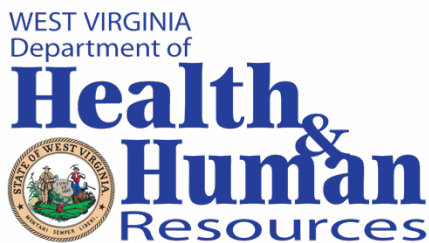

Baseline Evaluation Report for Community-Based Stakeholders

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



Prepared for: West Virginia Department of Health and
Human Resources

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October 31, 2023 (Revised January 2024)

Executive Summary

The West Virginia University Health Affairs Institute is conducting a multi-year mixed methods evaluation of the West Virginia Department of Health and Human Resources (WV DHHR) Children's In-Home and Community-Based Services Improvement Project. The Children's Mental Health Evaluation (the Evaluation) is designed 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. In fact, this Evaluation collects perspectives from stakeholders across mental and behavioral health system, as well as partners within the juvenile justice system, which are not captured by other existing (primarily administrative) datasets.

To date, three Evaluation reports have been previously published: 1) Baseline findings for providers, organizations, and system-level stakeholders (March 2022); 2) Baseline findings for youth in RMHT in 2021 and their caregivers (July 2022); and, 3) Year 2 findings for providers, organizations, youth in RMHT on July 1st, 2022 and their caregivers (hereafter referred to as the July 2023 Evaluation Report). This report contains Baseline findings for youth who were based in the community and were at risk of placement in RMHT, as well as their caregivers. (At risk determination was based on their status in Quarter 4 of calendar year 2021; see more below.) Data from organizations that provide the in-home and community-based mental and behavioral health services of interest to this Evaluation are also included. Evaluating youth who are at risk for out-of-home placements (and their caregivers) helps provide greater insights into:

- The current needs of community-based youth and their families.
- Community-based youth and family experiences with the WV mental and behavioral health system.
- Mechanisms that can help keep youth in their homes and schools when clinically feasible.

This report also provides additional context by making comparisons to the experiences reported by youth in RMHT and their caregivers when appropriate.

Youth- and Family-Level Data Collection

“At risk” youth (hereafter referred to as “community-based youth”) were defined by the State as any WV youth (under age 21) with an SED diagnosis in 2021. The January 2023 DHHR Semi-Annual Report includes explanations of SED and the at risk criteria, which were used for the purpose of this Evaluation:

- An SED is defined by International Classification of Disease-10 (ICD-10) diagnosis codes in the psychiatric range, or F-range (that is, starting with F) except for the F1, or SUD, range and F55 (also a SUD diagnosis) and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021).

Youth were considered at risk for placement in RMHT if they had an SED diagnosis and met any of the following criteria in the last 3 months of 2021:

- Medicaid/CHIP member with a visit to a hospital emergency department for a psychiatric episode.
- Medicaid/CHIP member with a psychiatric hospitalization episode.
- Use of Children with Serious Emotional Disorders (CSED) Waiver Mobile Response services.
- Youth who are in state custody because of CPS or YS involvement.
- Youth with an SED as a primary diagnosis on a Medicaid claim in 2021.
- Youth with scores on the Children and Adult Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) of 90 or above.

Administrative data were used to identify community-based youth using the afore mentioned criteria, and to obtain contact information for their caregivers. As noted in the main report, there was a gap between finalizing the definition of the community-based sample (in early 2022) and the data collection window (in late 2022), which was largely due to the lag times for claims reporting and the availability of other administrative data used to identify the sampling frames. Nevertheless, this report was generated within a few months of data collection, whereas other evaluations might take up to a year or more to clean and analyze data of this nature. As described in greater detail below, two surveys were administered to collect primary data from this population: the Youth Survey and Caregiver Survey. A qualitative case series was conducted as well (see more below).

The *Youth Survey* was administered to West Virginians between the ages of 12 and 21 who met the aforementioned criteria. There were 51 community-based youth who completed the 2022 Youth Survey. Given this sample size, it was not possible to quantify responses to all questions about community-based youth experiences; therefore, this report draws heavily on survey findings from community-based caregivers, and from case series interviews conducted with community-based caregiver-youth dyads.

The *Caregiver Survey* was administered to parents or legal guardians of community-based youth. There were 174 community-based caregivers who completed the 2022 Caregiver Survey.

Eleven individuals participated in Round 1 of the community-based case series interviews. The community-based case series includes semi-structured interviews conducted every six months with five caregiver-youth dyads, as well as a sixth caregiver whose youth did not respond to requests for an interview at the time of Round 1 data collection.

As mentioned, some comparisons are made in this report to youth in RMHT on July 1st, 2022 (hereafter referred to as youth in RMHT in 2022) and their caregivers. As described in greater detail in the July 2023 Evaluation Report, there were 156 youth in RMHT in 2022 and 174 of their caregivers who completed surveys. This report also includes summaries of and comparisons to

data collected as part of the case series interviews with youth in RMHT and their caregivers, which include nine caregiver-youth pairs as well as one youth who is a ward of the State.

Community- and Provider-Level Data Collection

The Organization and Facility Survey captures perspectives of administrators of the youth mental and behavioral health services of interest. Previous reports included data collected from all organizations and facilities that completed the survey, including RMHTFs, in 2021 (n=79) and in 2022 (n=52). Details about data collection methods, analytics, and findings can be found in the 2022 System and Community-Level Evaluation Report and the July 2023 Evaluation Report respectively. For this report, a subset of the 2022 Organization and Facility Survey data was used to focus more specifically on organizations that provided community-based services of interest to this Evaluation. After removing organizations and facilities that only provided RMHT, the analytic sample used in this report included 42 community-based organizations.

This report includes summaries of Provider Survey data collected in 2022. The Provider Survey was administered 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 in 2022 (n=1,141). These data are inclusive of providers who work in both community-based and RMHT settings. Details about data collection methods, analytics, and findings can be found in the July 2023 Evaluation Report.

System-Level Data Collection

This report includes a summary of data from the Centers for Disease Control and Prevention's National Syndromic Surveillance Program (NSSP), which were used to assess trends in utilization of hospital emergency departments to access mental and behavioral health services by youth 21 years of age or younger since the beginning of in-home and community-based service expansion work. The complete analytic methods used to examine the syndromic data are detailed in the July 2023 Evaluation Report.

In addition to this summary of methods and data collection tools, this Executive Summary provides an overview of the main findings from community-based samples at Baseline. 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.

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. Stakeholders have noticed differences resulting from these expansion efforts, as documented in the July 2023 Evaluation Report; however, stakeholders consistently report the desire for more—caregivers and youth expressed the need for more community-based services with higher levels of intensity, and organizations are still experiencing difficulties with service coverage and hiring and retaining staff with advanced degrees and certifications. 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 Community-Based Caregivers and Youth

Seventy percent of community-based youth received at least one of the services of interest to this Evaluation, and at least 57% received one or more in the last 12 months, according to their caregivers. However, overall awareness and usage of community-based services was low among community-based caregivers and youth. Community-based caregivers and youth could more readily recall the type of mental and behavioral health interventions that youth received (e.g., therapy or counseling), and the locations from which they received them, than the specific names of services of interest to this Evaluation, even when service descriptions were provided to them. Wraparound was the one service consistently mentioned by community-based caregivers and youth across surveys and interviews. Awareness and usage of Behavioral Support Services (including PBS) was also higher than other community-based services of interest to this Evaluation, likely related to the size and reach of the service.

Caregivers reported that 29 of their community-based youth (17%) received RMHT in the 12 months prior to data collection, and 12 youth (7%) received RMHT more than 12 months prior, for a total of 41 community-based youth with a history of RMHT. Community-based caregivers reported that their youth who had a history of RMHT were significantly lower in functioning (12.39 on a scale of 24) than youth who had no history of RMHT (16.42 on a scale of 24), indicating that RMHT may be utilized by those who need it most. Caregivers of community-based youth with a history of RMHT felt like out-of-home placements were necessary due to a lack of high-intensity and/or specialized services in their communities. Caregivers indicated that continued expansion of community-based mental and behavioral health services should help keep their youth at home and prevent readmissions in the future.

Overall, few community-based caregivers or youth reported using crisis services, such as emergency rooms, police, or crisis response. However, differences emerged when accounting for use of mental and behavioral health medication. When asked to reflect over the last 12 months, caregivers who reported about their youth managing medications were significantly *more* likely to have (a) called the police for assistance during a mental or behavioral health crisis involving their youth, (b) visited a hospital emergency department to access mental and behavioral health services for their youth, (c) had their youth stay in an acute psychiatric facility, and/or (d) had their youth stay in a RMHTF. Possible explanations for these differences are discussed in Section 9 of this report.

Notably, caregivers of youth in RMHT *and* community-based service settings agreed that their youth would be able to get mental and behavioral health services outside of a hospital setting if needed again in the future, and expressed interest in additional trainings and resources focused on actions they can be taking to further promote youth functioning at home.

Overall, community-based caregivers reported moderate to high levels of engagement and satisfaction with mental and behavioral health services. Determinants of caregiver and youth engagement and satisfaction included the need for consistent and high-quality communication with the care team, 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 access to people who can help advocate for youth, which for caregivers included DHHR staff, CSED Waiver and Wraparound providers as well as probation officers. An additional theme that emerged was the need to help reduce mental health stigma that youth felt contributed to their initial reluctance to get diagnosed or initiate and/or engage in services. Community-based caregivers and youth reported that they were satisfied with the mental and behavioral health services that youth received, which they also attributed to feeling engaged and respected by providers.

Lastly, community-based caregivers mentioned in the surveys and during interviews that their youth responded well to highly structured services and supports. They felt that the primary sources for structured support were in RMHT or from probation, and to a lesser degree from social activities such as church, sports, and ROTC. It could be that caregivers are not aware of the continuum of services available in the community that might also offer the level of structure that they felt was beneficial for their community-based youth.

1.1.2 Providers

As detailed in the July 2023 Evaluation Report, providers are aligned with DHHR policies and priorities for promoting the use of in-home and community-based mental and behavioral health services to delay or reduce the need for RMHT for WV youth. Providers are committed to delivering high-quality evidence-based care. However, providers expressed concerns about having adequate mental and behavioral health services in their counties and regions. Much like caregivers, providers 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. Additional reasons for referrals to RMHT, as reported by providers, included a lack of qualified providers in their networks or areas, lack of resources, and lack of information about resources available in the community.

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) reported challenges with workforce, capacity, and service accessibility.

A greater percentage of RMHTFs reported having adequate staff than community-based organizations in 2022. However, a greater percentage of community-based organizations reported having the staff with the necessary training and skills to provide services to youth with mental and behavioral health needs. Community-based organizations also tended to have fewer and shorter waitlists than RMHTFs. It is worth noting, though, that these findings varied by service and region, which will continue to be accounted for in future reports.

1.1.4 Recommendations

Data-driven 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.

1.2 Concluding Summary

When taken together, findings from this Evaluation indicate that mental and behavioral health services are working. When they are available and accessible, in-home and community-based services are helping to delay or avoid out-of-home placements, thereby helping to ensure that WV youth receive mental and behavioral health services in the least restrictive settings possible. It is expected that WV DHHR will continue to forge ahead in making changes and refinements to community-based services across the state. The baseline data contained within this report will inform future comparisons as that work continues.

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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
NSSP	National Syndromic Surveillance Program
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 University Health Affairs Institute is conducting a multi-year mixed methods evaluation of the West Virginia Department of Health and Human Resources (WV DHHR) Children’s In-Home and Community-Based Services Improvement Project (hereafter referred to as the Evaluation). The purpose of the Evaluation is to assess progress toward and impact of the expansion and enhancement of services for youth with mental and behavioral health needs across the state. 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; PBS)
- Assertive Community Treatment (ACT)
- Residential mental health treatment (RMHT)
- Children’s Crisis and Referral Line (CCRL; 844-HELP4WV)

This project provides unique insights and perspectives from stakeholders that are not captured in other existing (primarily administrative) datasets. Stakeholder feedback is critical for ensuring the planned and executed system improvements are having their intended effects.

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. Notably, DHHR and partner organizations have implemented changes while also responding to a pandemic during the same period of time. Progress has not only been significant, but also directly responds to both administrative and Evaluation data findings to prioritize policy and practice improvements across the system. Examples of the most recent highlights previously detailed in the Evaluation Report: Year 2 (dated July 31, 2023) are:

- Activities that helped facilitate access to services.
- Innovative approaches for identifying areas of WV with the greatest need.
- Methods to increase stakeholders’ awareness of the continuum of services in the mental and behavioral health system.
- Ongoing service expansion.
- Continuous quality assurance monitoring.

- The promotion of screening and assessment tools to help identify the least restrictive environment in which youth might receive services and the types of services needed.

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 WV 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.

During this phase, workgroups were convened to help identify and prioritize specific areas for mental and behavioral health service expansion:

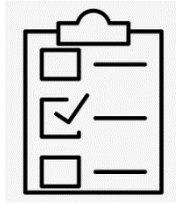
- Executive Steering Committee
- Workgroup Leads
- Pathway to Children’s Mental Health Services Workgroup
- Home and Community Based Services Workgroup
- Quality Assurance and Performance Improvement Workgroup
- Outreach and Education to Stakeholders Workgroup
- Workforce Workgroup
- R3 (Reducing Reliance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

Workgroups contributed to development of the evaluation questions and continue to meet regularly to review results and implement systems improvements.

The second phase of the Evaluation (5/1/2021 – 7/31/2022) focused on collecting baseline data for all stakeholder groups *except youth at risk of residential placement and their caregivers*. Baseline findings for organizations, providers, and system-level stakeholders were presented in the System and Community-Level Evaluation Report dated March 31, 2022 (revised June 15,

2022). Baseline findings for youth in RMHT and their caregivers were presented in the Youth and Family-Level Evaluation Report dated July 29, 2022 (revised September 15, 2022).

The Evaluation is currently in its third phase of work (8/1/2022 - 10/31/2023). Evaluation activities for this phase included mixed methods data collection using:



Surveys



Case Series Interviews



Secondary Data Analysis

Year 2 findings from data collected from providers, organizations, youth in RMHT and their caregivers can be found in the Evaluation Report: Year 2 (dated July 31, 2023). The current report focuses on Baseline data collected from community-based youth who are at risk of being placed in RMHT, their caregivers, and organizations that offer the in-home and community-based mental and behavioral health services of interest to this Evaluation.

“At risk” youth (hereafter referred to as “community-based youth”) were defined by the State as any WV youth (under age 21) with an SED diagnosis in 2021. The 2023 January DHHR Semi-Annual Report includes explanations of SED and the at risk criteria, which were used for the purpose of this Evaluation:

- An SED is defined by International Classification of Disease-10 (ICD-10) diagnosis codes in the psychiatric range, or F-range (that is, starting with F) except for the F1, or SUD, range and F55 (also a SUD diagnosis) and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021).

Youth were considered at risk for placement in RMHT if they had an SED diagnosis and met any of the following criteria in the last 3 months of 2021:

- Medicaid/CHIP member with a visit to a hospital emergency department for a psychiatric episode.
- Medicaid/CHIP member with a psychiatric hospitalization episode.
- Use of Children with Serious Emotional Disorders (CSED) Waiver Mobile Response services.
- Youth who are in state custody because of CPS or YS involvement.
- Youth with an SED as a primary diagnosis on a Medicaid claim in 2021.
- Youth with scores on the Children and Adult Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) of 90 or above.

Administrative data were used to identify community-based youth using the afore mentioned criteria, and to obtain contact information for their caregivers. One limitation of administrative data is the lag time in claims reporting. The definition of the at risk sample was finalized in late 2021; however, sample data did not become available until fall of 2022, hence why data collection for community-based caregivers did not start until December 2022. Nevertheless, this report was generated within a few months of Baseline data collection for community-based caregivers and youth, as can be seen in Table 1. Other evaluations generally take a year or more to clean and analyze data of this nature.

Table 1: Survey Data Collection Timelines To-Date

Stakeholder Group	Setting	Wave of Data Collection	Population identified	Data collected	Report delivered
Youth and their caregivers	RMHT	Baseline	October 2021	November 2021-March 2022	July 2022
	RMHT	Year 2	July 2022	November 2022-March 2023	July 2023
	Community-based	Baseline	October – December 2021	December 2022-March 2023	October 2023
Providers	Both	Baseline	June 2021	August 2021- November 2021	March 2022
	Both	Year 2	October 2022	November 2022-March 2023	July 2023
Organizations and Facilities	Both	Baseline	July 2021	August 2021- November 2021	March 2022
	Both	Year 2	September 2022	November 2022-February 2023	July 2023*

* The sample of community-based organizations was derived from the larger group of Year 2 organizations and facilities who responded to the survey.

Table 2 provides a timeline of the case series interviews (to-date).

Table 2: Case Series Data Collection Timelines To-Date

Stakeholder Group	March 2022	Oct 2022	March 2023
Youth in RMHT and their caregivers	Round 1	Round 2	Round 3
Community-based youth and their caregivers	-	-	Round 1

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 Assessment Overview

Youth- and family-level assessments capture 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 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 who care for WV youth with mental and behavioral health needs. More specifically, the Caregiver Survey was designed to collect information from caregivers of youth in RMHT and caregivers of community-based youth who are at risk for placement in RMHT. (Findings from caregivers of youth in RMHT can be found in other reporting; see Table 1 for additional information.)

The current report focuses on establishing a baseline for caregivers of community-based youth who were at risk for placement in RMHT. Survey participants were contacted by letter and by telephone and given the option to participate online or via phone. Data were collected between December 2022 and March 2023. There were 174 completed surveys, resulting in an overall response rate of 26.4%.

This report makes some comparisons to caregivers of youth in RMHT in 2022, given the overlap in timelines for data collection (see Table 1 above for more details). The same survey was used to collect data from community-based caregivers as was used to collect data from caregivers of youth in RMHT in 2022, with the exception of a handful of questions specific to RMHT. The Caregiver Survey uses a combination of Likert-type scales, multiple choice questions, and open-

ended text responses. The Caregiver Survey included five scales that measure functioning, service experiences, and treatment outcomes:

- 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 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 Youth Functioning Scale that measures caregivers' perceptions of their youth's functioning in daily, social, school, and family life.

A detailed explanation of the data collection methods for the Caregiver Survey is included in Appendix A. Details concerning the analytic methods that were employed for the Caregiver Survey can be found in Appendix B.

2.3.2 Caregiver Survey Respondent Descriptive Findings

There were 174 community-based caregivers who completed the survey, which included 138 individuals who identified as female (79%) and 31 individuals who identified as male (18%); 1% preferred not to answer, 2% were missing; (Appendix C, Demographics & Awareness, Table 1.2). The majority of respondents identified as White (90%, n=156) and non-Hispanic (93%, n=162). In addition, eight respondents (5%) described their race as African American/Black, three respondents (2%) described their race as American Indian or Alaska Native and one respondent identified their race as Asian (2% other, 2% preferred not to answer, 2% were missing). There was variation in employment status; the greatest percentage (50%) indicated that they were employed/self-employed, 17% reported that they were unable to work, 13% reported that they were homemakers, and 7% were retired. Respondents were employed in a variety of professions, with the highest number of respondents employed in healthcare/social care (13%). Most respondents (84%) had a combined household income below \$75,000. Additionally, 29 caregivers (17%) reported that their youth received RMHT in the last 12 months, while 26 caregivers (15%) reported that their youth received RMHT more than 12 months ago.

2.3.3 Youth Survey

The purpose of the Youth Survey was to collect information from WV youth 21 years of age or younger who have mental and behavioral health needs. Youth ages 18 and older, or who were identified as wards of the state, or another independent status, were contacted directly and asked to participate in the survey by phone. Caregivers were asked as part of the caregiver survey to provide consent for youth ages 12 to 17 to be contacted. There were 99 eligible community-based youth between the ages of 12 and 17 who were not wards of the State, and caregivers consented

for 62 of them to participate in the Youth Survey, for a consent rate of 56%. Survey participants were contacted by telephone and completed the survey via phone or video call using Zoom meeting software.

Data were collected between December 2022 and March 2023. As mentioned, the lag between solidifying the definition of the at risk samples (in early 2022) and obtaining the sample (in late 2022) was primarily due to the lag in reporting cycles of administrative data. There were 51 completed community-based youth surveys. When taking the entire sample into account, the overall response rate for youth was 16.5%.

The same survey was used to collect data from community-based youth as was used to collect data from youth in RMHT in 2022, with the exception of a handful of questions specific to RMHT. The Youth Survey uses a combination of Likert-type scales, multiple choice questions, and open-ended text responses. Survey results are included in this report when the survey question garnered either a sufficient quantitative response or produced rich write-in data. There were four scales included in the Youth Survey:

- 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 Access and Satisfaction Scale that measures youth's ability to access services and their satisfaction with those services.
- The Youth Social Support Systems Scale that measures youths' access and comfort with someone that they can talk to and crisis support.
- The Youth Functioning Scale that measures youth's perceptions of their functioning in daily, social, school, and family life.

A more detailed description of the data collection methods for the Youth Survey is included in Appendix A. Details concerning the analytic methods that were employed for the Youth Survey can be found in Appendix B.

2.3.4 Youth Survey Respondent Descriptive Findings

The 51 community-based youth who completed the survey included 25 respondents (49%) who identified as a girl/woman, 21 respondents (41%) who identified as a boy/man, one respondent who identified as transgender (2%) and one respondent who reported that they did not identify with any category (2%); 4% preferred not to answer, 2% were missing; (Appendix D, Demographics & Service Awareness, Table 1.1). Slightly over twenty percent of respondents (22%, n=11) were wards of the State. A majority of the respondents (80%, n=41) identified as White. Other races reported by respondents included African American/Black (14%, n=7), and American Indian/Alaska Native (10%, n=5) (4% were missing, 4% didn't know). In addition, four respondents (8%) identified as Hispanic, Latino/a, or of Spanish origin.

Twenty-four respondents (47%) were between 18-21 years old, 21 respondents (41%) were between the ages of 15-17 years old, and 6 respondents (12%) reported that they were between

12-14 years old. With respect to sexual orientation, (61%, n=31) identified as heterosexual or straight, (4%, n=2) identified as gay or lesbian, (22%, n=11) identified as bisexual, (2%, n=1) were unsure, and (10%, n=5) preferred not to answer (2%, missing). Twelve youth (23%) reported that they received RMHT in the last 12 months, while 15 youth (29%) reported that they received RMHT more than 12 months ago.

2.3.5 Case Series Youth and Caregiver Interviews

The case series includes semi-structured, qualitative interviews that provide an in-depth understanding of youth and family experiences with mental and behavioral health services over time. The current report details the findings from Round 1 of community-based case series interviews. Recruitment began in December 2022. Community-based caregivers and youth who completed surveys and expressed willingness to participate in a series of follow-up interviews were eligible to participate in the case series. Youth were invited to participate once their corresponding caregiver provided informed consent. Round 1 interviews were conducted between March and May of 2023. Eleven individuals participated in Round 1 case series interviews, which resulted in five caregiver-youth dyads, as well as a sixth caregiver whose youth had not responded to requests for an interview at the time of data collection.

Round 1 community-based case series interviews were conducted with eleven participants (six caregivers, five youth), including: six caregivers who identified and were assigned female at birth (100%), all of whom (100%) selected “White” when asked to indicate their race. No caregiver identified as of Hispanic/Latino origin. Their reported relationship to their paired youth included: two biological mothers (33%) and four adoptive mothers (67%). Two caregivers (33%) reported that they were employed at the time of 2022 data collection, two (33%) identified as homemakers, one (17%) was a student, and one (17%) was unemployed and unable to work. Two caregivers (33%) reported an annual household income above \$75,000, and four (67%) below \$75,000. Six youth were contacted to participate in Round 1 of the community-based case series, five of whom were interviewed. Of the initial six youth recruited to participate in the community-based case series study, four (67%) identified and were assigned male at birth, and two (33%) identified and were assigned female at birth. One youth (17%) was between 12-14 years of age, and five (83%) were between 15-17 years old. Five youth (83%) identified as “White”, and one as American Indian/Alaskan Native (17%). No youth identified as of Hispanic/Latino origin, though two (33%) selected “I don’t know.” At time of Round 1 interviews, four youth (67%) were currently residing at home with their paired caregivers, and one (17%) was placed in a WV RMHTF. The one youth not interviewed (17%) identified as male, white race, 15-17 years old and was presumably residing with his biological caregiver at time of interview.

