MH services access those services in their communities?	▪ DHHR records ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Surveillance Data	▪ Available providers by region ▪ Caregiver agreement with convenient location ▪ Youth 18-21 agreement on convenient location ▪ Caregiver and Youth perceptions of availability and/or use of Telehealth ▪ Use of WV emergency department for MH	▪ High

[15] The Evaluation Questions included in this table are at the Initiative-level but are indicated within the workgroup specific logic model.

		related ICD-10 codes	
How has awareness of MH services for children changed among MH providers and medical providers?	▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ Surveillance Data ▪ DHHR records	▪ Change in level of awareness of available MH services ▪ Awareness of newly available MH services (crisis line, mobile crisis) and processes for access ▪ Use of WV emergency department for MH related ICD-10 odes ▪ Volume of calls to law enforcement related to juvenile cases	▪ Medium
How has capacity of the MH workforce changed?	▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System-Level Focus Groups	▪ Number in workforce ▪ Number and type of certifications ▪ Number of MH providers by educational level and training specialty ▪ Number of providers by type of licensure ▪ Number of providers who are able to meet need for MH services (self-report) ▪ Provider perception of workforce capacity to meet population MH needs	▪ High

Table 84: Outreach-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question[16]	Data Source	Indicators	Priority
Did fewer children with serious MH conditions unnecessarily enter RMHTF (after the agreement)?	▪ FACTS (PATH as of 1/2023) ▪ DHHR records ▪ KEPRO ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Provider Survey ▪ Provider Focus Groups ▪ System-Level Focus Groups	▪ Number of children in RMHTF ▪ Previous MH-related diagnoses ▪ Use of a validated and timely assessment ▪ Attitudes/philosophy toward referrals for RMHTF ▪ Awareness of child MH treatment services	▪ Highest
How engaged are WV families in the MH treatment services for their children?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Provider Survey	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery	▪ High

[16] The Evaluation Questions included in this table are at the Initiative-level but are indicated within the workgroup specific logic model.

How has awareness of MH services for children changed among (families, MH providers, medical providers, DOE staff, courts, police)?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System-Level Focus Groups ▪ Surveillance Data ▪ DHHR records	▪ Change in level of awareness of available MH services ▪ Awareness of newly available MH services (crisis line, mobile crisis) and processes for access ▪ Use of WV emergency department for MH related ICD-10 codes ▪ Volume of calls to law enforcement	▪ High
How have coordination and communication among agencies and bureaus changed?	▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey	▪ Level of provider and professional stakeholder agreement on existence of communication among service organizations ▪ Level of provider agreement on existence of coordination for treatment planning and delivery	▪ Medium
How have referral pathways changed?	▪ Provider Survey ▪ KEPRO ▪ Provider Focus Groups ▪ Organization and Facility Survey	▪ Number of children referred to community-based programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types	▪ High

	▪ System Focus Groups		

Table 85: R3-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How has family engagement throughout the period of placement in residential treatment changed? [17]	▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series	▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators	▪ High
How has the philosophy/attitude toward community-based services (including residential) among families changed? (understanding the continuum of services)	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series	▪ Attitudes toward RMHTF use, in-home care	▪ High
How has family engagement in aftercare planning as aa part of discharge planning changed?	▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Provider Survey	▪ Increased engagement with aftercare planning	▪ *
How has the philosophy/attitude toward community-based services (including residential) among RMHTF staff? (understanding the continuum of services)	▪ Provider Survey ▪ Provider Focus Groups	▪ Level of agreement that West Virginia DHHR supports in-home and community-based care over unnecessary out-of-home placement ▪ Level of agreement that West Virginia	▪ High

[17] New question based on workgroup feedback.

		agencies (not DHHR) support in-home and community-based care over unnecessary out-of-home placement	
How has the philosophy/attitude toward community-based services (including residential) changed among stakeholders? (understanding the continuum of services)	▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus groups ▪ Key Informant Interviews	▪ Attitudes toward residential, in-home and community-based services ▪ Level of agreement that West Virginia DHHR supports in-home and community-based care over unnecessary out-of-home placement. ▪ Level of agreement that West Virginia agencies (not DHHR) support in-home and community-based care over unnecessary out-of-home placement (e.g., juvenile judges, law enforcement, school educational agencies)	▪ High