Additional details concerning the case series interviews can be found in Appendix F.

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 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 stakeholders associated with the juvenile justice system. Regional analyses were guided by the six regions defined by DHHR's Bureau for Behavioral Health (BBH). Though the current report focuses on the community-based population of youth at risk for RMHT and their caregivers, findings from the 2021 and 2022 Provider Surveys are included here when relevant. Please see Table 1 for additional details about data collection and reporting timelines.

2.4.2 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 (hereafter referred to as organizations) that provide mental and behavioral health services to WV youth. Baseline data was collected during 2021; Year 2 data was collected during a 14-week period starting on November 16, 2022. It is worth noting that the sampling strategy was adjusted between 2021 and 2022 data collection 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 in 2021 to 81 in 2022. There were 56 surveys completed in 2022, for an overall response rate of 76%. Of those, 52 organizations provided at least one service of interest to this Evaluation and were included in the analytic sample. These findings are presented in the Evaluation Report: Year 2 (dated July 31, 2023).

The current report focuses on community-based youth who are at risk for placement in RMHT and their caregivers. For this report, organizations who provide *only* residential mental health treatment and no other services being evaluated (n=10) were removed from the analytic sample, thereby creating a sample of 42 "community-based organizations." The data were then re-analyzed for high priority questions in this report, and findings are included when relevant. The demographic details of these 42 community-based organizations and facilities are presented in the next section. Regional analyses were guided by the six regions defined by BBH.

Please note that the term "organization" will be used to refer to any individual professional that responded 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.

Additional details concerning the data collection methods for the Organization and Facility Survey can be found in Appendix A. An outline of the analytic methods that were employed for this survey is included in Appendix B.

2.4.3 Organization and Facility Respondent Descriptive Findings

As previously mentioned, this report focuses on 42 organizations from the 2022 sample who provided community-based services of interest to this Evaluation. Of these 42 organizations and facilities, 5 (12%) offered Assertive Community Treatment, 8 (19%) offered Children's Mobile Crisis Response and Stabilization, 7 (17%) offered CSED Waiver Mobile Response, 32 (76%) offered Behavioral Support Services (including PBS), 8 (19%) offered RMHT, 3 (7%) offered WV Children's Mental Health Wraparound, and 14 (33%) offered CSED Waiver Wraparound. Survey respondents also indicated that they provide services across all six regions defined by DHHR's Bureau for Behavioral Health (BBH): Region 1 (n=17), Region 2 (n=29), Region 3 (n=24), Region 4 (n=33), Region 5 (n=28), and Region 6 (n=27).

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 were used to assess trends in the utilization of emergency departments to access mental and behavioral health services by youth 21 years of age or younger 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 are detailed in the Evaluation Report: Year 2 (dated July 31, 2023).

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 presents results 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 G.

3.1.1 Summary

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

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

This section presents results 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 G.

3.2.1 Summary

Community-based caregivers were more aware of mental and behavioral health services than their youth. However, community-based caregivers and youth seemed more familiar with mental and behavioral health interventions (e.g., counseling, therapy), and service locations (e.g., Chestnut Ridge), than they were with services by name (e.g., Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization). Community-based caregivers and youth were most aware of RMHT, followed by Behavioral Support Services (including PBS) and Wraparound; both were least aware of Assertive Community Treatment. Caregivers who were familiar with the services being evaluated agreed that they had the knowledge needed to start

and use them. Survey responses were limited among community-based youth, but data trended toward agreement as well.

Community-based caregivers reported improvements in their understanding of how to access mental and behavioral health services over the last 12 months. Approximately half of community-based caregivers reported an increased understanding of how to access services in the last 12 months, and for two thirds it also increased the likelihood of using mental and behavioral health services if they are needed in the future.

Many community-based caregivers and youth became aware of mental and behavioral health services from direct interactions with system-level stakeholders, providers, stakeholders associated with the judicial system, schools, and from their own social networks. Additionally, approximately 40% of community-based caregivers and youth had teachers, doctors, or other trusted adults help them identify that youth had mental and/or behavioral health needs, and nearly 20% also had those trusted adults recommend that the county or State intervene to provide help.

3.2.2 Caregiver and Youth's General Awareness of Services

DHHR has prioritized outreach to youth and families. The January 2023 DHHR Semi-Annual Report described a number of outreach efforts, including the "Resource Rundown," which include videos and FAQs posted to the Kids Thrive website (www.kidsthive.wv.gov) to provide information, answer caregivers' questions, and increase awareness of services and supports. The need for continued outreach was evident in the survey data: caregivers and youth were not aware of many mental and behavioral health services when asked about by service name and service description. 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, community-based caregivers and youth had a lot to report.

- Community-based caregivers indicated that they were aware of counseling, therapy, medication management/psychiatry, residential programs, waiver programs, DHHR, Wraparound (including Safe at Home), occupational/speech/physical therapy, CPS, juvenile services (e.g., drug court, probation), school-based services, hospital-based services, and many also listed specific facilities and providers.
- Community-based youth mentioned counseling, therapy, residential services, medication management/psychiatry, Safe at Home, DHHR, waiver programs, juvenile services, school-based services, CPS, and shelters.

Community-based caregivers and youth who tended to recall mental and behavioral health interventions, providers, and service settings; Wraparound (including Safe at Home) was the only service that was consistently mentioned by name. This finding emerged in the surveys and during interviews.

3.2.3 Caregiver and Youth Awareness by Service

The surveys asked if caregivers and youth had "heard of" each service, and those who answered "Yes" received several follow up questions, including whether they had the knowledge to start and

use the services of interest. As mentioned, caregivers and youth are not always familiar with the names of specific services. Service descriptions were included in the surveys to help mitigate this, but in general, caregivers and youth could more readily recall mental and behavioral health interventions and service settings than services by name.

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

Children’s Mobile Crisis Response and Stabilization and CSED Waiver Mobile Response were combined into one category in the 2022 Caregiver Survey and the 2022 Youth Survey because both services provide similar mental and behavioral health interventions from similar providers and organizations throughout the state; therefore, caregivers and youth would not necessarily know if the team responding to the request for services was funded by BBH or by the CSED Waiver.

Awareness:

- 28% of community-based caregivers and 22% of community-based youth were aware of Children’s Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response (Appendix C, Demographics & Awareness, Table 1.3.1; Appendix D, Demographics & Service Awareness, Table 1.3.1).

Knowledge of how to initiate services:

- Based on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers agreed (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). There were few community-based youth responses to this survey item (n=11), but data trended toward agreement that they also 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).

3.2.3.2 Wraparound

Caregivers and youth tended to use “Wraparound” and “Safe at Home” interchangeably. Subsequently, the three main types of Wraparound offered in West Virginia were collapsed into one category in the 2022 Caregiver Survey and the 2022 Youth Survey, thereby covering CSED Waiver Wraparound, WV Children’s Mental Health Wraparound, and Safe at Home. This survey strategy aligns with DHHR’s work to standardize Wraparound services across funding streams.

Awareness:

- 40% of community-based caregivers and 24% of community-based youth were aware of Wraparound (Appendix C, Demographics & Awareness, Table 1.3.1; Appendix D, Demographics & Service Awareness, Table 1.3.1).

Knowledge of how to initiate services:

- Based on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers agreed (3.7) that they had the necessary knowledge to start and use Wraparound (Appendix C, Future Service Needs, Table 7.1). There were few community-based youth responses to this survey item (n=12), but data trended toward agreement that they also had the necessary knowledge to start and use Wraparound (Appendix D, Future Service Needs, Table 6.1).

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

Given the size and reach of the program, it was somewhat expected for awareness of Behavioral Support Services (including PBS) to be high. In fact, community-based caregivers and youth reported more awareness of Behavioral Support Services (including PBS) than any other community-based service included in this Evaluation, even though Wraparound (including Safe at Home) was the only service mentioned consistently by name during interviews and in the write-ins to open-ended survey items.

Awareness:

- 44% of community-based caregivers and 31% of community-based youth were aware of Behavioral Support Services (including PBS; Appendix C, Demographics & Awareness, Table 1.3.1; Appendix D, Demographics and Service Awareness, Table 1.3.1).

Knowledge of how to initiate services:

- Based on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers agreed (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). There were few community-based youth responses to this survey item (n=14), but data trended toward agreement that they also have the knowledge to start and use Behavioral Support Services (including PBS; Appendix D, Future Service Needs, Table 6.1).

3.2.3.4 Assertive Community Treatment

Assertive Community Treatment's target population (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:

- 18% of community-based caregivers and 8% of community-based youth were aware of Assertive Community Treatment (Appendix C, Demographics & Awareness, Table 1.3.1; Appendix D, Demographics & Service Awareness, Table 1.3.1).

Knowledge of how to initiate services:

- Based on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers agreed (3.6) that they had the necessary knowledge to start and use Assertive Community Treatment (Appendix C, Future Service Needs, Table 7.1). There

were too few community-based youth to quantify their knowledge of how to start and use Assertive Community Treatment (n=4; Appendix D, Future Service Needs, Table 6.1).

3.2.3.5 Residential Mental Health Treatment (RMHT)

Fifty-seven percent of community-based caregivers and 59% of community-based youth were aware of RMHT (Appendix C Demographics & Awareness, Table 1.3.1; Appendix D, Demographics & Service Awareness, Table 1.3.1).

3.2.3.6 Children's Crisis and Referral Line (CCRL)

Awareness:

- 35% of community-based caregivers and 27% of community-based youth were aware of the CCRL (Appendix C, Demographics & Awareness, Table 1.3.1; Appendix D, Demographics & Service Awareness, Table 1.3.1).

Knowledge of how to initiate services:

- Based on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers agreed (3.9) that they had the necessary knowledge to start and use the CCRL (Appendix C, Future Service Needs, Table 7.1). There were few community-based youth who responded to this survey item (n=14), but data trended toward agreement that they also have the knowledge to start and use the CCRL (Appendix D, Future Service Needs, Table 6.1).

3.2.4 Caregiver and Youth Understanding of How to Access Services

Caregivers and youth were asked to reflect on their understanding of how to access services over the last 12 months. Table 3 displays changes in understanding of how to access mental and behavioral services, as reported by community-based caregivers. **Approximately half of community-based caregivers reported that their understanding of how to access mental and behavioral health services had gotten better in the last 12 months** (Appendix C, Crisis Support and Access, Table 2.3).

Table 3: Changes in Community-Based Caregivers’ Understanding of How to Access Services

Caregiver Understanding in the Last 12 Months	%
Got better	52%
Stayed the same	44%
Got worse	3%

There were not enough community-based youth responses to this survey item to include in this section of the report. Alternative methods and tools that can improve the amount and quality of community-based youth responses are being considered for future data collection activities.

3.2.5 How Caregivers and Youth Heard About Services

Many community-based caregivers and youth had teachers, doctors, or other trusted adults help them identify that youth had mental and/or behavioral health needs. Specifically:

- 44% of community-based caregivers and 39% of community-based youth had a teacher, doctor, or other trusted adults help them identify that youth had mental and/or behavioral health needs (Appendix C, Crisis Support and Access, Table 2.1; Appendix D, Experiences with Mental Health, Table 2.5).
- 17% of community-based caregivers and 18% of community-based youth reportedly had a teacher, doctor, or trusted adult request that the county/State intervene to help them (Appendix C, Crisis Support and Access, Table 2.1; Appendix D, Experiences with Mental Health, Table 2.5).

Surveys also asked how caregivers and youth found out about mental and behavioral health services (Appendix C, Demographics & Awareness, Table 1.5; Appendix D, Demographics & Awareness, Table 1.5). Table 4 displays the percentage of caregivers who heard about services from the sources listed in the 2022 survey; there were not enough youth responses to include in the table.

Table 4: Sources by Which Caregivers Heard About Mental and Behavioral Health Services

Information Source	Caregivers (n=174)
Referred by a doctor	23%
Radio	1%
Television	2%
Internet	10%

CCRL (844-HELP4WV)	1%
A friend	6%
From their youth	2%
Do not remember	13%
Other	45%

The greatest percentage (45%) of community-based caregivers found out about services from sources “other” than what was listed in the surveys. These sources included the judicial system (e.g., in court, from probation officers), school (e.g., teachers, school officials), system-level stakeholders (e.g., DHHR caseworkers), social networks (e.g., friends and family), referrals from providers, and through information they received in the mail. Caregivers also mentioned that they heard about services as part of their personal experiences. Even though there were not enough responses from community-based youth to include in Table 4, there were eight who selected “other” sources and wrote in responses that are worth noting. Similar to reports from caregivers, these sources included the judicial system, system-level stakeholders, school, and family. Participants in the community-based case series also reiterated that their awareness and access was mainly facilitated through interactions with providers, other stakeholders within the mental and behavioral health system, as well as stakeholders associated with the juvenile justice system.

The surveys ask what information would be useful for initiating youth services in the future. Qualitative analysis of the write-in responses indicated that community-based caregivers and youth would like more detailed service descriptions and contact information for people who they can talk to about service offerings. Similarly, during case series interviews community-based caregivers expressed difficulties finding resources that would help them identify the right services for their youth, especially when their needs first started to emerge.

3.2.6 Comparisons to Youth in RMHT and their Caregivers

Awareness varied by service but overall, less than half of caregivers and youth were aware of the community-based mental and behavioral health services included in this Evaluation, and this finding was consistent across RMHT and community-based service settings. Interestingly, youth in RMHT were generally more aware of services than their caregivers, whereas community-based caregivers were more aware of services than their youth. Of note, **awareness of the Children’s Crisis and Referral Line was 10% higher among community-based caregivers than caregivers of youth in RMHT** in 2022. One explanation is that families in the community might have greater need for Children’s Crisis and Referral Line services than youth in RMHT who already have access to an array of services and supports.

Caregivers and youth seemed to be more familiar with the names of service locations and mental and behavioral health interventions than they were of the names of specific services and programs, and this finding was consistent across community-based and RMHT settings.

Caregivers reported being knowledgeable about how to access services, and this was consistent across settings. Caregivers who had heard of youth mental and behavioral health services felt that they have the knowledge necessary to start and use them. Caregiver awareness of how to access services was associated with intentions to use services if their youth need them again in the future, and this finding was also consistent across RMHT and community-based service settings.

Caregivers and youth are primarily hearing about services directly from stakeholders in the WV mental and behavioral health system, from partners associated with the juvenile justice system, and from people within their own social networks; this finding was consistent across settings.

3.2.7 Recommendations

Recommendations outlined in the July 2023 Evaluation Report were centered around targeted outreach for the Children’s Crisis and Referral Line and Wraparound, continuing to supply outreach materials to providers, and more widespread marketing of different types of mental and behavioral health services available for youth and their families. One additional recommendation emerged from trends observed across RMHT and community-based service settings.

Recommendation: Continue interactive outreach efforts targeting caregivers and youth. For example, outreach strategies might leverage the fact that many caregivers and youth became aware of services by word-of-mouth.

4 Evaluation Results: Reducing Unnecessary Placement in RMHT

4.1 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 presents results 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 G.

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

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 presents results 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 G.

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

4.3 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 presents results 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

DHHR promotes mental and behavioral health services that are designed to keep youth in their homes and communities when it is clinically feasible to do so, thereby helping to ensure that youth can receive services in the least restrictive settings possible.

The community-based services of interest to this Evaluation are helping to delay or reduce the need for out-of-home placements, according to community-based caregivers. They indicated that Wraparound and Behavioral Support Services (including PBS) were particularly helpful in this regard. Few community-based youth used crisis services in 2022, but when they did, caregivers also felt that they helped delay or reduced the need for out-of-home placements.

4.3.2 Service-Specific Findings

The surveys ask if caregivers and youth had “heard of” the services of interest to this Evaluation, and if yes, whether youth received those services in the last 12 months and if they felt that the services helped make it so that they (the youth) could stay at home to receive mental or behavioral health care instead of having to “go to a group home or be checked in to RMHTFs or hospitals.” The following sections describe caregiver perceptions by service. There were few community-based youth who reported that they were aware of and had received services; as a result, there were not enough youth survey responses to include in this section of the report.

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

Community-based caregivers reported that three of their youth received Children’s Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services in the 12 months prior to data collection, and for two (67%) it helped delay or avoid out-of-home placements for services (Appendix C, Demographics & Awareness, Table 1.3.2).

4.3.2.2 Wraparound

Community-based caregivers reported that 17 of their youth received Wraparound in the 12 months prior to data collection and that it helped delay or avoid out-of-home placements for 76%

of them (Appendix C, Demographics & Awareness, Table 1.3.2). However, experiences with Wraparound were mixed, according to community-based caregivers who participated in the case series interviews. For example, one caregiver mentioned that her youth's Wraparound provider "wasn't reachable" and "wouldn't show up [in] crisis." Another caregiver had a considerably different experience, recounting how Safe at Home helped provide an array of mental and behavioral health interventions that their youth was able to receive while remaining at home. The caregiver stated, "Safe at Home was one of our biggest helps. [The provider] was amazing...Whenever we had a crisis, I could reach out to her. You know, she could talk me through, you know de-escalation and all that stuff. So during the worst part of things, she was our biggest help," (Caregiver).

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

Community-based caregivers reported that 20 of their youth received Behavioral Support Services (including PBS) in the 12 months prior to data collection and for 50% it helped avoid out-of-home placements (Appendix C, Demographics & Awareness, Table 1.3.2).

4.3.2.4 Assertive Community Treatment

Assertive Community Treatment is intended for older youth at the top of the age range of interest to this Evaluation. As expected, usage of Assertive Community Treatment was low. Community-based caregivers reported that only one of their youth received Assertive Community Treatment in the 12 months prior to data collection, and they were unsure whether it helped delay or avoid out-of-home placements (Appendix C, Demographics & Awareness, Table 1.3.2).

4.3.2.5 Children's Crisis and Referral Line (CCRL)

Community-based caregivers reported that two of their youth received services from the Children's Crisis and Referral Line in the 12 months prior to data collection and it helped delay or avoid out-of-home placements for both of them (Appendix C, Demographics & Awareness, Table 1.3.2).

As mentioned, these survey findings are only reflective of caregivers who had heard of the community-based mental and behavioral health service included in this Evaluation based on the names and service descriptions provided in the survey, *and* when their youth received the specified services in the last 12 months. Stated differently, the skip logic built into the survey resulted in a subset of perspectives on this topic, likely resulting in underreporting of the impact that these community-based services have on the timing and need for out-of-home placements. Nevertheless, when youth received community-based services, their caregivers felt like it made a difference.

4.3.3 Comparison to Youth in RMHT and their Caregivers

Caregivers of youth in RMHT and in community-based service settings indicated that many of the community-based mental and behavioral health services of interest to this Evaluation have helped delay or reduce the need for out-of-home placements for their youth. Caregivers found

Wraparound and Behavioral Support Services (including PBS) to be particularly helpful, and these findings were consistent across RMHT and community-based settings.

4.3.4 Recommendations

The recommendations outlined in the July 2023 Evaluation Report were to continue to promote the Children’s Crisis and Referral Line, and to consider what factors contribute to delaying or avoiding out-of-home placements. For example, community-based caregivers indicated that therapy and counseling services were particularly valued and were perceived to help avoid out-of-home placements.

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 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

Thirty six percent (36%) of community-based caregivers reported that the value of community-based mental and behavioral health services has gotten better over the last 12 months, and for nearly half the perceived value stayed the same. While community-based mental and behavioral health services are valued, caregivers and youth expressed in the surveys and interviews that more are needed, especially at varying levels of intensity.

4.4.2 Caregiver perceptions about the value of services

The perceived value of community-based services affects decisions about utilization. As displayed in Table 5 below, most community-based caregivers (83%) 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).

Table 5: Community-Based Caregivers’ Perceived Value of Services Over the Last 12 Months

Perceived Value of Services	%
Gotten better	36%
Stayed the same	47%
Got worse	16%

During case series interviews, caregivers and youth indicated that they valued community-based mental and behavioral health services but want more of them at varying and higher levels of intensity and specialization.

4.4.3 Comparison with Youth in RMHT and their Caregivers

Most caregivers reported that the value of community-based mental and behavioral health services has gotten better or stayed the same over the last 12 months, and this finding was consistent across RMHT and community-based settings.

Another theme that emerged is that while community-based services are valued, more are needed, especially at varying and higher levels of intensity, and this finding was also consistent across RMHT and community-based settings.

4.4.4 Recommendations

Recommendations outlined in the July 2023 Evaluation Report focused on continued outreach and promotion of community-based programs and services, as well as methods for increasing caregiver and youth inclusion and engagement in service planning and service delivery.

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 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 G.

4.5.1 Summary

As detailed in the July 2023 Evaluation Report, there was an overall downward trend in average lengths of stay in RMHT between 2019 and 2022.

There are evaluation questions and indicators related to lengths of stay for inpatient hospitalizations among youth receiving Wraparound and Assertive Community Treatment. Previously, Medicaid claims data were used to explore these evaluation questions; however, there are important limitations to these data, including the lag time for claims reporting and the scope of what is available. Alternative sources of administration data, such as PATH, are being explored and will be included in future reports when applicable. In the interim, findings from the community-

based case series interviews were able to provide some insights. A few community-based caregivers and youth reported prior inpatient hospitalizations and stays in PRTFs in Round 1 of the case series interviews, and several themes emerged. In these cases, youth behaviors were extreme and presented as dangers to themselves and others (including self-harm, suicidal ideation, assault, and violent behaviors). Resulting hospitalizations ranged from a few days to several months or more, and caregivers reported that ultimately longer-term, specialized placement made a difference, although those improvements were not always sustained over time.

4.5.2 Recommendations

The recommendation included in the July 2023 Evaluation Report highlighted the need to continue to identify actionable barriers and facilitators that contribute to lengths of stay in RMHT or PRT, such as the availability of high-intensity community-based services.

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

This section presents results 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 G.

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

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 presents results 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 G.

5.1.1 Summary

As detailed in the July 2023 Evaluation Report, the mental and behavioral health services included in this Evaluation are offered by at least one organization in every region. 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 reported some difficulty providing service coverage in every county in WV in 2022. The other community-based mental and behavioral health services being evaluated reported difficulties in six or more WV counties. The greatest percentage of organizations that had difficulties providing service coverage in 2022 were 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 who responded to the 2022 survey, and little difference was observed among community-based organizations.

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

Many who participated in the community-based case series interviews indicated that youth were able to access and receive needed services, particularly through more intensive out-of-home placements and therapy with community-based providers. Similar to caregivers of youth in RMHT, community-based caregivers viewed past out-of-home placements as the best way to access intensive mental and behavioral health services, largely because they perceived that those resources were not available in the community. Specifically, the safety, security, and structure provided by RMHT served as a respite for families during times of escalated severity of mental and behavioral health issues. Therefore, even if caregivers could access community-based services (and many reported these services as generally helpful), they did not provide the more intensive, specialized, consistent care, as well as supervision, that some youth need during times of significant need (e.g., instances of violence or destruction; encounters with law enforcement).

5.1.3 Recommendations

Recommendations included in the 2023 July Evaluation Report focused on expanding the workforce and improving service accessibility. The recommendation to increase stakeholder awareness of the continuum of community-based services available in the mental and behavioral health system is also relevant here.

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

This section will present results 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 G.

5.2.1 Summary

Seventy percent of community-based youth received at least one of the services of interest to this Evaluation, and at least 57% received one or more in the last 12 months, according to their caregivers. Thirty one percent of youth received mental and behavioral health services that were not listed in the surveys. Of those included in this Evaluation, Behavioral Support Services and Wraparound were two of the most used community-based services. Community-based caregivers also reported that 17% of community-based youth (n=29) received RMHT within 12 months of data collection. Utilization of Assertive Community Treatment, Children’s Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response, or services from the Children’s Crisis and Referral Line was reportedly low. Few youth were on the waitlist for additional services at the time of data collection, although 31% of community-based caregivers reported that their youth needed additional services that were perceived as not available at the time of data collection. Caregivers also expressed the need for individual and family therapy, as well as in trainings or other resources that can help them identify their youth’s needs, contribute to their wellbeing at home, and avoid and/or de-escalate crisis situations involving their youth.

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 services, although few reported waiting for services at the time of data collection and considerably fewer caregivers felt that wait lists made it difficult to continue services once they were initiated.

Caregivers are confident that they have the knowledge needed to access services if they are needed again but some were unsure about service availability once their youth transitioned into adulthood.

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 if services are available, accessible, have capacity, and offer varying levels of intensity across different interventions. The surveys ask if caregivers and youth had “heard of” the services being evaluated, and if yes, several follow up questions were asked about usage. This section focuses on caregiver reports, due to there being too few community-based youth responses to the survey to include in this section of the report. Findings on utilization are broken down by service below.

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

Community-based caregivers who were aware of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response represented 48 youth, three of whom (6%) received these services in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- No community-based youth were waiting for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response services at the time of data collection.
- 6 community-based youth (13%) received Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response more than 12 months ago.
- 33 community-based youth (69%) had not received and were not waiting for Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response at the time of data collection.
- 6 community-based caregivers (13%) had heard of Children's Mobile Crisis Response and Stabilization or CSED Waiver Mobile Response but did not know whether their youth had received it in the last 12 months.

5.2.2.2 Wraparound

Community-based caregivers who were aware of Wraparound represented 70 youth, 17 of whom (24%) received Wraparound in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- 3 community-based youth (4%) were waiting for Wraparound at the time of data collection.
- 20 community-based youth (29%) received Wraparound more than 12 months ago.
- 24 community-based youth (34%) had not received and were not waiting for Wraparound at the time of data collection.
- 6 community-based caregivers (9%) had heard of Wraparound but did not know whether their youth had received it in the last 12 months.

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

Community-based caregivers who were aware of Behavioral Support Services (including PBS) represented 77 youth, 20 of whom (26%) received these services in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- 1 community-based youth (1%) was waiting for Behavioral Support Services (including PBS) at the time of data collection.
- 14 community-based youth (18%) received Behavioral Support Services (including PBS) more than 12 months ago.

- 34 community-based youth (44%) had not received and were not waiting for Behavioral Support Services (including PBS) at the time of data collection.
- 9 community-based caregivers (12%) had heard of Behavioral Support Services (including PBS) but did not know whether their youth had received it in the last 12 months.

5.2.2.4 Assertive Community Treatment

Community-based caregivers who were aware of Assertive Community Treatment represented 31 youth, one of whom (3%) received these services in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- 1 community-based youth (3%) was on the waitlist for Assertive Community Treatment at the time of data collection.
- 5 community-based youth (16%) received Assertive Community Treatment more than 12 months ago.
- 19 community-based youth (61%) had not received and were not waiting for Assertive Community Treatment at the time of data collection.
- 5 community-based caregivers (16%) had heard of Assertive Community Treatment but did not know whether their youth had received it in the last 12 months.

5.2.2.5 Residential Mental Health Treatment (RMHT)

Community-based caregivers who were aware of RMHT represented 100 youth, 29 of whom received RMHT in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- 4 community-based youth (4%) were waiting for RMHT at the time of data collection.
- 26 community-based youth (26%) received RMHT more than 12 months ago.
- 42 community-based youth (42%) had not received and were not waiting for RMHT at the time of data collection.
- 5 community-based caregivers (5%) had heard of RMHT but did not know whether their youth had received it in the last 12 months.

One explanation for the use of RMHT among community-based youth is that their caregivers perceived it as the main resource for higher intensity services.

5.2.2.6 Children's Crisis and Referral Line (CCRL)

Community-based caregivers who were aware of the CCRL represented 61 youth, two of whom (3%) received CCRL services in the 12 months prior to data collection (Appendix C, Demographics & Awareness, Table 1.3.2). According to community-based caregivers:

- No community-based youth were waiting for CCRL services at the time of data collection.
- 8 community-based youth (13%) received CCRL services more than 12 months ago.
- 43 community-based youth (70%) had not received and were not waiting for CCRL services at the time of data collection.
- 7 community-based caregivers (11%) had heard of the CCRL but did not know whether their youth had received CCRL services in the last 12 months.

It is possible that youth contacted the CCRL without their caregivers' knowledge; however, only 14 community-based youth (28%) indicated awareness of CCRL in the Youth Survey.

5.2.3 Other Services and Supports Reported by Caregivers and Youth

Community-based youth received additional services and supports not listed in the surveys.

- 31% of community-based caregivers reported that their youth received and 6% said they were waiting to receive other mental and behavioral health services that were not listed in the surveys (Appendix C, Demographics & Awareness, Table 1.4).
- 22% of community-based youth reported that they received and 4% were waiting to receive other mental and behavioral health services that were not listed in the surveys (Appendix D, Demographics and Service Awareness, Table 1.4).

Community-based caregivers and youth wrote in the following services and interventions that youth received, in addition to what was listed in the surveys:

- Counseling/therapy/behavioral health services.
- Medication management.
- Speech/occupational/physical therapy.
- Evaluations.
- Residential services.
- Wraparound.
- School-based services.
- Services associated with waivers or programs outside of this Evaluation.

In Round 1 of community-based case series interviews, all caregivers and youth mentioned mental and behavioral health interventions such as individual, group, and family therapy/counseling, psychiatry, and medication. Most have had probation services, which they felt provided youth with support and structure to participate in services. Some also reported interventions (such as individual and group therapy focused on trauma specialization, life skills, or dialectical behavior therapy (DBT)) to address anger and aggression, anxiety, trauma, depression, ADHD, substance use, suicidal ideation, and life skills.

As evidenced by case series findings and write-in responses to open-ended survey items, there is the possibility that youth are receiving one or more of the mental and behavioral health services, but they do not necessarily 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. Caregivers and youth continue to be able to name the organizations and facilities from which services were received and are able to describe the mental and behavioral health interventions that are included as part of care delivery. Given their enthusiasm to provide feedback in surveys and interviews, there is little evidence that social desirability affected caregiver or youth reports on usage of services. 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.

5.2.4 Barriers to Starting Services

Community-based caregivers and youth reported that there were barriers that affected the initiation and continued use of mental and behavioral health services. For example, the surveys asked participants to indicate whether they encountered barriers to starting services for community-based youth. 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 not listed.

- 47% of community-based caregivers experienced barriers to starting youth mental and behavioral services (Appendix C, Starting Service Barriers, Table 4.1).
- 5 of 19 community-based youth who responded to this survey item (26%) experienced barriers to starting youth mental and behavioral services (Appendix D, Starting Service Barriers, Table 4.1).

Table 6 below provides a breakdown of the percentage of community-based caregivers who experienced specific barriers to starting services. The number of community-based caregivers included in Table 6 represents the number who responded “Yes” to experiencing barriers to starting mental and behavioral health services for their youth (n=41), which was used to calculate the percentages; there were too few youth responses to these survey items to include in the table.

Table 6: Caregiver-Reported Barriers to Starting Services

Barriers to Starting Services	Community-Based Caregivers in 2022
	n=41
The people you needed to contact to start services were unavailable, unresponsive, or too busy.	56%
The system was too complicated.	32%
You didn't understand what you needed to do.	34%
Meetings where things were decided about your child's care were at times that you could not make.	12%
Meetings where things were decided about your child's care were at a location that you could not get to.	10%
Meetings where things were decided about your child's care used technology that you do not have or know how to use.	0%
None of the programs chosen for your child were a good fit for your child and/or your family.	24%
You couldn't afford the services needed.	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.	44%
The services that were chosen for your child weren't available in your area.	34%
The services that were chosen for your child weren't available at times when you could join.	12%
The services that were chosen for your child were for a different age group.	10%
You did not have a way to get to and from the services that were chosen for your child.	15%
You decided your child didn't need services.	0%
Other (please specify).	41%

To summarize, the most common barriers to initiating services were as follows:

- Community-based caregivers did not know how to initiate services for their youth.
- Community-based caregivers reported difficulties contacting the people responsible for initiating services.
- Community-based caregivers reported difficulties starting services because the selected services were not available in their area.
- Community-based caregivers cited long wait times as a barrier to starting services.

There were 41% of caregivers who encountered “other” challenges to starting services that were not listed in the survey. Two of the barriers most commonly cited by community-based 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). With regard to communication, community-based caregivers wanted more interaction with providers in general, as well as more information about treatment plans and recommended services. Service availability included a range of barriers were also reported by community-based caregivers with respect to service availability, such as wait times, inconvenient hours that conflicted with caregiver schedules, a lack of local providers, multiple attempts had to be made to receive help, and difficulties navigating the system. Two additional themes that emerged from the write ins included difficulties finding services that were a good fit, and positive experiences with services (therapists and in-school services in particular).

Caregivers were asked whether they wanted to share anything else about their experiences with initiating services. Similar themes emerged in the write-in responses, of wanting more communication, greater involvement in decision making, and logistics around service availability and accessibility (Appendix C, Starting Service Barriers, Table 4.5). Similar themes as well as four additional themes emerged from the case series interviews.

- Community-based caregivers would like more guidance and support navigating the system.
- Community-based caregivers expressed difficulties finding higher intensity and/or specialized services in the community.
- Many community-based youth recounted their own initial reluctance to engage in services. Some reasons included:
 - Not wanting an associated “label.”
 - Not being in the “right mental state.”
 - Generally not perceiving the benefit and utility of services.
 - Running away.
- Some community-based caregivers and youth described the State as a facilitator to accessing intensive services.

- Some community-based caregivers and caregivers of youth in RMHT indicated that they were advised to take legal/court action, including filing incorrigibility, pursuing State custody, and/or criminal charges, to gain access to intensive out-of-home services that they felt their youth needed at the time.
- Caregivers described it as “heartbreaking” to give up custody but in some cases found it to be the best way to gain access to intensive services for their youth and found it provided extra encouragement needed for reticent youth to engage in services. One caregiver stated that DHHR “became strongly involved” once they took her youth “into state custody [because] that’s the only way they could get her help, [and] get it paid for,” (Caregiver). Youth reiterated that between their caregivers and the State, they were able to access and receive the services they needed. One youth stated, “If I wasn’t [in] State’s custody...[service accessibility] probably would have been a struggle,” (Youth). Another stated, “State custody had a bunch of resources for me to use [like] really good therapy, [and] they also helped me with like meds [and] healthcare” (Youth).
- Several community-based caregivers described similar experiences with the juvenile justice system. DHHR and juvenile justice were viewed as having the authority to ensure that youth with higher intensity needs get the right services, namely through out-of-home placements. Probation officers and attorneys were viewed by community-based caregivers as particularly helpful and supportive.

5.2.5 Barriers to Continuing Services

Caregivers and youth were asked to indicate whether they encountered barriers to continuing services after their first appointments. 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 that were not listed.

- 48% of community-based caregivers reported that they experienced barriers to continuing mental and behavioral health services for their youth (Appendix C, Continuing Service Barriers, Table 5.1).
- Approximately half of community-based youth who responded to this survey item (10 of 19) experienced barriers to continuing mental and behavioral health services (Appendix D, Continuing Service Barriers, Table 5.1).

Table 7 displays the percentage of community-based caregivers who experienced barriers to continuing services. The number of caregivers included in Table 7 (n=42) represents the number of community-based caregivers who responded “Yes” to experiencing barriers to continuing mental and behavioral health services for their youth, which was used to calculate the percentages; there were too few youth responses to these survey items to include in the table.

Table 7: Caregiver-Reported Barriers to Continuing Services

Barriers to Continuing Services	Community-Based Caregivers in 2022
	n=42
The people you needed to contact to continue services were unavailable, unresponsive, or too busy.	45%
The system was too complicated.	19%
You didn't understand what you needed to do.	19%
Services were at a time that you or your child could not make.	7%
Services were at a location that you or your child could not get to.	12%
Services used technology that you or your child do not have or know how to use.	5%
None of the programs chosen for your child were a good fit for your child and/or your family.	26%
You couldn't afford the services needed.	2%
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.	24%
The services that were chosen for your child were for a different age group.	2%
You or your child did not have a way to get to and from the services that were chosen for them.	12%
You decided your child did not need services.	0%
You were unable to balance the time commitment for your child's services with your job and other family commitments.	12%
The services did not seem to be working.	26%
Other (please specify).	48%

To summarize, nearly half of community-based caregivers encountered challenges continuing services. Of those who encountered challenges continuing services:

- 45% of community-based caregivers reported difficulties reaching the people necessary to continue services.

- A quarter of community-based caregivers reported difficulties continuing services because they did not feel like the services were a good fit for their youth.
- A quarter of community-based caregivers felt that selected services did not seem to be working.

Community-based caregivers felt that wait times made it difficult to start services; however, considerably fewer community-based caregivers indicated that wait times made it difficult to continue services after they were initiated. Interestingly, few community-based caregivers also indicated that transportation, technology, cost, and age-appropriateness were barriers to starting or continuing services in 2022. Community-based case series participants echoed these experiences.

Qualitative analysis of the write-ins for barriers to continuing services revealed similar themes around communication, decision making, and service availability and accessibility. Additionally, community-based caregivers reported that youth engagement can present as a significant barrier to continuing services (Appendix C, Continuing Service Barriers, Table 5.2). Similar themes emerged when caregivers were asked if there was anything else they wanted to share about their experiences continuing services (Appendix C, Continuing Service Barriers, Table 5.4). Communication-related barriers reported by community-based caregivers:

- Lack of provider responsiveness.
- Wanting to know more about the care plan.
- Wanting an advocate/system navigator to answer questions.
- Barriers related to service availability, as reported by community-based caregivers:
 - Needing flexible appointment times.
 - Wanting more and regular updates from providers.
 - Wanting to know what services were available, even if they were not nearby.
 - Wanting more services that can be delivered online.

Some caregivers also mentioned disagreeing with providers on youth needs or level of services needed, and some found it difficult to get/keep their youth engaged. Lack of provider responsiveness was the most cited barrier to continuing services by community-based youth (Appendix D, Continuing Service Barriers, Table 5.3).

5.2.6 Services That Were Perceived to be Needed but Not Available

Community-based caregivers and youth reported that there were services that were needed but that they perceived were not available at the time of data collection.

- 31% of community-based caregivers and 20% of community-based youth reported that there were services that youth needed that were perceived as not available at the time of data collection (Appendix C, Starting Service Barriers, Table 4.4; Appendix D, Starting Service Barriers, Table 4.4).

- Community-based caregivers and youth expressed the need for more behavioral health services (e.g., counseling, therapy, medication management) as well as services designed to assist youth with enhancing their social skills (e.g., programs that provide mentorship or peer interaction opportunities).
- Additional services mentioned by community-based caregivers included more community resources/local providers, family services, improved residential services and discharge planning, school-based interventions, and specialized programs focusing on substance use.

Additional themes that emerged during community-based case series interviews with caregivers included:

- The need for more information about early detection, prevention, and intervention.
 - Most community-based caregivers expressed interest in learning more about preventing, mitigating, and de-escalating crisis situations involving their youth.
 - Community-based caregivers who are fostering or in the process of adopting youth mentioned that it would be helpful if assessments were conducted earlier on, to help them get a better sense of youths' history and needs.
- The need for more services and resources.
 - Community-based caregivers noted that in-home and in-school services could be more consistent, intensive, and individualized.
 - Several community-based caregivers expressed interest in information, training, and support groups to effectively meet their youths' needs at home.

Many of these services and supports were in fact available in the community at the time of data collection, and the State is working to identify ways to increase awareness of them.

The surveys also asked what barriers were impacting access to services that were perceived as needed but not available. Table 8 provides a breakdown of the percentage of community-based caregivers who experienced specific barriers when trying to obtain services that were perceived as needed but not available. The number of caregivers included in Table 8 represents the number of community-based caregivers who responded "Yes" to perceiving that there were mental and behavioral health services that youth needed but were not available (n=53), which was used to calculate the percentages; there were too few youth survey responses to include in the table.

Table 8: Barriers Preventing Youth from Getting Needed Services That Were Not Available

Barriers to Accessing Needed Services	Community-Based Caregivers in 2022
	n=53
The people you needed to contact to start services were unavailable, unresponsive, or too busy.	23%
The system was too complicated.	15%
You didn't understand what you needed to do.	11%
Meetings where things were decided about your child's care were at times that you could not make.	6%
Meetings where things were decided about your child's care were at a location that you could not get to.	4%
Meetings where things were decided about your child's care used technology that you do not have or know how to use.	0%
None of the programs chosen for your child were a good fit for your child and/or your family.	23%
You couldn't afford the services needed.	6%
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.	23%
The services that were chosen for my child were no longer available in my area.	30%
The services that were chosen for my child were no longer available at times when I could join.	4%
The services that were chosen for your child were for a different age group.	8%
You or your child did not have a way to get to and from the services that were chosen for them.	2%
Other (please specify).	38%

To summarize, the top barriers to accessing services that were needed but were perceived as unavailable were as follows:

- Community-based caregivers were unable to reach the people who can initiate mental and behavioral health services for youth. It could be that caregivers interpreted lack of provider responsiveness as lack of service availability.
- Community-based caregivers reported challenges with access because the selected services were not available in their area. Similarly, community-based caregivers did not feel that the selected programs were a good fit for their youth.
- Community-based caregivers reported long wait times between when services were selected for their youth and when they were able to start receiving the services. However, DHHR monitors administrative data that indicates that few community-based services have long wait times. One explanation is that caregivers are not aware of administrative processes, including confirmation of youth eligibility for services, that can affect the timing of service initiation. Probes have been added to the case series interviews to try to gain additional insights.

Community-based caregivers also wrote-in “other” reasons that prevented youth from getting needed services, including:

- Restrictive eligibility criteria.
- Provider turnover.
- Youths’ behavioral issues and/or a lack of engagement
- Insurance and cost.

Community-based caregivers were fairly optimistic about accessing services 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:

- Community-based caregivers agreed (3.7) 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).
- Community-based caregivers agreed (3.6) that the mental and behavioral health services that youth need will continue to be available to them (Appendix C, Future Service Needs, Table 7.2).

It is worth noting that a few community-based caregivers voiced concerns about service availability and accessibility as youth transition into adulthood. During case series interviews, community-based caregivers were concerned about the impact of having few structures and supports (e.g., State involvement) that they felt have helped encourage youth participation and engagement in mental and behavioral health services in the past.

- One caregiver relayed that she was “definitely” confident in services “up until [youth is] 18, yeah. But then he’s off probation [and] free to be able to contact bio family and stuff. So from between now and 18, I feel confident. After that, you know I have a lot of concerns,” (Caregiver).

5.2.7 Comparisons to Youth in RMHT and their Caregivers

Similar barriers to accessing services were reported across RMHT and community-based service settings (see more below).

A smaller percentage of community-based caregivers and youth perceived that youth needed additional services that were not available at the time of data collection, compared to the residential samples. Otherwise, there was a considerable amount of alignment in caregivers and youth reported perspectives on starting and continuing services across RMHT and community-based service settings.

- Caregivers and youth agreed that Behavioral Support Services (including PBS) and Wraparound were the most used community-based services; few youth 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 of data collection.
- Long wait times emerged as a barrier to accessing services, but fewer community-based caregivers felt that wait times affected their youth's continued use once services were initiated. Moreover, few youth were waiting for additional services at the time of data collection.
- Caregivers and youth viewed RMHT as the right fit when youth have needs that were particularly complex and required higher-intensity services that they did not feel are available in the community.
- Caregivers felt that eligibility criteria were sometimes too restrictive and resulted in youth not being able to access needed services.
- Caregivers and youth expressed the need for more and varied types of community-based therapy for youth and their families.
- Caregivers and youth desired more and higher quality communication with providers. Caregivers and youth attributed this in part to provider turnover which also affected continuity of care.
- Caregivers would like additional assistance with navigating the system.
- Caregivers viewed the juvenile justice system as a point of entry into the mental and behavioral health system. Caregivers in the community went on to explain that court involvement will often times incentivize youth who otherwise seemed reluctant to start services and/or who were unsure about the benefits of mental and behavioral health services. Youth engaged once they were more familiar with their needs and how mental and behavioral health services can help meet them.
- Caregivers agreed that they know who to contact if youth need services again in the future, even though they have had some challenges in the past.
- Transportation, technology, cost, and age-appropriateness were not perceived to be barriers to starting or continuing services in recent years. However, community-based

caregivers did cite issues with insurance and cost as prohibitive to accessing additional services they perceived to be needed but not available at the time of data collection.

5.2.8 Recommendations

Recommendations outlined in the July 2023 Evaluation Report were to continue to develop methods to ensure that services are the best fit for youths' needs and strengths, and to continue to expand the number and types of providers such as Wraparound facilitators who can help caregivers and youth navigate the mental and behavioral health system. The recommendation to continue to promote 844-HELP4WV is also relevant here. The Children's Crisis and Referral Line is well-suited to help meet community-based caregivers' desire for earlier and ongoing assessments, to help find services in their area that are a good fit for their youth, to get help with de-escalating crisis situations involving their youth, and to obtain more information about things caregivers can be doing to help keep their youth at home when possible. Additional recommendations focused on themes observed across RMHT and community-based care settings:

Recommendation: Continue to explore how youth gain access to the continuum of mental and behavioral health services available in the system. Caregivers described involvement by the State and the juvenile justice system as helpful in facilitating access to more intensive services. Granted, DHHR promotes a "no wrong door" approach to entry into the mental and behavioral health system. That said, it is preferable for youth to gain access to mental and behavioral health services without court involvement, when possible. At least those who gained entry into the mental and behavioral health system through the juvenile justice system felt that the ends justified the means because youth were able to get the services they needed and showed marked improvements because of it.

Recommendation: When possible, include service descriptions and/or the name specific mental and behavioral health interventions in outreach materials targeting caregivers and youth. Doing so should increase awareness of services and supports that are available in the community but were perceived as lacking.

One additional recommendation emerged from data reported by community-based caregivers and youth.

Recommendation: Continue to increase awareness of services that can help youth transition into adulthood. Caregivers anticipated that youth would continue to need long-term mental and behavioral health services but were uncertain about what would continue to be available to them in the future.

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

This section presents results 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 G.

5.3.1 Summary

Forty percent of organizations reported having waitlists in 2022. The greatest percentage of organizations with waitlists in 2022 were those that offered RMHT (67%) and CSED Waiver Wraparound (57%). Region 5 had the smallest percentage of organizations with waitlists in 2021 but the greatest percentage of organizations with waitlists in 2022.

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

5.3.2 Statewide Survey Findings on Waitlists

Statewide, 40% of organizations across the mental and behavioral health system reported having waitlists in 2022. As described in the 2023 July Evaluation Report, RMHTFs had the greatest percentage with waitlists in 2022 (67%), followed by organizations that offer CSED Waiver Wraparound. The smallest percentage of community-based organizations with waitlists in 2022 were those that offered Children’s Mobile Crisis Response and Stabilization and/or WV Children’s Mental Health Wraparound (Appendix E, Community-Based Organizations, Table 5.1). It was expected that Children’s Mobile Crisis Response and Stabilization would not have waitlists given that it is designed to provide immediate support, especially to those who call in to 844-HELP4WV and urgently need mental and behavioral health services. It is also encouraging that there was no wait for WV Children’s Mental Health Wraparound given that it provides interim or long-term services for youth waiting for an eligibility determination or were determined to be ineligible for the CSED Waiver (and/or CSED Waiver Wraparound).

5.3.3 Wait Times

As mentioned in the July 2023 Evaluation Report, perceptions of wait times were mixed. For example, 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:

- Community-based caregivers neither agreed nor disagreed (3.2) that their youth was able to get mental and behavioral health services without having to wait too long (Appendix C, Crisis Support and Access, Table 2.2).
- There were 17 community-based youth who responded to this survey item; data were trending toward neither agreeing nor disagreeing that they were able to get mental and behavioral health services without having to wait too long (3.5; Appendix D, Experiences with Mental Health, Table 2.1).

Relatedly, some caregivers and youth reported that wait times made it difficult for youth to start and/or continue using services, and this finding was consistent across contexts (see Section 5.2 for more details); however, findings from the surveys and interviews indicated that few youth were waiting for services at the time of data collection. In Round 1 of the community-based case series, caregivers spoke to past issues with access and timeliness but were not experiencing any current issues with wait times for services.

When asked to reflect over the next 12 months, community-based caregivers neither agreed nor disagreed that their youth will be able to access services in a timely manner in the future. 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:

- Community-based caregivers neither agreed nor disagreed (3.5) that their youth will be able to access services in the future without having to wait too long (Appendix C, Future Service Needs, Table 7.2).

Next year's report will be able to provide greater insights into trends over time.

5.3.4 Comparison to Youth in RMHT and their Caregivers

Caregivers and youth reported previous challenges with waitlists, but few were experiencing difficulties with wait times at the time of data collection. Caregivers neither agreed nor disagreed that their youth would be able to access services in the future “without having to wait too long” and these findings were consistent across RMHT and community-based service settings.

5.3.5 Recommendations

The recommendation provided in the July 2023 Evaluation Report was to reduce the number of organizations with waitlists, particularly in Region 5. Additional recommendations about service availability and accessibility are included in other sections of this report.

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 G.

5.4.1 Summary

Several data sources provided evidence that few community-based youth are calling the police or going to hospital emergency departments (EDs) to access mental and behavioral health support. **Community-based caregivers were also confident that their youth would be able to access mental and behavioral health services outside of a hospital setting if they are needed again in the future.**

Few community-based caregivers or community-based youth called the police during a mental or behavioral health emergency. In fact, community-based caregivers 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. A similar percentage of community-based youth self-reported calling the police or social services for help.

DHHR reported an increase in the use of the Children’s Crisis and Referral Line over time. Further analysis of caller data indicated that recidivism is low; 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.

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

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 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. As detailed in the July 2023 Evaluation Report, syndromic data suggested an overall decline in ED visits for mental or behavioral health-related reasons between 2019 and 2022. 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 continue to decline in response. Thus, data will continue to be monitored and these analyses will be included in future reports.

Survey findings also indicated that few community-based youth visited the ED to access mental and behavioral health services in the 12 months prior to data collection.

- According to community-based caregivers, 13% of their youth visited the ED to access mental and behavioral health services (Appendix C, Crisis Support and Access, Table 2.1).
- Similarly, 14% of community-based youth self-reported that they visited the ED to access mental and behavioral health services (Appendix D, Experiences with Mental Health, Table 2.5).

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), community-based caregivers agreed (3.7) that they would be able to get mental and behavioral health services for their youth outside of a hospital setting, if services are needed again in the future (Appendix C, Future Service Needs, Table 7.2). There were not enough youth responses to this survey item to include in this section of the report.

5.4.3 Involving Law Enforcement During Mental and Behavioral Health Emergencies

Survey findings indicated that few community-based caregivers or youth called the police for a mental and behavioral health emergency. When asked to reflect over the last 12 months:

- 9% of community-based caregivers called the police for help with a mental and behavioral health emergency involving their youth (Appendix C, Crisis Support and Access, Table 2.1).
- 4% of community-based youth reported that they called the police for help with a mental health emergency (Appendix D, Experiences with Mental Health, Table 2.5).

There were two write-in responses from youth describing the most recent time they contacted the police for help with a mental or behavioral health emergency. Precipitating factors mentioned in these responses included having an adverse reaction to medication and experiencing feelings of extreme anger.

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

As mentioned, the Children's Crisis and Referral Line is set up to serve as an access point to services for caregivers and families. The January 2023 DHHR Semi-Annual Report indicated that calls to 844-HELP4WV significantly increased between 2021 and 2022, with more calls occurring in the last part of 2022 than in all of 2021. Further analysis of the caller data indicated that approximately 8% were 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 (see the July 2023 Evaluation Report for additional details).

Few community-based 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. For example, 5% of community-based caregivers and 4% of community-based youth reported that they called to have a mobile crisis team come to the youth’s home or school (Appendix C, Crisis Support and Access, Table 2.1; Appendix D, Experiences with Mental Health, Table 2.5). It could be that few community-based youth and families are experiencing mental or behavioral health crises; it could also be that they are unsure what resources to access to help de-escalate crisis situations. For example, some community-based caregivers who participated in the case series interviews mentioned wanting more training and resources on how to prevent, mitigate, and de-escalate crisis situations. Two also mentioned past difficulties with accessing crisis services at home or in schools; in these instances, interviewers provided caregivers with information about 844-HELP4WV.

5.4.5 Use of Social Services

Community-based caregivers 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. A similar percentage of community-based youth reported calling the police and calling social services in the 12 months prior to data collection.

- 21% of community-based caregivers called social services or another support service for mental and behavioral health help for their youth (Appendix C, Crisis Support and Access, Table 2.1).
- 14% of community-based youth 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 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 EPSDT 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. As indicated in the July 2023 Evaluation Report, none of the organizations that offered Children’s Mobile Crisis and Stabilization and/or CSED Waiver Mobile Response reported using the EPSDT in 2022; however, the training took place during the data collection period, so changes might not be detectable until the next wave of data collection.

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

Many providers reported offering crisis response and stabilization services as part of their delivery of care to youth with mental and behavioral health needs, but many also expressed interest in additional trainings in these topics (please see the July 2023 Evaluation Report for more details). Overall, 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 Comparisons to Youth in RMHT and their Caregivers

Fewer community-based youth went to the ED to access mental and behavioral health services than youth in RMHT in 2022. Caregivers agreed that their youth would be able to access mental and behavioral health services outside of a hospital setting if services are needed again in the future, and this finding was consistent across RMHT and community-based service settings.

Fewer community-based caregivers reported calling the police during mental and behavioral health crises involving their youth than caregivers of youth in RMHT in 2022. Fewer community-based caregivers and youth also reported calling social services or other support services for help than the residential samples. Probes are being added to case series interview guides so that these differences can be explored in greater detail in next year's report.

5.4.9 Recommendations

The recommendation included in the July 2023 Evaluation Report was to 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. Doing so 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 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 G.

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. Approximately half of all organizations reported having adequate staff, and 71% indicated that they have the staff with the necessary training and skills to provide mental and behavioral health care to youth. Many organizations reported issues with capacity, but these findings varied by service and region.

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. Organizations have also implemented staffing models that can help with capacity.

- 52% of community-based organizations contracted with outside health providers in 2022, compared to 58% of all organizations in 2022 (Appendix E, Workforce & Capacity, Table 3.1).
- 29% of community-based organizations had joint staffing arrangements in 2022, compared to 31% of all organizations in 2022 (Appendix E, Supervision Staffing, Table 2.1).
- 32% of community-based organizations had joint supervision arrangements in 2022, compared to 37% of all organizations in 2022 (Appendix E, Supervision Staffing, Table 2.1).

More than half of all organizations across the mental and behavioral health system reported having adequate staff and having the staff with the necessary training and skills to provide youth mental and behavioral health services.

- 55% of community-based organizations adequate staff in 2022, compared to 62% of all organizations in 2022 (Appendix E, Workforce & Capacity, Table 3.1).
- 71% of community-based organizations agreed that they have staff with the necessary training and skills to serve all of the youth who needed services in 2022, compared to 73% of all organizations in 2022 (Appendix E, Workforce & Capacity, Table 3.1).

When asked about challenges with hiring and retention in 2022, 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 the 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. Please see the July 2023 Evaluation Report for additional strategies implemented by organizations to maximize their capacity to provide mental and behavioral health services to WV youth.

Organizations reported some challenges with capacity in 2022, even with expansions made to the workforce. In fact, a third of community-based organizations (33%) reported having the capacity to serve the youth receiving referrals to obtain mental and behavioral health services in 2022 (Appendix E, Workforce & Capacity, Table 3.1). Several organizations noted that they lacked capacity because youth needed services that they did not offer, the salary ranges in WV, lack of workforce in general, and lack of qualified providers and staff; for more information, please see the July 2023 Evaluation Report.

6.1.3 Workforce Capacity by Service

This section provides additional comparisons of community-based organizations to RMHTFs. Organizations were asked 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.

Statewide, a greater percentage of RMHTFs reported having adequate staff to support all of the youth who need services than community-based organizations. However, the greatest percentage that reported having staff with the necessary training and skills to provide youth mental and behavioral health services were organizations that offered Children's Mobile Crisis Response and Stabilization. With regard to capacity, a greater percentage of community-based organizations reported the ability to serve all of the youth being referred to them when compared to RMHTFs. It is also worth noting, though, that all of these findings varied by region, and additional details about service-specific challenges with workforce and mitigation strategies can be found in the July 2023 Evaluation Report; the next wave of data collection is currently underway and new findings will be included in next year's report.

6.1.4 Case Series Participants' Perceptions of Workforce Capacity

During case series interviews, community-based caregivers reported experiencing difficulties with workforce shortages, provider turnover, and provider specialization in the past but were not experiencing any current challenges. Notably, community-based caregivers tended to attribute their levels of engagement and satisfaction directly to workforce capacity (see Section 8 for additional details).

6.1.5 Recommendations

The recommendation included in the July 2023 Evaluation Report was to continue to develop strategies that facilitate partnerships between stakeholders 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 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 G.

7.1.1 Summary

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

7.2 Finding: Stakeholder communication varies over time and by stakeholder

This section will present results 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 G.

7.2.1 Summary

Please see the July 2023 Evaluation Report for the most recent findings that address these evaluation questions. These evaluation questions will be addressed again in next year's report.

7.3 Finding: Referral pathways changed across the system over time

This section will present results 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 G.

7.3.1 Summary

The Assessment Pathway helps streamline referrals to mental and behavioral health services. Implementation began after baseline data collection tools were developed. Changes have been made to the Organization and Facility Survey, and questions about the Assessment Pathway have been added the discussion topics for focus groups and interviews with system-level stakeholders and providers during this year's data collection.

Caregivers and providers agreed that there is room for improvement in policies and procedures for following up after youth receive referrals.

7.3.2 Statewide Referral Pathways

Implementation of the Assessment Pathway began in 2021, which might explain why changes in referral pathways were observed between 2021 and 2022 data collection periods (see the July 2023 Evaluation Report for more details). For example, it is possible that organizations are referring caregivers and youth to the Assessment Pathway and/or the CCRL rather than to other types of provider organizations. It is also possible that the change in sampling strategies that resulted in fewer surveys from organizations in 2022 might have contributed to some of the observed changes in referral pathways compared to reports in 2021. Updates have been made to data collection tools to ask about the Assessment Pathway specifically, and to continue to capture nuanced trends and changes in referral processes and pathways.

7.3.3 Following Up After Referrals Are Made

There are some opportunities to increase provider and organizational awareness of DHHR-preferred policies and procedures for following up after youth receive referrals for mental and

behavioral health services. Providers neither agreed nor disagreed that there are clear policies and procedures for following up after youth are referred to RMHT. Similarly, providers indicated in the 2021 and 2022 surveys that there is room for greater clarity in their policies for following up with youth or their families after a referral to community-based mental and behavioral health services has been made.

It is important to follow up after referrals have been made to help ensure that youth are able to access needed services. For example, findings from the surveys and case series interviews indicate that some community-based youth received referrals for services that lacked the capacity to serve youth. In some cases, caregivers were able to get additional referrals, but they felt that referrals for youth with intensive needs “snowballed” as they continued to seek out services that they felt were the right fit.

7.3.4 Recommendations

The recommendations outlined in the July 2023 Evaluation Report were to expand and/or reinforce policies for making and following up on referrals, and to continue to explore ways to strengthen referral pathways with the Children’s Crisis and Referral Line.

8 Evaluation Results: Caregiver and Youth Experiences with Services and Discharge Planning

8.1 Finding: Caregivers and their youth generally reported moderate to high levels of engagement, but also expressed the desire for greater involvement

This section will present results 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 G.

8.1.1 Summary

Most community-based caregivers and youth reported moderate to high levels of engagement in mental health treatment services. They also noticed and appreciated when providers valued and prioritized family engagement.

A reciprocal relationship between youth and caregivers was observed in the community-based sample related to their engagement. Engagement was described as mutually enhancing, such that the more caregivers were involved, the more youth engaged, and the more youth engaged the more caregivers engaged. Community-based case series interviews revealed the following factors related to engagement: communication with the care team, feeling like a valued member of the care team, staffing and turnover, and service availability. Community-based caregivers also valued advocates such as probation officers, attorneys, and CSED Waiver and Wraparound providers who they felt championed for their youth and helped them navigate the system.

Community-based caregivers and youth who had prior experiences with RMHT described two major contributors to successful transitions home: caregiver involvement in discharge planning and access to an array of community-based mental and behavioral health services and social supports. Specific services and supports they found particularly helpful included individual and family therapy, psychiatric services, sports, church, and assistance with obtaining vocational training and other job and life skills that can help youth transition into adulthood.

8.1.2 Provider Perceptions of Family Engagement

Providers indicated that they value family and caregiver involvement in youth's treatment. Providers somewhat agreed that they maintain regular communication with caregivers about their youth's progress/status as part of their delivery of services. The July 2023 Evaluation Report contains additional provider perspectives on communication and engagement with caregivers and youth.

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 can be seen in Table 9, **most community-based caregivers reported moderate to high levels of participation in the treatment of their youth.**

Table 9: Community-Based Caregiver Treatment Participation Scale Findings

Score	Community-Based Caregivers (n=68)
Low	10%
Moderate	52%
High	38%

During Round 1 of the community-based case series interviews, caregivers expressed how much they appreciated communication with their youths' care teams. They also wanted even more involvement, and expressed the importance of feeling like their expertise, opinions, and preferences are considered during decisions about their youth's care. This was true for families accessing community-based treatment as well as those who had a history of previous RMHT. Caregivers of youth with a history of out-of-home placement wanted to be invited to multi-disciplinary team meetings and asked for their input on their youth's care. Probation officers, DHHR workers, and other types of providers were mentioned as frequently keeping caregivers informed of youth progress during placement. Still, caregivers desired more engagement from DHHR and treatment teams. Families who primarily accessed community-based services discussed therapists and other providers who included them in their youth's care. This ranged from updating the caregiver of the youth's progress to individual meetings with the caregiver where they could provide input. Some mentioned that their youth's therapists would provide the caregiver with skills and resources for supporting their youth, their families, and themselves. Caregivers of community-based youth frequently advocated to work with providers who would include and listen to them, which led to greater engagement and satisfaction.

8.1.4 Service-Specific Engagement with Caregivers

Caregivers' perceived involvement, inclusion, and agreement with treatment goals for mental and behavioral health services varied by service. The survey captured whether caregivers perceived that they were included in creating care plans for youth who received Assertive Community Treatment, Behavioral support Services (including PBS), Wraparound, and/or RMHT in the last 12 months. Due to low utilization of Assertive Community Treatment, only findings for Wraparound, Behavioral support Services (including PBS), and RMHT are reported here. Level of agreement with the treatment goals set for each service were captured on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

8.1.4.1 Wraparound

Community-based caregivers felt included in the creation of care plans for Wraparound and agreed with the treatment goals set for their youth.

- Community-based caregivers agreed (4.1) that they helped create care plans for their youth who received CMHW (Appendix C, Experiences w Mental Health Ser, Table 3.6).
- Community-based caregivers agreed (4.2) with the treatment goals set for their youth who received CMHW (Appendix C, Experiences w Mental Health Ser, Table 3.6).

8.1.4.2 Behavioral Support Services (including PBS)

Community-based caregivers neither agreed nor disagreed that they were involved in the creation of care plans for Behavioral Support Services (including PBS), and neither agreed nor disagreed with the treatment goals set for their youth.

- Community-based caregivers neither agreed nor disagreed (3.3) that they helped create care plans for their youth who received Behavioral Support Services (including PBS; Appendix C, Experiences w Mental Health Ser, Table 3.4).
- Community-based caregivers neither agreed nor disagreed (3.5) with the treatment goals set for their youth who received Behavioral Support Services (including PBS; Appendix C, Experiences w Mental Health Ser, Table 3.4).

8.1.4.3 Residential Mental Health Treatment (RMHT)

Caregivers represented 29 community-based youth who received RMHT in the 12 months prior to data collection (17%). Community-based caregivers neither agreed nor disagreed that they were included in creating plans of care but agreed with the treatment goals set for RMHT; however, these findings should be interpreted with caution given the number of valid responses to these survey items (n=29).

- Community-based caregivers neither agreed nor disagreed (3.2) that they were included when creating a care plan for RMHT (Appendix C, Experiences w Mental Health Ser, Table 3.5).
- Community-based caregivers agreed (3.6) with the treatment goals for RMHT (Appendix C, Experiences w Mental Health Ser, Table 3.5).

8.1.5 Youth Engagement in Treatment

Survey findings indicate that overall, community-based youth felt engaged in their treatment. Youth were asked to rate their level of agreement to a series of related statements on scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

- Community-based youth neither agreed nor disagreed that they helped choose their mental and behavioral health services (3.4; Appendix D, Experiences with Mental Health, Table 2.2)
- Community-based youth agreed that they helped choose their treatment goals (3.9; Appendix D, Experiences with Mental Health, Table 2.2).
- Community-based youth agreed that they participated in their own treatment (4.1; Appendix D, Experiences with Mental Health, Table 2.2).

More data are needed to help reconcile these self-reports, given that caregivers and youth described engagement as a barrier. It could be that caregivers and youth are recalling previous issues with engagement that they are no longer experiencing. It could also be the case that the youth who completed surveys are not the ones who had/are having challenges with engagement.

8.1.6 Caregiver and Youth Treatment Engagement and Respect Scale Findings

Feeling heard and respected by members of their care team contributes to service engagement. As displayed in Table 10, community-based caregivers felt like provider staff treated them with respect and generally engaged them in care delivery.

Table 10: Community-Based Caregiver Treatment Engagement and Respect Scale Findings

Score	Community-Based Caregivers (n=61)
Low	7%
Moderate	48%
High	46%

Respect and trust were highly valued by community-based caregivers. During case series interviews, caregivers expressed the importance of being able to provide insights into their youths' needs and care. They also wanted to avoid being viewed as "bad parents."

Half of the community-based youth who responded to this scale experienced moderate and half experienced high levels of treatment engagement and respect; importantly, no youth who responded to these survey items fell within the low end of the Treatment Engagement and Respect Scale, although these findings should be interpreted with caution given the number of valid responses to these survey items (n=18).

8.1.7 Opportunities to Enhance Caregiver and Youth Engagement

Caregivers and youth provided a great deal of information about service engagement in Round 1 of the community-based case series interviews. Many of the barriers to starting and continuing services (as reported in Section 5.2) such as lack of communication with providers, service availability, and lack of youth participation in treatment were also reported to affect engagement. Community-based caregivers also wanted trainings or other resources that better prepared them to help meet their youths' needs.

While community-based caregivers and youth expressed moderate to high engagement, they still desired more. Caregivers in particular discussed facilitators, preferences, and priorities related to engagement in their youth's treatment. Table 11 displays the facilitators and preferences caregivers mentioned when asked about factors that could or did increase engagement.

Table 11: Facilitators and Preferences for Engagement Reported by Caregivers in Case Series Interviews

Facilitators	Description	Example Quotations
Quality communication with providers*	Caregivers wanted to be able to contribute as a substantive member of the care team.	<ul style="list-style-type: none"> ▪ “The new social worker [was] absolutely great, [and] came to the house [for] home visits... She just made sure that we knew the meeting times, [and] was just very, very open with what was going on, and how she felt with what should be happening... So she just really, really involved me and his father in everything.” (Caregiver) ▪ “Both [community-based providers] are good listeners...They hear me as a parent [and] they trust me when I say, this is what I'm seeing, this is what's happening. And so yeah, I'm very involved [and] being listened to, and being trusted as his parent.” (Caregiver) ▪ “Communication is the bottom line of everything. With [providers], with [youth]. You know, understanding how I can articulate things I need to say or think, or do. As a family, as a single [mother]... [a WV therapist] was really awesome. She listened to everything I needed to say. You know, whatever I wanted to talk about, [and] any kind of pointers or strategies for stuff she was really good about.” (Caregiver)
Support from juvenile justice partners	Caregivers reported that juvenile justice partners helped facilitate access to youth services and resources.	<ul style="list-style-type: none"> ▪ “Everything went through our local judge for like for final approval of what we come up with as a team. And he was wonderful! He was very helpful. He listened and cared about our concerns and our thoughts and not just the professionals’...Our best contact was her probation officer.” (Caregiver) ▪ “We knew if we called the probation officer, she could get us what we needed...She had connections with social workers, police courts, everything so, and she knew at the facilities where he was, she knew what was going on with that. So, she was kind of our go to.” (Caregiver) ▪ “They finally appointed me another lawyer, who gave me the skills and tools, and sent [and] directed me everywhere I had to go [and] everything I had to do...[Lawyer] guided me if I had questions...If it wasn't for my attorney at the time, I wouldn't [have gotten] through a whole lot.” (Caregiver)

<p>Caregiver advocacy and agency</p>	<p>Several caregivers employed their own advocacy and felt that they had the agency to speak up when needed.</p>	<ul style="list-style-type: none"> ▪ "Other than just being me [and] being outspoken and letting them know that I will be a part of it...I feel like it's maybe a little better. But I think that's because I speak my mind, and I don't just agree, and that I advocate for my child more. (Caregiver) ▪ "I'm proactive. I go out there, and I look for [services]. I have no qualms with changing doctors [who] won't listen to me. I come from a history myself, [and], and we've learned things over the years, and I will not work with someone that won't trust me as a parent. I know what [I'm] talking about... If there was a problem, I always went out looking... I have a lot of friends and stuff, and they've struggled with getting the services. But like I said, I'm proactive. I go out there, and I look for it. But sometimes people don't know what's all out there. They don't know what they could be getting for their kids." (Caregiver) ▪ "I had to call supervisors and managers in [WV city] over top of everyone, because of no one ever getting back to me or authorizing, or even just communicating with me. So I had to like, be a jerk a few times." (Caregiver) ▪ "[I] had to research and do homework because I've done online classes, too, for parenting, and [a] whole course...because no one was getting me set up with anything quick enough, [but] either way it was still beneficial." (Caregiver)
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*These experiences were reflected in survey data when caregivers and youth were asked about barriers to starting and continuing services (see Section 5.2 for additional details).

8.1.8 Improvements in Engagement Over Time

Several community-based youth indicated that mental and behavioral health stigma contributed to their initial uncertainties about getting diagnosed and/or initiating services. Exposure to the mental and behavioral health system helped with de-stigmatization by increasing their understanding of their needs and how services are designed to meet them.

8.1.9 Involvement in Decisions to Change Youth's Level of Care and Discharge Planning

Caregivers represented 29 community-based youth who received RMHT in the 12 months prior to data collection. There were only 12 community-based youth who indicated in the surveys that they received RMHT in the 12 months prior to data collection, 11 of whom responded to items about discharge planning. Community-based caregivers and youth indicated that they neither agreed nor disagreed that they were included in planning for changes in youths' care or in planning for discharge from RMHT, although these findings should be interpreted with caution given the number of valid responses to these survey items (Appendix C, Experiences w Mental Health Ser, Table 3.5; Appendix D, Experiences with Mental Health, Table 2.4).

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. Policy-related changes in provider behavior were reported in the July 2023 Evaluation Report and will be included again in next year's report.

8.1.11 Case Series Participants' Experiences with Discharge Planning and Transitioning Youth Back into Their Communities

Community-based case series participants who had past experiences with RMHT discussed facilitators that helped transition youth back to their homes and communities such as:

- Caregiver involvement in discharge planning.
 - Community-based caregivers wanted to make sure it was safe to keep or transition their youth back home. Several caregivers recounted negative past experiences where youth were prematurely discharged from RMHT while still exhibiting visible and intensive mental and behavioral health needs.
- Prearranged community-based services that reduced or eliminated gaps in care upon discharge from RMHT.
 - Transition services that helped sustain the benefits gained in RMHT included but were not limited to community-based therapies, psychiatric care, Wraparound, and CSED Wavier services.

- Structured supports from the State.
- One youth explained that “probation is good, [and] I’m not really struggling like I was...Being in probation, I can’t fight, [and] it honestly does help. There have been times I wanted to fight. But I’m like, you can’t do that. You want to be home.”
- Youth with higher intensity needs responded well to regularly scheduled appointments that required participation, as is often characteristic of probation and RMHT.
- Structured social activities.
- Community-based caregivers indicated that ROTC, sports, church, employment, and vocational trainings offered structure and a level of commitment/obligation that youth responded well to.

8.1.12 Comparisons to Youth in RMHT and their Caregivers

A greater percentage of community-based caregivers fell within the moderate to high end of the Caregiver Treatment Participation Scale than caregivers of youth in RMHT in 2022. It is possible that community-based caregivers have more opportunities to engage in service delivery (e.g., through daily interactions, assistance with transportation to or from appointments, etc.) than caregivers of youth who have been placed outside of the home,

Caregiver involvement in developing care plans varied by service. Caregivers felt involved in creating care plans and agreed with the treatment goals set for Wraparound, and this finding was consistent across service settings. Caregivers across service settings neither agreed nor disagreed that they were involved in creating care plans for Behavioral Support Services (including PBS) or RMHT. Caregivers of youth in RMHT in 2022 agreed with the treatment goals set for Behavioral Support Services, whereas community-based caregivers agreed with the treatment goals set for RMHT.

Youth reported similar experiences with service planning across settings. Youth neither agreed nor disagreed that they helped choose their services but agreed that they helped choose their treatment goals and participated in their own treatment.

Caregivers and youth across service settings felt that staff respected them and engaged them in service delivery. Caregivers and youth also reported similar determinants of engagement across service settings. Caregivers and youth indicated that lack of communication, staff turnover, service availability, and lack of youth participation were barriers to engagement. During case series interviews, community-based youth elaborated on their lack of participation, sometimes attributing it to uncertainties about their mental and behavioral health needs. Caregivers and youth reported similar facilitators to engagement across service settings: regular and high-quality communication with the care team, shared decision-making, and assistance with navigating the system. The reciprocal relationship between youth and caregivers related to engagement occurred with youth in RMHT and their caregivers, but this theme was much more evident with community-based caregivers and youth.

Caregivers and youth valued structures and supports that were available upon discharge from RMHT, and this finding was consistent across service setting. Caregivers across settings also felt that transitions back home went smoothly when they were involved in discharge planning.

8.1.13 Recommendations

Recommendations included in the July 2023 Evaluation Report were to identify additional opportunities to engage caregivers and youth in service initiation, treatment planning, and discharge processes, to continue to examine youth living situations prior to discharge from RMHT, and to consider how to communicate screening and assessment findings to caregivers.

Recommendation: Consider ways to expand caregivers' knowledge and resources about ways they can help promote their youth's wellbeing at home.

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 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 G.

8.2.1 Summary

Most community-based caregivers reported moderate to high levels of satisfaction with services. Community-based caregivers also reported having strong natural support networks. Youth also reported high levels of satisfaction and strong natural support networks, although these findings should be interpreted with caution due to the number of valid youth responses to these survey items.

Community-based caregivers and youth reported similar determinants of satisfaction: regular and high-quality communication with the care team, engagement and involvement, continuity of care, relationships with advocates and other champions who can help navigate the system, and individualized services that can meet the unique needs of youth. Community-based caregivers indicated that it took time to find mental and behavioral health services that were the right fit for their youth but were ultimately satisfied with the care their youth were receiving at the time of data collection.

8.2.2 Satisfaction

Community-based caregivers reported moderate to high levels of satisfaction on the Access and Satisfaction Scale. Table 12 displays the percentages of community-based caregivers in the low, moderate, or high ranges of the scale.

Table 12: Community-Based Caregiver Satisfaction

Score	Community-Based Caregivers (n=66)
Low	11%
Moderate	56%
High	33%

There were 18 community-based youth responses to the Access and Satisfaction Scale in 2022. Trends in the data were similar to reports by community-based caregivers. Youth 15 years of age or older were asked to rate their level of agreement to items related to their experience with services in the last 12 months on scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). There were 18 youth who responded to these survey items and data trended toward agreement with the following:

- Community-based youth received services that were right for them (3.7).
- Community-based youth got the help they wanted (3.8).
- Community-based youth got as much help as they needed (3.9).

These experiences were echoed during community-based case series interviews with youth. However, community-based caregivers neither agreed nor disagreed to similar items in the survey (Appendix C, Experiences w Mental Health Ser, Table 3.1). Furthermore, during case series interviews community-based caregivers described previous challenges finding services that were a “good fit” for their youths’ needs with the right level of consistency, intensity, and specialization. It can take time to fully understand youths’ needs and identify the right services that can meet them, and it might also take several attempts before caregivers and youth find providers with whom they feel comfortable. Otherwise, as mentioned, community-based caregivers were generally satisfied with mental and behavioral health services their youth were receiving at the time of data collection. Determinants of satisfaction reported by community-based caregivers and youth during case series interviews are presented in Table 13. Communication continued to be a major theme.

Table 13: Barriers and Facilitators Related to Satisfaction Identified in Round 1 of Community-Based Case Series Interviews

Theme	Barriers to Satisfaction	Facilitators of Satisfaction
Communication	<ul style="list-style-type: none"> ▪ Lack of consistent communication. ▪ Caregivers not receiving updates about services, meetings, medications, and other changes. 	<ul style="list-style-type: none"> ▪ Probation officers were reportedly very communicative. ▪ Thorough and responsive DHHR case workers, therapists and providers, service staff, court agents, and other advocates within the system who communicate consistently with caregivers on the services, status, and processes impacting their youth and family.
Engagement and advocacy	<ul style="list-style-type: none"> ▪ Caregivers not feeling like a valued, trusted member of the care team. ▪ Youth hesitance or disinterest in participating in services. 	<ul style="list-style-type: none"> ▪ Participants feeling informed, included, and involved in various aspects of youth’s services; being made continually aware of resources available to them. ▪ Early, extensive evaluations of youths’ complex history and issues for caregivers to better engage with and prepare for the services needed. ▪ Providers and staff who clearly articulate and educate on youth’s needs as well as the purpose and value of services and related resources. ▪ Advocates and navigators within the system to help connect and secure the services and priorities of youth and their family across the continuum.
Access and availability	<ul style="list-style-type: none"> ▪ Difficulties accessing a community-based service, especially at higher levels of intensity and specialization. ▪ Lack of psychiatric care, evaluations, and medications, as well as therapies and facilities that can address specialized diagnoses and severe issues such as suicidal 	<ul style="list-style-type: none"> ▪ Safe at Home services were noted as exceptional in delivering therapy, being responsive to caregivers, and providing help finding and coordinating community-based resources. ▪ Access to psychiatric treatment and specialized therapy for youth and families. ▪ Access to responsive crisis and emergency services with de-escalation and mitigation expertise. ▪ In-school services.

	ideation, self-harm, and severe aggression.	<ul style="list-style-type: none">▪ Access to caregiver services and resources like education, training, and support groups to expand their knowledge and skills, including recognizing and helping to meet youths' needs at home.
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As mentioned in Section 8.1, access to a wide range of transition services for youth who were in RMHT also contributes greatly to caregiver satisfaction.

8.2.2.1 Improvements in Satisfaction Over Time

In case series interviews, community-based caregivers and youth both indicated that their satisfaction increased over time, with greater exposure to the mental and behavioral health system and the ability to get connected with case managers or other advocates and system navigators.

8.2.2.2 Satisfaction with RMHT

Most community-based case series participants reported prior placements in RMHT both in WV and out-of-state, and most were generally satisfied with the mental and behavioral health services received. Similar themes of communication, engagement, and service availability emerged from these case series interviews. Community-based caregivers also expressed the specific benefits they associated with RMHT:

- RMHT provides specialized services, providers, and staff who can meet more intensive youth needs.
- RMHTFs are a “hub” for an array of services and supports, including on-campus schools.
- RMHT staff can help manage youth’s medications.

Continuity of care was also valued by community-based caregivers and youth.

8.2.2.3 Satisfaction with DHHR

Participants in the community-based case series interviews described three major determinants of their satisfaction with DHHR: 1) developing an understanding of what it means to involve the State and the resources they can provide, 2) proactive engagement and involvement of caregivers and youth, and 3) establishing a shared understanding of youths’ needs.

8.2.2.4 Satisfaction with Community-Based Services

Case series participants were satisfied with the community-based services that their youth were receiving at the time of Round 1 data collection. In addition to communication and engagement, major contributors to satisfaction with community-based services included:

- Access to individualized therapy for youth and families.
- Resources that helped caregivers better identify and understand youths’ needs.
- Advocates and champions that demonstrated an understanding of families’ needs and preferences. Probation officers, attorneys, and CSED Waiver and Wraparound providers were specifically mentioned by community-based caregivers.

8.2.2.5 Youth Satisfaction

Youth who participated in the community-based case series interviews were generally satisfied with the services they received within the mental and behavioral health system. All youth reported liking and/or valuing their service experiences, especially with regard to therapy. Other aspects of mental and behavioral health services that contributed to satisfaction among community-based youth were:

- Individualization of services.
- Structures that helped them engage in services and that reinforce the mental and behavioral health interventions that they received.
- Assistance with medication management, when applicable.
- Job and life skills that will help them transition into adulthood.

Community-based youth reported high satisfaction with mental and behavioral health services with these features.

8.2.3 Social Support

Caregivers and youth benefit from having social networks that can support them during challenging times. **Community-based caregivers reported having strong social support systems**, as can be seen in Table 14.

Table 14: Community-Based Caregiver Social Support Scale Findings

Score	Community-Based Caregivers (n=169)
Low	6%
Moderate	27%
High	67%

There were only 18 community-based youth responses to the Social Support Scale. Trends in the data were similar to community-based caregiver responses. Community-based caregivers and youth also mentioned the importance of social supports during case series interviews, especially with regard to promoting youth functioning (see more below).

8.2.4 Comparisons to Youth in RMHT and their Caregivers

Community-based caregivers reported more satisfaction with services than caregivers of youth in RMHT. Available data suggest that community-based youth are also more satisfied than youth in RMHT.

Youth felt that they were able to get services that met their needs, and this finding was consistent across RMHT and community-based settings. They felt that they got the right kinds of help that they needed from services that were right for them. Caregivers neither agreed nor disagreed, and across service settings reported initial challenges finding services that were a good fit for their youth. Nevertheless community-based caregivers were satisfied with the services youth were receiving at home at the time of data collection.

Caregivers and youth reported similar determinants of satisfaction across RMHT and community-based service settings. Community-based caregivers were somewhat more vocal about

successful partnerships with juvenile justice, and probation officers in particular, than caregivers of youth in RMHT.

Caregivers reported high levels of social support across RMHT and community-based service settings. Similar trends emerged in the youth data, although this interpretation is made with caution due to the number of community-based youth responses to this scale.

8.2.5 Recommendations

Recommendations included in the July 2023 Evaluation Report were to continue to identify determinants of caregiver and youth satisfaction, and to encourage providers to leverage the strong social support systems reported by caregivers and youth.

9 Evaluation Results: Youth and Family Status

9.1 Finding: Mental and behavioral health services help improve youth functioning

This section will present results 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 G.

9.1.1 Summary

Overall, community-based caregivers reported moderate functioning among their youth. Data from caregivers also suggested that community-based youth who received RMHT had significantly lower functioning scores than youth with no history of RMHT.

Community-based youth self-reported slightly higher functioning than caregivers but overall, the distributions of scores were similar. Noticeable improvements after youth received mental and behavioral health services included better emotional regulation, better self-expression, and for some, fewer encounters with police and better school attendance. Structured services, continuity of care, individual and family therapy, and strong social support systems were perceived to be major contributors to youth functioning.

Medication also emerged as a theme in the survey and interview data. For example, community-based caregiver responses allowed for comparisons of the “medication group” to the “non medication group.” Caregivers of youth in the medication group reported greater use of crisis services and more out-of-home placements than caregivers of youth in the non-medication group. In the case series interviews, community-based caregivers recounted some negative past experiences with medication but were involved enough to know when these instances had occurred and spoke up to help get the issues resolved. Ultimately medications were viewed as beneficial when there was a clear indication that youth needed them, as long as the medications were treated as supplementary to and not a replacement for other types of mental and behavioral health services such as therapy and counseling.

9.1.2 Youth Functioning

A Youth Functioning Scale was developed and 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 valid tools such as the CAFAS and the CANS assessment (e.g., youth’s ability to handle daily life, how youth are doing in school or at work).

The original Caregiver Youth Functioning Scale (for caregiver-reported youth functioning) included seven survey items, and the original Youth Functioning Scale (for youth self-reports) included six items. The extra item included in the caregiver version but excluded from the youth version of the functioning scale captures whether youth are better able to follow directions on how to take their medication (see more below). Caregiver and youth responses to the survey items were captured on Likert-type scales that were anchored by 1 (Strongly Disagree) and 5 (Strongly Agree), with additional options of “I don’t know” and “Not applicable.”

Caregivers and youth who responded to all of the survey items in the scale using the 1-5 Likert-type response options were included in the main Youth Functioning Scale analyses; these are referred to as valid responses. Scores were summed across the items in the Youth Functioning Scale and were categorized as low, moderate, and high, with higher scores indicating higher functioning. Caregivers and youth who skipped items in the Youth Functioning Scale, or who selected “I don’t know” or “Not Applicable” were removed from the main analyses because the summed scores on a subset of items are not directly comparable to scores on all items. For

example, summed responses to two items using the 1-5 Likert-type agreement options would range from 0-8, whereas the original Caregiver Youth Functioning Scale ranged from 0-28 and the original Youth Functioning Scale ranged from 0-24. Table 15 describes how the original scales were scored.

Table 15: Original 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

Exploratory analyses for this report indicated that community-based caregivers responded differently to the item about medication management than caregivers of youth in the residential samples. Community-based caregivers who responded to this survey on the Likert-type agreement scales ranging from 1-5 (presumably because their youth were receiving medications; n=116) reported significantly different experiences than community-based caregivers who skipped this survey item or who selected “I don’t know” or “Not Applicable” (n=58). These results led to two findings:

- The item about medication management was not as strongly associated with and was not as strong of a predictor of youth functioning as the other items in the scale when it was administered to community-based caregivers. Therefore, the item related to medication management was ultimately dropped from the scale for the main analysis of community-based caregiver-reported youth functioning. Along with statistical justification to drop the item for medication management, doing so changed the range of the scale to 0-24, making it easier to compare functional scores reported by community-based caregivers and youth.
- Caregivers reported significant differences among youth who were and were not taking medication. For example, youth in the medication group were significantly older than youth in the non-medication group (See Section 9.1.4 and Appendix B for more details).

To gain a full picture of the youth functioning scores, data are displayed in three ways: categorically, as overall scale means, and in line graphs with trend lines. Table 16 provides the percentage of youth functioning scores that fell within the low, medium, and high ranges of the scale, as reported by all community-based caregivers and self-reported by community-based youth who responded to the survey scale items. The n’s in Table 16 represent the number of valid community-based caregiver and youth responses to the scale, which were used to calculate the percentages. As can be seen in Table 16, a greater percentage of community-based caregivers

rated their youth as low functioning, a similar percentage of scores fell within the mid-range of the scale, and a greater percentage of youth self-reported as high functioning.

Table 16: Youth Functioning Scale Results Reported by Community-Based Caregivers and Youth (All Responses)

Categorization	Caregiver-Reported Youth Functioning (n=132)	Youth Self-Reported Functioning (n=44)
Low	13%	7%
Moderate	36%	34%
High	51%	59%

Examination in the overall scale means also indicated that among all valid responses, community-based youth self-reported higher functioning (16.77 on a scale of 24) than their caregivers (15.17 on a scale of 24). Despite differences in mean scores, reports of community-based youth functioning were similarly distributed when placed on line graphs. Figure 1 displays the caregiver-reported data for community-based youth functioning for all respondents, and provides a trend line that demonstrates the overall trajectory of the data. Functioning among community-based youth varied, according to their caregivers, but many scores fell within in the upper mid-range of the scale (between 17 and 19 on a scale of 24).

Figure 1: Trends in Caregiver-Reported Youth Functioning (All Responses)

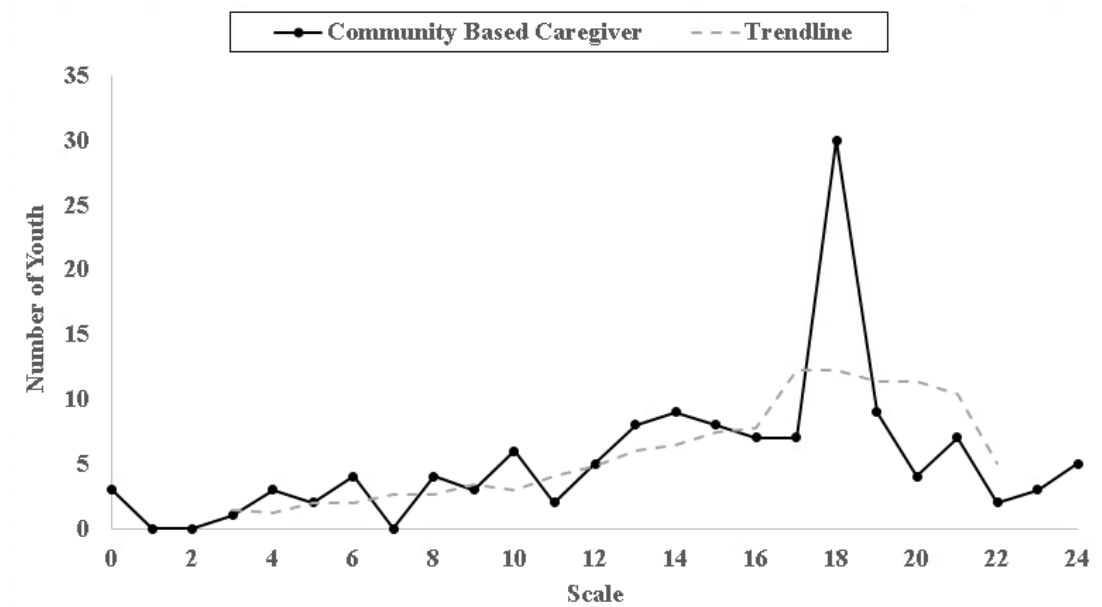
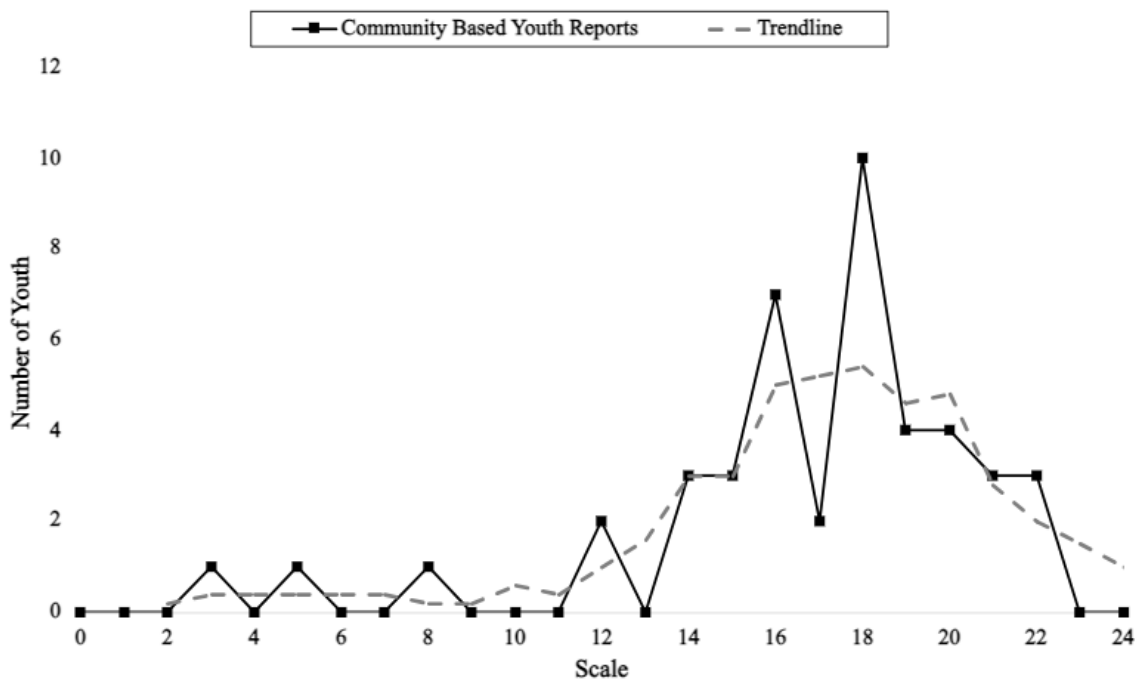


Figure 2 displays the line graph and trendline for self-reported functioning among community-based youth. While community-based youth self-reported slightly higher functioning than caregivers, overall, their scores followed similar trajectories in that many fell between 16 and 19 on the scale of 24.

Figure 2: Trends in Youth Self-Reported Functioning (All Responses)



As mentioned, some community-based youth received RMHT in the past. According to caregivers, there were 29 youth who received RMHT in the last 12 months, and an additional 12 youth who received RMHT more than 12 months ago, leading to a total of 41 youth with a history of RMHT and 91 with no history of RMHT, according to caregivers. To account for potential differences based on a history of RMHT, scale analyses were rerun using these community-based caregiver data. There were not enough community-based youth responses to rerun analyses on those data. As expected, findings indicated that functioning was significantly lower among youth with a history of RMHT (12.39 on a scale of 24) than youth without a history of RMHT (16.42 on a scale of 24). Table 17 provides the percentage of caregiver-reported youth functioning scores that fell within the low, medium, and high range of the scale for youth with and without a history of RMHT.

Table 17: Youth Functioning Scale Results Reported by Community-Based Caregivers Representing Youth With and Without a History of RMHT

Categorization	Caregiver-Reported Youth Functioning: Youth with No History of RMHT (n=91)	Caregiver-Reported Youth Functioning: Youth with a History of RMHT (n=41)
Low	5%	29%
Moderate	35%	39%
High	59%	32%

There are several evaluation questions that ask about changes in youth functioning by service. Due to low utilization of community-based services during the data collection period, there was not enough power to detect differences in youth functioning scores by service.

9.1.2.1 Discussions of Youth Functioning During Case Series Interviews

In Round 1 of the case series interviews, community-based caregivers largely agreed that mental and behavioral health services have had a positive impact on youth functioning. The following themes emerged from the interviews:

- Observable improvements as a result of receiving mental and behavioral health services included better emotional regulation, more openness and better self-expression.
- Continuity of care helped promote and sustain improvements in youth functioning, whereas lack of services and/or service disruptions led to regression.
- Structured services and activities promoted stability and helped to sustain benefits gained from mental and behavioral health services.

- Individual and family therapy, as well as strong social support systems contributed to better youth functioning.

9.1.3 Encounters with Police

Police interactions can serve as an indicator of youth functioning, including how often youth had interactions with the police and whether they were arrested or detained. As reported in Section 5.4, 9% of community-based caregivers and 4% of community-based youth reported calling the police for assistance with a mental and behavioral health emergency in the 12 months prior to data collection. 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.

- Caregivers reported that 27 of their community-based youth (16%) had encounters with police in the last 12 months, eight of whom (30%) were arrested and 9 of whom (33%) went to court because of their police encounter (Appendix C, Law Enforcement, Table 8.1).
- There were 14 community-based youth (27%) who self-reported having encounters with the police in the last 12 months, three of whom (21%) were reportedly arrested and five of whom (36%) went to court because of their police encounter (Appendix D, Health & Behavior Outcomes, Table 3.2).

Most community-based youth experienced the same amount or fewer interactions with police than in previous years (Appendix C, Law Enforcement, Table 8.1; Appendix D, Health & Behavior Outcomes, Table 3.2). Community-based caregiver- and youth-reported findings regarding police encounter frequency are displayed in Table 18 below.

Table 18: Frequency of Youth Encounters with Police

Frequency of Police Encounters	Community-Based Caregivers in 2022 (n=174)	Community-Based Youth in 2022 (n=51)
Fewer police encounters in the last 12 months than in previous years	39%	47%
The same amount of police encounters in the last 12 months than in previous years	51%	51%
More police encounters in the last 12 months than in previous years	4%	2%

Few community-based youth experienced more police encounters in the 12 months leading up to data collection than they had in previous years.

9.1.4 Activities of Daily Living

Many youth functional assessments capture activities of daily living such as school attendance and educational involvement. Nearly 40% of community-based caregivers and 22% of community-based youth noticed improvements in school attendance as a result of youth receiving mental and behavioral health services (Appendix C, Law Enforcement, Table 8.2). Changes in school attendance are reported in Table 19 below:

Table 19: Changes in School Attendance

Changes in School Attendance	Community-Based Caregivers in 2022 (n=174)	Community-Based Youth in 2022 (n=51)
Youth attended more school since starting services	39%	22%
Youth attended the same amount of school since starting services	45%	51%
Youth attended less school since starting services	8%	4%

Few community-based youth were reported to have dropped out of school. Lastly, suspensions and expulsions are a proxy for how well youth function in school settings. **Less than 20% of community-based youth were suspended in the last 12 months:**

- Caregivers reported that 17% of their community-based youth had been suspended or expelled in the last 12 months (Appendix C, Law Enforcement, Table 8.2).
- 18% of community-based youth self-reported being suspended in the last 12 months (Appendix D, Health & Behavior Outcomes, Table 3.3).

During the case series interviews, community-based caregivers and youth shared that youth were getting better grades, were bullied less and/or engaging in less bullying behaviors, were getting into fewer fights, and were better able to regulate their emotions after receiving mental and behavioral health services. Caregivers noted that some community-based youth who also had learning needs had difficulties with the transition back into public schools where they received less structured and individualized attention than they had in RMHT settings.

Lastly, medication compliance is an important indicator of daily functioning. On scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), community-based caregivers neither agreed nor disagreed (3.5) that youth have been better able to follow directions on how to take medication over the last 12 months (Appendix C, Outcomes of MH Services, Table 6.1). As mentioned above, some additional analyses were conducted comparing caregiver reports based on their response to this item about medication management. There were 116 community-based caregivers who

responded to the item about medications, which are referred to here as the *medication group*. There were 58 community-based caregivers who responded “I don’t know,” “Not Applicable,” or who skipped this question in the survey, which are referred to here as the *non-medication group*. Significant differences between the medication and non-medication groups were as follows:

- Community-based youth in the medication group were older (14.5 years old) than those in the non-medication group (11.7 years old).
- Caregivers of community-based youth in the medication group were more likely to involve the police during mental and behavioral health emergencies (93%) than caregivers of community-based youth in the non-medication group (7%).
- Caregivers of community-based youth in the medication group were more likely to involve social services (78%) than caregivers of community-based youth in the non-medication group (22%).
- Community-based youth in the medication group were more likely to visit hospital EDs for access to mental and behavioral health services (91%) than community-based youth in the non-medication group (9%).
- Community-based youth in the medication group were more likely to have stayed in an acute psychiatric facility in the last 12 months (94%) than community-based youth in the non-medication group (6%).
- Community-based youth in the medication group were more likely to have received RMHT in the last 12 months (83%) than community-based youth in the non-medication group (17%).

While currently available data do not provide adequate information to draw strong conclusions, there are several potential underlying reasons for these differences. First, youth who take mental and behavioral health medications may have more and higher intensity needs than youth who were not taking medications. Second, it is also possible that youth in the non-medication group need them but have not had enough exposure to the mental and behavioral health system to have received prescriptions for them yet. Finally, family perspectives on and experiences related to mental and behavioral health medications vary and may influence results.

During case series interviews, some caregivers recounted negative past experiences with medication for their youth but felt involved enough to know when these instances happened and were able to actively advocate for changes. For the most part, community-based caregivers and youth were open to using mental and behavioral health medication, as long as they felt like youth were prescribed the right medication for the right reasons, and that youth would continue to be able to receive mental and behavioral health services while taking medications. One caregiver shared “some kids need counseling, some kids need medication, some need placement, [and] some kids need all three” (Caregiver).

9.1.5 Comparisons to Youth in RMHT and their Caregivers

Currently available data do not allow for meaningful comparisons between youth in RMHT in 2022 as reported in the July 2023 Evaluation Report and community-based samples. However, there are two important factors to consider when interpreting the data presented here:

- The timing of youth assessments matters.
- Youth functioning is expected to improve as they respond to treatment, which could not be accounted for given the data collection timelines and the types of data available for this Evaluation. DHHR is continuing to implement the CAFAS in RMHTFs, upon entry and at regular intervals across youth placements, and these data will be included in this Evaluation as they become available. Case series interviews will also continue to provide rich insights into changes in youth functioning across their service experiences.
- There was unexpected overlap in the samples.
- As is true of all administrative data, there is a lag between data collection, reporting, and analysis. As a result, some youth in RMHT had transitioned back home (presumably due to improved functioning) by the time survey and interview data were collected, and as documented above, some community-based youth also received RMHT in the past. Additional analyses also revealed potential differences in needs and functioning among community-based youth that coincided with whether they were taking medication. This year's data collection activities will help provide additional insights into these observations.

Lastly, youth across RMHT and community-based settings tended to self-report slightly higher functioning than their caregivers.

9.1.6 Recommendations

Recommendation: Continue to explore youth functioning across different service experiences. Planning is already underway for additional analysis of administrative data as well as data from this Evaluation, which should provide greater insight into youth functioning and other related outcomes based on whether, how many, and the types of mental and behavioral health services youth received.

Recommendation: Compare youth functional scores across the different types of assessments currently being used in WV. For example, a low CAFAS score should correspond with a higher score on the Youth Functioning Scale that was developed for this Evaluation, and the distribution of youth needs within the CANS assessment are expected to be different than the needs of lower functioning youth. Data analysis plans are being developed in collaboration with DHHR and Marshall University in anticipation of CAFAS and CANS data becoming more widely available. Additional analyses might also pair caregiver and youth survey data to examine whether the dyads are perceiving youth functioning similarly.

Recommendation: Continue to explore the multifaceted nature of youth functioning, as well as other relevant youth and family outcomes.

Next year's report will continue to document stakeholder perceptions about DHHR's progress toward generating and implementing policies that expand and improve in-home and community-based services to help ensure that youth can receive mental and behavioral health services in the least restrictive service settings possible.

10 Appendix A: Quantitative Data Collection Methods

This section provides an overview of the data collection methods for the community-based Caregiver Survey and the community-based Youth Survey. Please see the July 2023 Evaluation Report for details about the data collection methods for the Organization and Facility Survey.

10.1 Caregiver Survey and Youth Survey Collection Methods

The Youth Survey was sent to West Virginians who were 21 years of age or younger who met the State's criteria for being "at risk" for placement in RMHT, and the Caregiver Survey was sent to their legal guardians (when applicable, see more below). The at risk criteria can be found in the Executive Summary and Introduction of this report, as well as in the Residential Mental Health Treatment Facility Caregiver and Youth Methods and Non-Response Report (dated October 31, 2023). The Youth Survey and Caregiver Survey were designed to better understand awareness of and experiences with the mental and behavioral health services of interest to the Evaluation, as well as relevant youth outcomes, and demographic information. Survey administration was conducted in collaboration with the consulting firm Abt Associates between December 2022 and March 2023.

10.1.1 Overview of Samples

The main focus of this report is to establish a baseline for community-based youth with mental and behavioral health needs that put them at risk for out-of-home placements, and their caregivers. The State determined that factors that put youth at risk include an SED diagnosis and recent visits to hospitals and/or psychiatric facilities, use of crisis services, CPS or YS involvement, and/or low functional wellbeing as determined by the CAFAS/PECFAS; please see the Executive Summary or Introduction sections of this report or the Residential Mental Health Treatment Facility Caregiver and Youth Methods and Non-Response Report for the full description of the at risk criteria. At risk determination was based on youth status between October and December 2021.

10.1.2 Defining the Samples

DHHR provided the sampling frames for community-based caregivers and youth who had at least one piece of viable contact information. The sampling frames were derived from Medicaid claims data, FACTS, and other data sources that had any corresponding contact information available. The resulting sampling frames provided by DHHR included 903 community-based caregivers and 818 community-based youth. However, there were 46 caregivers and 37 youth who were removed from the sampling frames because they completed surveys as part of the residential samples, leaving 857 community-based caregivers and 781 youth in the sampling frames. Of those 781 youth, 525 were between the ages of 12 and 17, and 256 were 18 years of age or older. Youth at risk for 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.

10.1.3 Development of the Surveys

The Youth Survey and Caregiver Survey were developed by the WVU Health Affairs Institute for data collected from youth in RMHT at Baseline (on July 1, 2021) and their caregivers. As part of the continuous quality improvement efforts associated with the Evaluation, the surveys were updated in preparation for Year 2 data collection among youth in RMHT on July 1, 2022, and their caregivers. Modifications included the removal of 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, streamlined question wording and question order, and updating the demographics section to align with best practices. The survey was then reviewed by Abt for clarity of wording to ensure smooth administration. The Youth Survey and the Caregiver Survey that were administered beginning in December 2022 were further refined for use among at risk samples by removing questions specific to RMHT.

10.1.4 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 the community-based sample for the data collection period. Caregivers who responded “No” were screened out as ineligible and no further questions were asked. Caregivers of youth between the ages of 12 and 17 were asked to provide consent for the project team to reach their youth to request their youth’s participation in the Youth Survey. The consent portion was skipped for caregivers of youth under 12 or 18 years of age or older.

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 surveys 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 services for at risk youth, including types of services received, length of service, and if they felt services helped keep their youth in the home. There were several questions, such as changes in the perceived value of services over the last 12 months, that were only asked of youth who self-identified as being 18 years of age or older.

10.1.5 Survey Administration

They surveys were administered using REDCap software. The Caregiver Survey was launched on December 22, 2022, and the Youth Survey launched January 9, 2023. Both surveys remained

in the field through March 31, 2023. Given the constraints of the project’s timeline as well as the relatively small samples, there were no formal pretest or “soft launch” of the surveys this year. Outreach to caregivers started with mailers and then phone calls. For youth, outreach started with 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 at risk youth who were between the ages of 12-17; these youth were added to the scheduling process once caregiver consent was received.

In 2022, 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. Youth surveys were administered through the call center. Caregivers had the option to take the survey online or with a call center survey administrator.

Caregivers were offered a \$25 Visa gift card as a token of appreciation for their time, and caregivers who completed the survey online were also entered into a drawing to win one of five \$100 Visa gift cards. Youth were offered a \$10 Visa gift card as a token of appreciation for their time. Youth who completed the survey were also entered to win one of five \$50 Visa gift cards.

10.1.5.1 Caregiver Sample Characteristics

Table 20 provides a summary of the total number of caregivers, the total number of caregivers eligible to be surveyed, and the caregivers who completed or partially completed the survey. Table 20 also provides a breakdown by region, and age of their youth. Region 5 had the highest number of caregivers in the sample. Most caregivers had youth that met the at risk criteria through CPS involvement (66.7%).

Table 20: Youth Characteristics by Caregiver Completion Rates

	Total Sample of Caregivers		Caregivers Eligible to be Surveyed		Caregivers Who Completed or Partially Completed the Survey	
	n	%	n	%	n	%
Youth Sex						
Female	381	44.5	335	44.6	68	39.1
Male	470	54.8	413	54.9	103	59.2
Not Available	6	0.7	4	0.5	3	1.7

	Total Sample of Caregivers		Caregivers Eligible to be Surveyed		Caregivers Who Completed or Partially Completed the Survey	
	n	%	n	%	n	%
BBH Region of Residence*						
BBH Region 1	49	5.7	49	6.5	3	1.7
BBH Region 2	70	8.2	62	8.3	19	10.9
BBH Region 3	83	9.7	76	10.1	20	11.5
BBH Region 4	201	23.5	179	23.8	45	25.9
BBH Region 5	266	31.0	219	29.1	53	30.5
BBH Region 6	146	17.0	128	17.0	32	18.4
Outside of WV	41	4.8	38	5.1	2	1.1
Unknown Location	1	0.1	1	0.1	0	0.0
At risk Criteria^						
Emergency department	27	3.2	24	3.2	2	1.1
Hospitalization	30	3.5	27	3.2	4	2.3
CAFAS	42	4.9	36	4.8	11	6.3
CPS	572	66.7	498	66.2	102	58.6
YS	296	34.5	268	35.6	72	41.4
Age of Primary At risk Youth						
Under 12 years	233	27.2	203	27.0	48	27.6
12 to 17 years	466	54.4	408	54.3	101	58.0
18 to 21 years	158	18.4	141	18.7	25	14.4
Total Caregivers	857	100.0	752	100.0	174	100.0
<p>^Youth could be categorized in more than one at risk criterion, and thus columns will not add up to the total youth.</p> <p>*BBH region was defined here by the initial sample provided by DHHR before data collection occurred, since not all addresses were able to be confirmed.</p>						

10.1.5.2 Caregiver Survey Response Rates

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 752 eligible caregivers, 174 caregivers (20.0%) fully or (0.3%) partially completed the Caregiver Survey. There were 17 surveys identified as partial incompletes (because less than 70% of the survey was filled out).

There were 857 individuals in the sampling frame. There were 91 caregivers for whom valid contact information could not be obtained, and 14 caregivers who screened out. Therefore, the response rate calculations were based the remaining 752 individuals. The overall response rate for the Caregiver Survey was 26.4% based on the AAPOR RR3 standard response rate definition. Table 21 presents completion rates among caregivers with varying amounts of contact information.

Table 21: Method of Completion by Contact Type

Contact Type	Web Complete		Phone Complete		Total	
	n	%	n	%	n	%
Phone Only	8	34.8	15	65.2	23	13.2
Mail Only	37	100.0	0	0.0	37	21.3
Phone and Mail	55	48.2	59	51.8	114	65.5
Total	100	57.5	74	42.5	174	100.0

As mentioned, caregiver consent was required for youth between the ages of 12 and 17 who were not wards of the State. There were 104 caregivers who responded to the survey item about consent, 58 provided it for a consent rate of 56%.

10.1.5.3 Youth Sample Characteristics

Table 22 provides a breakdown of youth by age, ward status, and the sex assigned to youth at birth, as reported by their caregivers.

Table 22: Comparison of Sample Characteristics of Youth

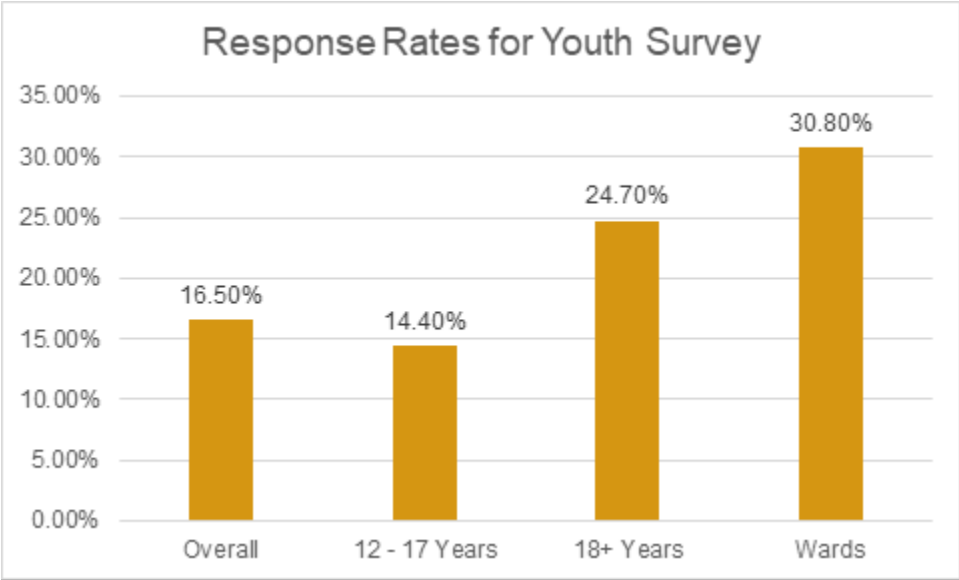
	Total Sample of Youth		Youth Eligible to be Surveyed		Youth Who Completed or Partially Completed the Survey	
	n	%	n	%	n	%
Age						
12 to 17 years	525	67.2	437	77.2	27	52.9
18+ years	256	32.8	129	22.8	24	47.1
Ward Status						
Ward of the state	149	19.1	62	11.0	11	21.6
Not a ward of the state	632	80.9	504	89.0	40	78.4
Sex at Birth						
Female	352	45.1	256	45.2	26	51.0
Male	418	53.5	306	54.1	23	45.1
Not Available	11	1.41	4	0.7	2	3.9
Total Youth	781	100.0	566	100.0	51	100.0

In the sample frame, wards of the State comprised only 19.1% of the total population of at risk youth ages 12 and older. However, these youth accounted for 21.6% of all respondents to the Youth Survey. All wards who completed the Youth Survey were 18 years of age or older, likely due to obstacles related to contact information for wards under 18 years. Although youth 18 years or older comprised 32.8% of the total sample, nearly half (n=24; 47.1%) of these youth completed the survey.

10.1.5.4 Youth Response Rates

Of the 781 youth in the sampling frame, there were 6.4% 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 51. According to the AAPOR RR3, the overall response rate was 16.5%. As shown in Figure 3, response rates were highest for wards of the State (30.8%).

Figure 3: Response Rates for the Youth Survey, Overall and by Category



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 community-based Caregiver Survey, Youth Survey and Organization and Facility 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 System¹ and R: A Language and Environment for Statistical Computing² data analytic software.

11.2 Caregiver and Youth Surveys

The analytic sample for the community-based Caregiver Survey included 174 parents and/or legal guardians. The analytic sample for the community-based Youth Survey included 51 respondents. The next section describes the scale variables included in these surveys.

11.2.1 Scale Analysis

Several scales were developed for the Caregiver Survey and the Youth Survey. Scale validity and reliability were established among the residential samples and reported in the Youth and Family-Level Evaluation Report dated July 29, 2022 (revised September 15, 2022). The scales were reassessed for community-based samples this year. The scale analyses described below were conducted on valid responses, meaning that only respondents who provided responses to all items in the scale were retained for the analyses.

11.2.1.1 The Caregiver Treatment Participation Scale

The Caregiver Treatment Participation Scale was included in the Caregiver Survey. This scale includes nine survey items. Responses to the survey items were captured on 5-point Likert-type scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). 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). The analytic sample for this year's report included 68 community-based caregivers who responded to all items in the scale. Exploratory factor analysis with Promax rotation indicated that all items loaded on the factor as expected. The 68 valid responses were then categorized as low, moderate, and high ranges of the scale.

¹ SAS [Computer software]. Version 9.4. Cary, NC: SAS Institute Inc.; 2016

² R [Computer software]. Version 4.1.2. Vienna, Austria: R Core Team; 2017

11.2.1.2 The Engagement and Respect Scale

The Engagement and Respect Scale was included in both the Caregiver Survey and Youth Survey. This scale captures caregiver and youth perceptions of culturally sensitive practices used during the delivery of mental and behavioral health services. The Engagement and Respect Scale includes six survey items. Responses to the survey items were captured on 5-point Likert-type scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). 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). There were 61 valid community-based caregiver responses and 18 valid community-based responses (to all items in the scale). An exploratory factor analysis with Promax rotation was conducted with the community-based caregiver data and indicated that all items loaded on the factor as expected. There were not enough youth responses to analyze.

11.2.1.3 The Access and Satisfaction Scale

The Access and Satisfaction Scale was included in both the Caregiver Survey and the Youth Survey. This scale captures caregiver and youth perceptions of initiating and accessing mental and behavioral health services. This scale includes seven survey items. Responses to the survey items were captured on 5-point Likert-type scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). 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). There were 66 valid community-based caregiver responses and 18 valid community-based youth responses (to all items in the scale). An exploratory factor analysis with Promax rotation was conducted with the community-based caregiver data and indicated that all items loaded on the factor as expected. There were not enough community-based youth responses to analyze.

11.2.1.4 The Social Support Scale

The Social Support Scale was included in both the Caregiver Survey and the Youth Survey. The Social Support Scale includes four survey items. Responses to the survey items were captured on 5-point Likert-type scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). 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). There were 169 valid community-based caregiver responses and 18 valid community-based youth responses (to all items in the scale). An exploratory factor analysis with Promax rotation was conducted with the community-based caregiver data and indicated that all items loaded on the factor as expected. There were not enough community-based youth responses to analyze.

11.2.1.5 The Youth Functioning Scale

The Youth Functioning Scale was included in both the Caregiver Survey and the Youth Survey. There were seven items in the original Caregiver-Reported Youth Functioning Scale that was administered to caregivers of youth in RMHT in 2021 and 2022. There are six items in the Youth Functioning Scale, used to capture youth self-reported functioning. As mentioned in the main body of the report (Section 9.1), exploratory factor analysis with Promax rotation indicated that

the extra item in the Caregiver-Reported Youth Functioning Scale related to improvements in medication management (“My child is better able to follow directions on how to take their medication”) did not load well using valid community-based caregiver responses. Additional exploratory analyses described below also indicated that there were significant differences among youth whose caregivers did/not respond to the medication item. Therefore, the item regarding medication management was ultimately dropped from the Caregiver Youth Functioning Scale, meaning both the community-based caregiver and youth versions of this scale contained the same six items.

Response options to the survey items included 5-point Likert-type agreement scales ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), as well as “I don’t know” and “Not applicable.” As mentioned, valid responses are those that used the 1-5 Likert-type agreement scale (i.e., excluding those who skipped the item, and who selected “I don’t know” or “Not applicable”). The analytic samples for “all respondents” included 132 valid community-based caregiver responses and 44 valid community-based youth responses (to all items on the scale). Valid responses were summed and then categorized as low (0-8), moderate (9-16), and high (17-24) for caregiver reports and youth self-reports. Overall scale means were also obtained for community-based caregiver and youth responses. Lastly, responses were placed on line graphs with trend lines to observe the distribution of scores across the scale.

Demographic data indicated that there were 41 community-based youth with a history of RMHT, 29 of whom received RMHT in the 12 months prior to data collection and 12 who received RMHT more than 12 months prior to data collection, according to their caregivers. Scale analyses were rerun on the analytic sample of caregiver responses among youth with (n=41) and without a history of RMHT (n=91). An independent samples t-test indicated that there were significant differences in youth functioning based on caregiver-reported history with RMHT. Average caregiver-reported youth functioning among community-based youth with a history of RMHT (12.39 on a scale of 24) was significantly lower than caregiver-reported youth functioning among community-based youth with no history of RMHT (16.42 on a scale of 24), $t(130)=-4.24$, $p < .001$.

11.2.1.6 Medication Management

The Caregiver Survey included an item about medication management. Caregivers responded differently to this item across RMHT and community-based service settings: there were fewer valid responses to this item among community-based caregivers, and exploratory factor analyses indicated that medication management was associated with youth functioning among caregivers of youth in RMHT but the item did not sufficiently load onto youth functioning among community-based caregivers. Therefore, additional exploratory analyses were conducted.

The Caregiver Survey asked participants to reflect over the last 12 months when responding to the item “My child is better able to follow directions on how to take their medication.” Response options to this survey item included a 5-point Likert-type scales that ranged from 1 (Strongly Disagree) to 5 (Strongly Agree), as well as “I don’t know” and “Not applicable.” A dummy variable was created to represent those in the “medication group” and “non-medication group” based on community-based caregivers’ responses to the survey item.

- The medication group included caregivers who responded on the 5-point Likert-type agreement scale indicating that they “Strongly disagree,” “Disagree,” “Neither agree nor disagree,” “Agree,” or “Strongly agree,” (n=116). The assumption was that by answering on this 5-point Likert type agreement scale, caregivers are implicitly indicating that their youth were taking medication in the 12 months prior to data collection.
- The non-medication group included caregivers who selected “I don’t know,” “Not applicable” or who skipped the item (n=58).

After defining the two groups, comparisons were made based on age, to test the hypothesis that younger youth would be less likely to be taking medication. Results of independent sample t-test indicated that the mean age among community-based youth in the medication group (14.5 years of age) was significantly higher than the mean age of community-based youth in the non-medication group (11.7 years of age), $t(101) = 4.54$, $p < 0.001$. Additional comparisons also revealed that use of crisis services and out-of-home placements were significantly higher among community-based youth in the medication group than those in the non-medication group, according to their caregivers (see Table 23). Chi-square tests of independence were used to calculate the p-values in Table 23.

Table 23: Use of Crisis Services and Out-of-Home Placements by Caregiver-Reported Medication Use

Topic*		Medication Group	Non-Medication Group	p-value
		n=116	n=58	
Called the police for help with a behavioral or mental health emergency involving youth	Yes	14 (93%)	1 (07%)	p = .029
	No	101 (65%)	35 (35%)	
	Unsure	0 (0%)	1 (100%)	
Called social services or another support system for help with youth	Yes	29 (78%)	8 (22%)	p = .041
	No	87 (65%)	46 (35%)	
	Unsure	0 (0%)	2 (100%)	
Visited the emergency room to get behavioral or mental health help for youth	Yes	21 (91%)	2 (09%)	p = .017
	No	94 (64%)	52 (36%)	
	Unsure	1 (33%)	2 (67%)	
Youth stayed at an acute psychiatric facility	Yes	17 (94%)	1 (06%)	p = .008
	No	98 (65%)	52 (35%)	
	Unsure	1 (25%)	3 (75%)	
Youth stayed in a RMHTF	Yes	45 (83%)	9 (17%)	p = .009
	No	70 (60%)	47 (40%)	
	Unsure	1 (50%)	1 (50%)	
*The surveys asked caregivers to reflect over the last 12 months when responding to the items included in the table.				

11.3 Organization and Facility Survey

The analytic sample for the 2022 Organization and Facility Survey included 52 organizations. The current report focuses on community-based youth and their caregivers. For additional context, some of the analyses included in the July 2023 Evaluation Report were replicated with a subset of organizations that offer the community-based mental and behavioral health services of interest to this Evaluation. There were 10 organizations in the 2022 sample that *only* provided RMHT, thereby resulting in an analytic sample of 42 community-based organizations.

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 24 below.

Table 24: 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 Limitations

There are several methodological limitations worth noting, in addition to the limitations discussed throughout this report.

First, following guidance from AAPOR, the overall response rate for the Caregiver Survey (26.4%) was lower than expected, given the sampling frame. The response rate for the youth survey (16.5%) was lower than expected. One concern is that participants who agree to take part in this Evaluation may be different in some ways from the target population of all youth and families accessing mental and behavioral health services in WV. For example, there were over 800 community-based youth who were at risk for placement in RMHT at baseline; however, only 51 completed the Youth Survey. The methods and non-response analyses also indicated that Region 1 was underrepresented in the analytic samples for community-based caregivers and youth. In an effort to mitigate these limitations, 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.

Lastly, as with any 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 stakeholders, which suggests that participants were generally forthcoming and shared information honestly.

12 Appendix C: Caregiver Survey Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_CB_CaregiverDataTables_20231031

Demographics & Awareness

Table 1.1: Caregiver Reports of Youth Demographics

Table 1.2: Demographic Characteristics of Caregivers of Youth

Table 1.3.1: Awareness of Services Among Caregivers of Youth

Table 1.3.2: Caregiver Reports of Service Use Among Youth

Table 1.4: Caregiver Reports of Other Mental and Behavioral Health Services Received by Youth

Table 1.5: How Caregivers Heard About Mental and Behavioral Health Services for Youth

Crisis Support and Access

Table 2.1: Caregiver Needs for Crisis Stabilization

Table 2.2: Caregiver Agreement Regarding Mental and Behavioral Health Services Received by Youth

Table 2.3: Caregiver Understanding of How to Access Mental and Behavioral 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

Table 4.4: Reasons Why Caregivers Were Not Able to Get the Services Youth Needed

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Continuing Service Barriers

Table 5.1: Caregiver Reported Challenges with Continuing Mental or Behavioral Health Services for Youth

Table 5.2: “Other” Challenges with Continuing Mental or Behavioral Health Services for Youth

Table 5.3: Caregivers’ Biggest Challenges to Continuing Mental and Behavioral Health Services

Table 5.4: Additional Challenges Continuing Mental or Behavioral Health Services

Outcomes of Mental Health Services

Table 6.1: Caregiver Perceived Youth Outcomes of Receiving Mental and Behavioral Health Services

Table 6.2: Caregiver Perceived Family Outcomes for Youth Receiving Mental and Behavioral Health Services

Future Service Needs

Table 7.1: Caregiver Perceived Future Youth Mental and Behavioral Health Services Needs by Service

Table 7.2: Caregiver Perceived Future Youth Mental and Behavioral Health Service Needs

Law Enforcement

Table 8.1: Caregiver Reports of Youth Experiences with Law Enforcement in the Past 12 Months

Table 8.2: Caregiver Reports of Youth School Experiences in the Past 12 Months

13 Appendix D: Youth Survey Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_CB_YouthDataTables_20231031

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Table 1.1: Youth Demographics, Statewide and by Status

Table 1.3.1: Youth Awareness of Services

Table 1.3.2: Use of Service Among Community-Based Youth

Table 1.4: Youth Reports of Other Mental and Behavioral Health Services Received

Table 1.5: How Youth 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 and Behavioral Health Care

Table 2.6: Youth Understanding Of How to Access Mental and Behavioral 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 Law Enforcement Interactions for 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

Table 4.4: Reasons Why Youth Were Not Able to Get Needed Mental and Behavioral Health Services

Continuing Service Barriers Tab

Table 5.1: Youth Perspectives on Challenges with Continuing Mental and Behavioral Health Services

Table 5.2: Youth's Perception of the Biggest Challenge to Continuing Mental and Behavioral Health Services

Table 5.3: "Other" Challenges to Continuing Mental and Behavioral Health Services

Future Service Needs Tab

Table 6.1: Youth Perceived Future Mental Health Service Needs

14 Appendix E: Organization and Facility Table Index

The following index lists data tables that can be found in the accompanying file, CMHE3_CB_Org&FacDataTables_20231031

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Table 5.1: Organizations and Facilities with Waitlists for New Clients to Receive Services, by Service and Region

15 Appendix F: Case Series

15.1 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, is invited to participate in separate one-on-one interviews that 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 and behavioral 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: WV youth in RMHTFs matched with their caregivers, and WV 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 in the first round of interviews with community-based youth who are at risk of placement in RMHT and their caregivers (i.e., "community-based youth" and "community-based caregivers").

15.2 Methods

15.2.1 Sampling

WVU Health Affairs Institute aimed to enroll a diverse sample of caregivers and youth in terms of service use and demographics. "At risk" youth (hereafter referred to as "community-based youth") were defined by the State as any WV youth (under age 21) with an SED diagnosis in 2021. The 2023 January DHHR Semi-Annual Report includes explanations of SED and the at risk criteria, which were used for the purpose of this Evaluation:

- An SED is defined by International Classification of Disease-10 (ICD-10) diagnosis codes in the psychiatric range, or F-range (that is, starting with F) except for the F1, or SUD, range and F55 (also a SUD diagnosis) and the F70-F80 range of intellectual and developmental disabilities during calendar year 2021).

Youth were considered at risk for placement in RMHT if they had an SED diagnosis and met any of the following criteria in the last 3 months of 2021:

- Medicaid/CHIP member with a visit to a hospital emergency department for a psychiatric episode.
- Medicaid/CHIP member with a psychiatric hospitalization episode.
- Use of Children with Serious Emotional Disorders (CSED) Waiver Mobile Response services.
- Youth who are in state custody because of CPS or YS involvement.

- Youth with an SED as a primary diagnosis on a Medicaid claim in 2021.
- Youth with scores on the Children and Adult Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) of 90 or above.

Recruitment began in December 2022. Caregivers were eligible to participate in the case series if they completed the community-based Caregiver Survey between December 2022 and March 2023 and expressed willingness to participate in a series of follow-up interviews. Community-based youth who completed the Youth Survey were eligible to participate; youth were contacted once their corresponding caregivers provided consent (as part of the Caregiver Survey). Efforts were taken to recruit participants that represented diversity in age and sex/gender. 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. Six community-based youth were recruited, and five completed interviews. In total, 11 individuals participated in the first round of interviews, composing five pairs of caregivers and youth, as well as a sixth caregiver whose youth was surveyed but was non-responsive to requests for an interview.

15.2.2 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 Round 1 of the community-based case series interviews were included in this report to provide in-depth, contextual data about caregiver and youth experiences with the WV mental and behavioral health system. As mentioned, separate interview guides were developed for each group of interviewees based on the corresponding evaluation questions identified in the WV Children's In-Home and Community-Based Services Improvement Project Evaluation Plan (April 2021). Semi-structured interview guides were drafted by the Principal Investigators and included 4-6 core questions with probes to be explored by interviewers. (Interview guides have been updated throughout the project as part of the continuous quality improvement efforts, for example if there were gaps in the survey data, or for further exploration of themes that emerged during interviews.) 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 group of interviewees. 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 caregiver consent and the youth's assent to participate. This process is repeated during each round of interviews. After Round 1, emails, text messages, and/or letters are sent to caregivers and youth based on their preferred method of communication and availability of up-to-date contact information. Round 1 interviews were conducted between March 2023 and May 2023.

Caregivers and youth were interviewed separately. All interviews were conducted using HIPAA-compliant Zoom accounts. Each session included one facilitator and one note-taker. 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 recognize participants for their time, participants received a thank you note and were offered a \$25 Visa gift card.

15.2.3 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 during 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 developed 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 are coded and summarized separately and are 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. 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 provide a cross-sectional Baseline; data from subsequent rounds will be 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.

15.2.4 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 the Evaluation, lessons learned, and limitations.

15.3 Results

The current report presents results from the first round of case series interviews with community-based caregivers and youth. As mentioned, this first round of interviews was conducted with 11 participants, including five caregiver-youth dyads as well as a sixth caregiver whose youth had recently left their home and was nonresponsive to interview requests.

According to Caregiver Survey data, the six caregivers identified and were assigned female at birth (100%), all of whom (100%) selected "White" when asked to indicate their race. No caregiver identified as of Hispanic/Latino origin. Their reported relationship to their paired youth included: two biological mothers (33%) and four adoptive mothers (67%). Two caregivers (33%) reported that they were employed at the time of Year 2 data collection, two (33%) identified as homemakers, one (17%) was a student, and one (17%) was unemployed and unable to work. Two caregivers (33%) reported an annual household income above \$75,000, and four (67%) below \$75,000. Six youth were surveyed as part of Baseline at risk case series surveys, five of whom were interviewed. Of the initial six youth surveyed, four (67%) identified and were assigned male at birth, and two (33%) identified and were assigned female at birth. One youth (17%) was between 12-14 years of age, and five (83%) were between 15-17 years old. Five youth (83%) identified as "White", and one as American Indian/Alaskan Native (17%). No youth identified as of Hispanic/Latino origin, though two (33%) selected "I don't know." At time of Round 1 interviews, four youth (67%) were currently residing at home with their paired caregivers, and one (17%) was placed in a WV RMHTF. The one youth not interviewed (17%) identified as male, white race, 15-17 years old and had relocated and was not responsive to interview requests. Table 25 contains

in-depth demographic information and clinical characteristics of community-based youth involved in the case series at Baseline (i.e., Round 1 interviews). The region variable included in Table 25 was based on six regions defined by DHHR's Bureau for Behavioral Health and was assigned based on available data for interviewee's living situation at the time of data collection.

It should be noted that four of five community-based youth who participated in Round 1 of the case series reported a history of RMHT. While previous placement was not part of the exclusion criteria for the community-based case series, the intent was to determine differences across community-based and RMHT settings, as well as to identify factors that may delay or reduce future placement. Thus, interpretation of data from these community-based youth and their caregivers should be done with caution, as they may not represent the experiences of community-based youth who have not been in RMHT.

Table 25: Demographic and Clinical Characteristics of Community-Based Case Series Youth at Baseline

ID	Demographics & Clinical Characteristics							BBH Region/ Eligibility*
	Age	Sex/ Gender	Race	Relationship	Income	Service History*	Placement	
1	17	Male	White	Biological mother	< \$75k	CMCRS CSED RMHT	WV CG home	6 Youth Services
2	15	Female	White	Adoptive mother	> \$75k	CMHW CSED RMHT	WV CG home	4 Youth Services
3	17	Male	White	Adoptive mother	< \$75k	CMHW CCRL BSS	WV biological CG's home	3 Youth Services
4	17	Male	American Indian/ Alaskan Native	Adoptive mother	< \$75k	RMHT	WV CG's home	3 Youth Services
5	12	Female	White	Biological mother	< \$75k	CMCRS	WV CG's home	4 Child Protective Services
6	16	Male	White	Adoptive mother	> \$75k	CMCRS RMHT	WV RMHTF	4 CAFAS scores

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.
Data were obtained from Baseline surveys and * indicates the use of administrative data from 2018-2022.

Table 26 provides a breakdown of dyad-reported scales in the Baseline community-based surveys. The Youth Functioning Scale captures perceptions of youth functioning in daily social, school, and family settings. The Social Support Scale captures caregivers' perceptions of access to and comfort with someone they can talk to. The Access and Satisfaction Scale captures perceptions of service access and satisfaction. The Engagement and Respect Scale captures perceptions of experiences with staff and providers, particularly related to cultural competence, respect, and communication. All dyads reported moderate or high youth functioning, with one exception. All caregivers reported high social support, with one exception. All dyads reported moderate or high service engagement and respect. All reported moderate service access and satisfaction, with one youth reporting high.

Table 26: Baseline Scale Scores Among Community-Based Case Series Participants

Dyad		Youth Functioning	Social Support	Access and Satisfaction	Engagement and Respect in
1	Y1	Moderate	n/a	Moderate	Moderate
	CG1	Moderate	High	Moderate	High
2	Y2	High	n/a	-	High
	CG2	High	High	-	-
3	Y3	Moderate	n/a	High	Moderate
	CG3	-	Moderate	-	-
4	Y4	Moderate	n/a	-	High
	CG4	High	High	Moderate	High
5	Y5	High	n/a	-	-
	CG5	High	High	-	-
6	Y6	-	n/a	Moderate	High
	CG6	Low	High	Moderate	Moderate

Note: A hyphen (-) indicates that the respondent did not complete the scale items; an "n/a" indicates scale items that were only offered to caregivers and not youth.

Table 27 provides information on the status of community-based youth and their caregivers as reflected in their survey and interview data.

Table 27: Youth and Caregiver Overall Status at the Time of Round 1 Interviews

Group	Status at Round 1 Interview
1	At Round 1, Youth 1 resides at his caregiver’s home in WV. He reports positive service access, engagement, and satisfaction, as well as positive life changes and moderate functioning. Caregiver 1 reports high treatment engagement and respect and high social support, as well as moderate service access, satisfaction, and youth functioning. She is satisfied with services received and youth’s positive mental and behavioral changes at home. She is also satisfied with youth’s current community-based therapist, DHHR worker, and probation officer. However, she feels less satisfied with the lack of inclusion and support received from her youth’s school.
2	At Round 1, Youth 2 resides at her caregiver’s home in WV. She reports high functioning and high treatment engagement and respect, as well as positive service satisfaction, life changes, and functioning. Caregiver 2 reports high social support and high youth functioning and feels “extremely involved” and satisfied with the mental and behavioral health services that her youth has received. However, she is less satisfied with communication, staff turnover, and medication issues encountered as well as a lack of support for caregivers.
3	At Round 1, Youth 3 had relocated and was no longer living with this caregiver. He reports high service access and satisfaction and moderate functioning and treatment engagement and respect in his survey but did not complete an interview. Caregiver 3 reports moderate social support and is satisfied with the services and system overall, relaying that her youth received the support needed though outcomes have varied. She reports little engagement with DHHR and reiterates the need for support for caregivers.
4	At Round 1, Youth 4 resides at his caregiver’s home in WV. He reports high treatment engagement and respect, positive service satisfaction and life changes, and moderate functioning. Caregiver 4 feels satisfied with services overall and reports high youth functioning, social support, family treatment participation, and engagement and respect. She feels that services were available and accessible, and she felt involved and included, with the exception of one WV RMHTF that was less communicative. She relays the need for expanded service awareness and for parents to be trusted and listened to as a valuable member of the care team.
5	At Round 1, Youth 5 resides at her caregiver’s home in WV. She reports high functioning and positive engagement, satisfaction, and life changes, though improvement has somewhat plateaued. Caregiver 5 reports high youth functioning and high social support as well as positive engagement, satisfaction, and life changes. She learned a lot throughout the service process. However, she shares challenges experienced obtaining the guidance, resources, and support needed and reiterates the need for more communication, advocacy, and thorough assessment of youth and family needs.
6	At Round 1, Youth 6 resides in a WV RMHTF where he has been for over a year. He reports high treatment engagement and respect and moderate service access and satisfaction and more recent positive life changes. Caregiver 6 reports high social support and moderate service access, engagement, and satisfaction. She reports lower youth functioning and family treatment participation. She is less satisfied with services overall but describes her DHHR worker and youth psychologist as “great,” noting how they have helped her learn new skills and navigate the system. She reiterates the need for caregivers to have the information, resources, and support.

15.4 Youth-Caregiver Case Profiles

Tables 28-33 below include summary profiles of each youth-caregiver pair in Round 1 of data collection. Data on youth functioning is reported from the perspective of youth ('Y') and caregiver ('CG') where available.

Table 28: Dyad 1 Case Profile

Youth	Relation	Income	Service History	Status/ Eligibility	Functioning
17 Male White	Biological mother	< 75k	CMCRS CSED RMHTF	WV CG home Region 6 Youth Services	Moderate (Y) Moderate (CG)

Youth 1 (Y1) resides at his caregiver's home in WV and reports positive service access, engagement, and satisfaction, as well as positive life changes and moderate functioning.

Y1 started receiving school-based services in grade school. Several years later, he needed a "break from home" and ran away. He was arrested and took a "plea deal" for grand theft auto, drug and gun trafficking charges. He was then sent to WV juvenile detention followed by mandated RMHT. Though initially resistant to services, his first placement in a WV RMHTF was "amazing." He valued the in-depth discussion through individual, group, and family therapy, as well as the "strict structure" that "worked" because "you couldn't really get away with stuff [and] had to be good and learn." Y1 was then sent to a second WV RMHTF, which was a less positive experience. He preferred his prior placement's firm school and service structure and therapy that was focused on specific problems rather than generic goals. Moreover, staff capacity was limited in attending to all youths' needs, and he couldn't visit his established healthcare providers who were "so far away." Y1 reported that the dyad has been very engaged throughout services but not in planning, discharge, or decision-making. Though distance was a challenge, Caregiver 1 (C1) continued to participate and advocate for the best services for him. The transition home has been somewhat "stressful," but he reports "doing really good right now" with "really good therapy" he receives once or twice per month depending on need. Probation and state custody offer him a "bunch of really good resources," too. He reports improved communication and relationship with his caregivers and a "good support system" including his family, probation officer, and friends. School is "a little bit worse," but has "always been a problem" which he attributes to poor teaching. He continues to enjoy therapy because talking about his problems makes him feel better. He is satisfied with both prior and current services though continues to dislike medications, as he was "on so many in placement." Y1 is currently interested in employment and vocational training like mechanics and welding. However, he shares the challenges of "a small town" where "we don't have a lot of options." What's more, "everybody really knows" his history, "so they don't want to like hire me. They don't think I'm reliable. So it's hard to get a job."

Caregiver 1 (C1) reports high treatment engagement and respect and high social support, as well as moderate youth functioning and service access and satisfaction.

C1 reports that Y1 has dealt with ADHD and school-related anxiety since early grade school. C1 was not aware of any services at that time. She worked with him at home, where issues improved but increased at school. She sought help at school, and he received an IEP and worked with the counselor. C1 reflected that a couple of years ago, Y1 started puberty and demonstrated defiance, anger, and aggression that continued to escalate. Y1 was placed in

WV juvenile detention followed by two WV RMHTF placements. Initial RMHT entry was delayed as the prosecuting attorney held up youth's evaluation paperwork. When C1 "raised cane" with the judge, their probation officer stepped up and continued to be their biggest advocate for information throughout. Her experience was that communication was generally poor with both RMHTFs and worsened during COVID. She felt she had "not much say at all" and had to be "outspoken [to] be a part of it." However, his second DHHR worker was "absolutely great," consistent, and "really, really involved" her. RMHT family therapy was also exceptional, and the smaller, more tailored attention at the facility's school "really helped him." He did "wonderful" in placement, successfully completing the program in record time. In Round 1, Y1 is "doing really well" at home and school. "He's a changed young man" and "very polite" with better listening and communication. He participates in court-ordered community-based therapy close to home, and the dyad really like his therapist. He also meets virtually with a psychiatrist who reportedly doesn't "listen" and promotes medication Y1 doesn't want due to "so many meds in placement." He still struggles in school with regular anxiety-induced migraines compounded by ongoing learning issues and bullying. C1 has felt very engaged throughout and continues to meet with school staff but perceives there's "not enough support in the school for the teachers to give to the kids." She hasn't felt supported by the school, where Y1 needs help most. She states, "I think if we had better support, we wouldn't be where we are now." However, it's "a little better [because] I speak my mind, and I don't just agree, and I advocate for my child more." She reiterates the need for caregivers to be informed and involved, sharing, "Let me be a part. You know, it was hard when I couldn't talk to my child. I didn't know what was going on in his life, [or] is anybody taking care of him?" Yet, she has a lot of family support in addition to Y1's "social worker and probation officer [who] really communicated [and] helped him through." Awareness and availability continue to be challenges, as C1 shares, "I really don't know what's out there to know what I could have had, [but] there aren't very many options for therapy [or] mental health in our area." She would like more school tutoring and mentoring resources and hopes Y1 can develop better skills and "self-confidence" to "see what we see in him."

Table 29: Dyad 2 Case Profile

Age	Sex/ Gender	Race	Relation	Income	Service History	RMHTF Status	Functioning
14	Male	White, Native American/ Alaska 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 30: Dyad 3 Case Profile

Youth	Relation	Income	Service History	Status/ Eligibility	Functioning
17 Male White	Adoptive mother	< \$75k	CMHW CCRL BSS RMHTF	Unknown - Region 3 Youth Services	Moderate (Y)

Youth 3 (Y3) reported high service access and satisfaction and moderate functioning and treatment engagement and respect in his survey. However, he was no longer residing with Caregiver 3 (C3) at home in WV at time of Round 1 interview and was nonresponsive to interview requests. He left C3's home shortly following discharge from a WV juvenile detention facility. C3 reports that they talk most days, and he seems well, though separation leaves her uncertain.

Caregiver 3 (C3) is satisfied with the services and system overall, as she feels youth got the support he needed, though outcomes have varied. She cites challenges with DHHR engagement and finding the parenting resources and support needed.

For the past few years, Y3 has been in RMHT in and out-of-state, as well as WV juvenile detention centers and temporary shelters. In pre-school, Y3 started exhibiting issues with ADHD and hyperactivity and frequently ran away from home. He started medication in first grade, and C3 moved him to a private school. In middle school, Y3 started stealing and breaking into cars and continued to run away. He entered his first juvenile detention around that time. She recounts, "You're dealing with a kid's DNA and possibly [biological] parents [who] have mental health issues [on] top of the teenage years." Unaware of other services to help, she relied on police intervention. When she found a stolen gun, she concluded, "He cannot come home...No way. This is it. [Y3] needs some help." She continues, "You hate to call the police and file a report on your kid, [but] we did." She filed incorrigibility, and Y3 went to court and was placed in a second detention. Rather than continue there, he chose to enter probation and RMHT, where he received individual, family, and group therapy. Between various placements, Y3 maintained school attendance and employment but continued to run away. In court once more, Y3 chose WV juvenile detention over additional RMHT, where he was most recently discharged after six months. He returned home briefly, and then left for his biological caregiver's residence to "move on" from C3's "rules" and expectations. She insists that he call regularly, reiterating "we're still your guardians until you're 18. You need to talk to me." Though he "seems safe enough" and not showing signs of depression that he has struggled with prior, C3 is concerned he's not complying with "big doses" of prescribed medications. She has felt "involved and informed" throughout, stating, "We did have all the services that I felt that we needed to help him [be] successful when he came home, [including] Safe at Home, his social worker, and probation officer." She continues, "we wanted everything to work, [so] we did whatever they asked us to do," and workers were "always there to help us do those things." However, she reports little interaction with DHHR stating, "I know that here, they were down to like two people." She thus relied on Y3's probation officer who was "really good" and supportive with "connections" across the system to keep them "in the loop." She feels progress now largely falls on Y3 and concludes that his "are not the decisions we would make, [but] we're doing the best we can" to try to "accept" and "support" his differences. Throughout foster to adoption care, C3 wishes she had more resources, stating "We're not trained psychologists [or] therapists. It's hard [being] an adoptive parent and just trying to do the right thing." She pursued parenting education on her own and thinks a DHHR "support group [would] be a wonderful thing for foster parents" with similar experiences to not "feel like you're all alone."

Table 31: Dyad 4 Case Profile

Youth	Relation	Income	Service History	Status/ Eligibility	Functioning
17 Male American Indian/ Alaskan Native	Adoptive mother	< \$75k	RMHTF	WV CG's home - Region 3 Youth Services	Moderate (Y) High (CG)

Youth 4 (Y4) resides at his caregiver’s home in WV and reports positive service engagement and satisfaction, as well as moderate functioning and life changes.

Y4 started dealing with anger, aggression, and running away several years ago, which predominantly impacted his family at home. Caregiver 4 (C4) recognized issues early on and sought services for him. He initially went into a WV RMHTF and successfully graduated after six months. He was home for about two years prior to a second placement at an out-of-state RMHTF for one year. Since he returned home about a year ago, Y4 feels “happy” and is “not angry [or] arguing as much” with his caregivers. School and his grades are going “great.” He’s currently receiving community-based therapy and medication, which continues to help him manage his “anger” issues at home and school. He likes therapy and relays, “I enjoy [C4] being with me and involved” and desires more joint sessions with her. Y4 didn’t choose treatment or services initially but is satisfied with those received. Services have been “helpful” for his needs as well as his relationships with C4 and family. The WV RMHTF was “great” and “helpful.” He liked the extracurriculars at his out-of-state placement as well, though peer “bullying” was an ongoing issue that he feels staff didn’t address. He now has some friends and a lot of support from C4 and his brother. He is involved in ROTC and art and otherwise reports sleeping a lot. He’s been able to access all the services he’s needed and wanted. He doesn’t need additional services but is interested in continuing therapy.

Note Youth 4 was brief in response and referenced sleeping extensively.

Caregiver 4 (C4) is satisfied with services overall and reports high youth functioning and social support, as well as high family participation, engagement and respect. She feels that services were available and accessible. Communication was a challenge with one WV RMHTF, and C4 relays the need for expanded service awareness and for parents to be trusted and listened to throughout.

Y4 has been home from an out-of-state RMHTF placement for about a year. C4 adopted Y4 many years ago, and “it’s been a long road for him.” He has a “big heart” and “loves to help people” but has always had learning issues that impede coping with a biological past of substance use and violence. About six months into their foster care, he started exhibiting violent reactions with a primary diagnosis of PTSD accompanied with depression, anxiety, and ADHD. Their adoption worker was “very involved” and connected them to his first WV RMHTF placement following a brief stay in a shelter. Y4 was there for about six months and successfully completed the program. C4 has always been engaged and there for him. However, poor communication with his WV RMHTF was “very frustrating” with “no information [or] communication” at discharge. She states, “I wanted to know what I should be doing at home to continue what they were doing, and I did not get anything like that.” Y4 then returned home and did well for a couple of years with community-based therapy and medication. However, the COVID shutdown instigated “violent behaviors” again, and virtual services were not as effective. One incident sent C4 to the ER with high blood pressure, causing her to seek residential

treatment once more. She filed incorrigibility, and Y4 violated his probation and ran away. He was court-ordered to his second out-of-state RMHTF, following another brief temporary placement. The second RMHTF was “amazing,” including the individual and family therapy, providers, case workers, and overall communication. C4 felt very involved throughout, though peer “bullying” and “staff supervision” were challenges. Y4 has been well at home and school since his return about a year ago. He continues medication and the community-based therapy he’s had for many years. He’s also received Safe at Home following each placement, which she states, “was one of our biggest helps.” The worker was “amazing...right when we needed it” during “de-escalation and crisis.” The biggest factor in her satisfaction is “being listened to [and] trusted as his parent,” and Y4’s current therapist and prescribing doctor are exceptional. She’s “very involved” and selective with providers, as she’s “learned things over the years” and has “no qualms changing doctors [who] won’t listen to me [or] trust me as a parent. I know what [I’m] talking about.” She’s had some prior issues with insurance authorization for medications but hopes she has it worked out. Y4 participates in ROTC and church, and recently left a job he excelled at but triggered his PTSD. C4 feels “blessed” for the “overall support” for the dyad. They’ve “always” had advocates like her adoption worker “to point us in the right direction [and] connect us...when we need it.” She “definitely” feels they’ve had the services required and reiterates that caregivers be “proactive. I go out there, and I look for it.” She further relays the need to improve public service awareness as people without “experience” have “struggled [and] don’t know what’s all out there [that] they could be getting for their kids.... There are so many more services out there for children.” Caregiver 4 is “definitely” confident between “now and 18...After that, I have a lot of concerns” because “then he’s off probation [and] free to contact bio family.” C4 continues, “he has this fantasy idea” of his biological caregiver, and “we’re dealing with it with his therapist right now.”

Table 32: Dyad 5 Case Profile

Youth	Relation	Income	Service History	Status/ Eligibility	Functioning
12 Female White	Biological mother	< \$75k	CMCRS	WV CG's home - Region 4 CPS	High (Y) High (CG)

Youth 5 (Y5) resides at her caregiver’s home in WV and seems positively engaged and satisfied with services, functioning and life changes, though she feels improvement has somewhat plateaued more recently.

When the dyad moved back to WV several years ago, Y5 lost weekend visits with her biological father and sister and began experiencing anger and anxiety. Home felt unstable and upsetting, and she largely kept to herself without anyone to confide in. After an altercation with Caregiver 5 (C5), she attempted to flee hours away to her father’s home. She was intercepted by family and then permitted by C5 to stay with her father temporarily. Y5 was there briefly before her father lost rights, and she entered a foster home for two years. Y5 then started weekly remote therapy for which her foster caregiver was very involved in initiating. She had two therapists during foster care, who she enjoyed and found helpful. She felt involved in meetings and decision-making, but her foster caregiver less so and C5 not at all. After a couple of years, she returned home to C5 and had good family therapy for one month during the transition. Y5 is positive about past and current services received and has no concerns at home or school. She has a good support system of friends, family, and neighbors. Since her return, C5 is “like a friend,” and their relationship is much improved. Y5 also continues a close and caring relationship with her foster caregiver, who is now part of the dyad’s family. She confides in her sister by phone nearly every day and often visits nearby family on school breaks. Y5 experienced bullying last year, and feelings of anxiety returned amid the transition back. Thus, she requested school-based counseling which “helps calm me down” and is “really fun” and game oriented. Therapy was recently reduced to every two weeks, as Y5 is consistently doing well. Bullying is no longer an issue, and she shares, “now I’m enjoying life. I have a whole bunch of friends, [and] I am just so much better than, especially, last year at my old school because none of the kids accepted me for me.” She still struggles and feels progress has somewhat plateaued, but therapy has given her tools to work through situations inducing anger and anxiety. She is very satisfied with services received and hopes to continue therapy to help “handle my anger” and “anxiety better.” She wishes C5 were more involved and is considering asking for family therapy. Though she is happy to rejoin C5, she regrets losing contact with her father. She hopes to soon reconnect with him and meet the “several siblings” she has yet to.

Caregiver 5 (C5) reports high service satisfaction and social support as well as positive engagement, life changes, and functioning. She has experienced many challenges getting the communication and resources needed but is “grateful” for her growth and support received through the process. She speaks to the need for stronger service engagement, advocacy, and awareness, as well as thorough assessment of youth and family needs.

Y5’s issues presented several years ago when C5 started working nights and their relationship unraveled at home. Y5 wasn’t being “heard” with the “love” and “attention she needed” and started exhibiting tantrums, rebellion, and physical aggression. C5 didn’t initially seek services, as she “didn’t believe in counseling or therapy [for] a long time” due to poor prior experiences. She pursued extracurricular outlets for Y5 but states that “nothing was available,” and she didn’t know what to do. She feared “asking for help” because she believed that “when you’re having a problem with your kid, you’re going to lose you’re your kid first thing instead.”

A big fight transpired, and she spanked Y5, who then packed a bag and ran away to her biological father's home. Thinking time apart would be good, C5 signed a temporary authorization for Y5's father to take her. Soon thereafter, he was arrested at home for substance distribution. Both caregivers were charged with child neglect and endangerment, and Child Protective Services placed Y5 in foster care. C5 spent the next "two or three years trying to get her back in doing everything they said." Her initial lawyer was disparaging, unhelpful and unsupportive. After "begging" the court, she was assigned a new lawyer who was a key ally thereafter. She states that he "was really, really informative, really helpful," and "gave me the skills and tools [and] directed me everywhere." C5 continued to meet obstacles in communication with DHHR and her case manager as well as in provider availability and insurance coverage. Fearing delay, C5 independently completed "beneficial" parenting classes online. It then took a few months to connect with the CSEDW worker who became a critical support for C5. The worker made her "feel safer" and "confident" to "get everything going...smooth from there." C5 started therapy and was "very comfortable" with the provider until she relocated, and the facility never followed up with referral. She then connected to a "really awesome" therapist with "strategies" for parenting, coping, and insurance barriers, and C5 continues to meet with her every month or so. Y5 finally returned home about one year ago. In the brief transition back, the dyad had family therapy that was helpful. C5 reflects that Y5 needed services "not for her own reasons" but for the "environments and situations" her caregivers put her in. Y5 is currently in school-based therapy and doing well at home. She helps care for her new baby sister with supportive family nearby. The dyad's communication is much improved, as Y5 knows "she can talk and express herself" to both C5 and her therapist and feel "stable and safe." Though it was a difficult journey, the dyad "learned a lot" with positive therapy and foster care experiences. Court-mandated services helped C5 gain trust and understanding in the system. The dyad also "gained a whole other family" who is "loving" and "supportive" in the process. C5 feels "grateful" and reiterates the need for public awareness that "you gotta do everything," but "it's possible [to] get your kids back." She reflects on WV workforce capacity limitations amid an overwhelmed foster system. She emphasizes that "adults and children both have needs," and some families distrust CPS and help-seeking. Prior to removing Y5, she wishes workers had offered "guidance" and "really assessed [what] the family needs," and "helped them in the home first." C5 concludes that "communication is the bottom line of everything." While they don't currently need additional services, she now knows she can and should ask DHHR for support when issues arise. Her CSED worker, lawyer, and therapist were key advocates to "have gotten through all that."

Table 33: Dyad 6 Case Profile

Youth	Relation	Income	Service History	Status/ Eligibility	Functioning
16 Male White	Adoptive mother	> \$75k	CMCRS RMHTF	WV RMHTF - Region 4 CAFAS score	Low (CG)

Youth 6 (Y6) resides in a WV RMHTF, level II, where he has been placed for over a year. He reports high treatment engagement and respect and moderate service access and satisfaction, and more recent positive life changes.

Y6 has prior placements in WV juvenile detention and RMHT in and out-of-state. He's doing well in treatment at his current WV RMHTF, where he was recently moved down to level II. He receives daily group therapy and individual and family therapy every two weeks to one month, depending on his therapist's case load. About once per month, he meets with the psychiatrist for medication and attends MDTs. He has a biological family history of substance use, "bipolar disorder, and schizophrenia" and was adopted as a toddler by Caregiver 6 (C6). In grade school, he began having issues with defiance, aggression, and ADHD as well as oppositional defiant disorder (ODD), depression, anxiety, impulsivity, and theft in the years following. Y6 underwent five years of therapy, counseling, medication, and psychological exams but felt he was managing okay. COVID escalated his depression and issues at home and school, including physical and verbal aggression. Around that time, Y6 entered his first WV acute facility with suicidal ideation. Behaviors intensified, and C6 filed incorrigibility. From there, he went to juvenile detention and then an out-of-state RMHTF placement for one year. He didn't complete the program and was discharged home. An incident at home triggered police intervention, and Y6 returned to detention, then to the WV RMHTF where he currently resides. He reports no wait or access barriers for services, except his own "defiance." He resisted services initially, as he "hated the label as the bad kid." Yet, he found the support helpful, and his engagement grew. He shares, "More recently, [when] I get mad [or] feel myself getting mad...I try talking to staff [who] I consider to be a worthwhile mentor [and] understand me...People that I actually hated when I first came here, and now like it's people that I love and that love me. It's weird how that happens." He reflects now, "I may not want [services], but I know I do need them...I still haven't really worked anything out, and I would rather not repeat the same mistakes." He feels he's improving but at fault for not having completed a prior treatment plan. After more than one year of staff "trying to convince" him to "have family sessions" with his caregivers, he recently agreed. Both "stressful" and "relieving," family therapy has helped them reconnect. Yet, C6 has remained engaged and at his side throughout. While Y6 wishes he had been more involved in planning and discharge, C6 is informed every week per court order and "overly involved" at times. Y6 tentatively plans to return home in the next couple of months if he completes his goals. He is doing well in school, "I love the teachers, they love me," and is pleased to be "very far ahead in credits" for a strong return to public school. He misses his close, trusted friends at home and keeps peace but distance from RMHT peers. He likes therapy, staff, and extracurriculars but wishes there was more capacity to attend to all youth. As he transitions to an adult, Y6 aims for a "resolved record" because there are "certain jobs that I want that I can't exactly do." He also hopes for "better terms" with C6 because "holding grudges" is "very stressful [and] very debilitating. I just end up suffering because of it." No additional services are needed or desired, but he will consider them in the future.

Caregiver 6 (C6) is less satisfied with services overall and reports moderate service access, lower treatment engagement and respect, and low youth functioning. Yet she has high social

and formal support, including a great DHHR worker and youth psychologist who have helped her learn parenting skills and navigate the system. She reiterates the need for caregivers to have the information, services, skills, and support at home to meet youths' complex needs.

C6 adopted Y6 very young and recognized immediately that "he was very apprehensive to certain body movements." For about six months into the adoption process, Y6 was in transitional counseling with a child psychologist and received routine medical and dental care. These providers pointed to signs of severe prior abuse and trauma. The adoption was then closed to his biological caregiver whose presence seemed to heighten Y6's anxiety and sleeping troubles. Concerns escalated in pre-K and throughout early grade school, including bullying, harassment, manipulation, stealing, and detention. C6 repeatedly sought support from their WV foster agency as well as various school staff and pediatric providers who reassured her that Y6 would acclimate and grow out of these issues. Their adoption agency referred them to Y6's now longstanding child psychologist who "has been the positive" and "really tried his hardest to help" the dyad throughout. The psychologist "would encourage me, encourage [Y6], and was just very helpful to us, making it through the next week, the next week...I just really needed that. 'You can do this. How about you try this,' [and] those methods they teach you, they work." Later in grade school, Y6 received psychiatric care and a second evaluation where he was diagnosed with bipolar disorder, hyper-activity, defiant behavioral disorder, childhood trauma, and ODD shortly thereafter. Psychiatry wasn't available in their area, so Y6 continued counseling through middle school. She states that "was really bad advice. Had I had to do it over again I would have driven [Y6] to the next state, had I had the knowledge of what I would have to go through, [but] hindsight is always 2020." He was "not manageable" with counseling and medication and continued to be destructive and abusive at school and home. A few years ago, he was hospitalized for suicidal threats, violence, and hearing voices. C6 filed incorrigibility, and Y6 was sent to his first WV RMHTF for about one year. C6 reflects, "some kids need counseling, some kids need medication, [and] then some need placement, [or] all three...And that's where [Y6] eventually ended up with his continued needs." Facility engagement and communication were strong until an abrupt discharge in which C6 feels staff intentionally "overlooked" threatening behaviors for "more beds." In the weeks following, Y6 was arrested for attempted assault. C6 describes CSED arriving three weeks later, when "everybody's nerves were shot," and intervention "was just not doable." C6 signed a second incorrigibility, and Y6 went to WV detention then the WV RMHTF where he has resided for over a year. Communication and engagement there have been poor, and she's had to "push and push" for "participation...multiple times during the different team meetings [and] court hearings." C6 states that she is most frustrated with what she perceived as a "negligent" delay in providing a new psychiatric evaluation to enable Y6 to continue medication for his bipolar diagnosis amid his "erratic" behavior since entry. She's gone to great lengths to advocate that he receive a "sixth or seventh" evaluation to obtain his medication, which the judge has recently mandated. The dyad has recently rekindled through family therapy, and Y6 now receives visits. C6 feels "more concerned about what's going to happen to him after 18... Who's going to take care of him then? He needs a family. We want to be there for him." C6 reiterates that caregivers be prepared "from the beginning of adoption" with "resources, knowing what's available, [and] what to expect from these children because they're so trauma-based sometimes." Caregivers further need responsive crisis services and support at home, which "is a level zero facility [with] zero backup...Get the programs in place before the child comes home. Have the parents have help."

15.5 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) service engagement, 3) changes in youth and family functioning, and 4) service satisfaction. In addition to using these data in response to relevant evaluation questions, summaries for each of the domains of youth and caregiver experiences from Round 1 of the community-based case series interviews have been compiled and are presented in tables below, along with illustrative quotes for each theme. Following are summaries of the pertinent themes under each primary domain, along with descriptions and illustrative quotes.

15.5.1 Service History and Experiences

When asked about mental and behavioral health services, caregivers and youth discussed their extensive service experiences, including their service needs and awareness, precipitating factors and processes to start and continue services, barriers met along the way, and hopes for future services. Caregivers and youth spoke to community-based therapy and counseling and related service use early on in their trajectory and referenced a few specific services such as Safe at Home, Wraparound, CSED, and CMCRS. There was no discussion of Assertive Community Treatment or Behavioral Support Services (including Positive Behavior Support) during case series interviews in Round 1.

One theme that emerged was the positive impact for families who connected to effective services that were tailored, engaging, and responsive to their youth’s complex needs. An additional major theme was the positive impact for families who connected to service advocates who were particularly inclusive and responsive to the dyad’s needs. These included agents affiliated with probation, court, DHHR, adoption, therapy/counseling, and other providers and staff who worked within the system to promote and secure their priorities throughout the process. Table 34 provides an illustrative summary of the Service Experiences domain.

Table 34: Service History and Experiences

Theme & Summary	Representative Quotes
<p>Services relevant to the Evaluation. Some participants reported prior usage of Wraparound, CSEDW, CMCRS, and Safe at Home with mixed perceptions of utility, engagement, and responsiveness. Safe at Home was especially helpful in engagement,</p>	<p>"Safe at Home was one of our biggest helps. [The worker] was amazing...Whenever we had a crisis, I could reach out to her [for] de-escalation...So during the worst part of things, she was our biggest help." (Caregiver 4)</p> <p>"I graduated out of [Safe at Home]. It was very helpful [with] good therapy." (Youth 2)</p> <p>"[CSEDW] is the one that used to help me get through everything. [The worker] made me feel safer, [and] took the time to actually [care] and listen... That really stood out. That helped us." (Caregiver 5)</p>

Theme & Summary	Representative Quotes
<p>therapy, and service coordination. Of note, use of additional services was reported by participants in surveys as well as administrative data, pointing to potential lack of recognition or recall in interviews.</p>	<p>"I think it was three weeks later before [CSED] got out here. At that time everybody's nerves were shot, and [intervention] was just not doable. [One worker] never felt safe, [and] a trauma specialist...was trying to teach me to parent, and he had no idea." (Caregiver 6)</p> <p>"We had Wraparound again, [but the worker] wouldn't show up. We would call her, and when [youth] was having a minor crisis, which is what we were supposed to do, she wasn't reachable...We just let her go." (Caregiver 2)</p> <p>"We don't have the crisis center. [They] don't actually have anybody to send out to you. [CSED worker] said, 'I usually go see people for them because I know in this area they cannot get out to people.'...You're supposed to be able to call the crisis center when you need help, [but] it doesn't matter if you call them or not, they cannot help you." (Caregiver 6)</p>
<p>Complexity of needs. Caregivers discussed their youths' unique, complex issues that required a higher level of care than some community-based services could meet. Caregivers called for more early detection and thorough evaluation of youths' individual needs and an intensive, specialized service continuum to meet them. This included more caregiver resources to expand their knowledge, skills, and support network to better meet youths' needs at home.</p>	<p>"Had there have been more in-depth evaluations of [adopted youth] under the DHHR care...Individualized [and] thorough evaluations...we would have been more prepared...We've done everything humanly possible we can do [and] tried to parent [her] like our other children and you can't....I signed up to be her parent, but I can't do 24/7 with a child that has high needs, and high risk. We'd already been to the ER you know several times." (Caregiver 2)</p> <p>"We're not trained psychologists [or] trained therapists. It's hard like sometimes being an adoptive parent, and just trying to do the right thing...I wish they had [a] support group." (Caregiver 3)</p> <p>"Communication is the bottom line of everything. With [providers], with [youth]. Understanding how I can articulate things I need to say or think or do. As a family, as a single [mother]...Adults and children both have needs. They went ahead and took her, instead of helping me in the home, instead of advising who and where to go." (Caregiver 5)</p> <p>"It's not like raising your own. You can't use the same skill set as you did [with] biological kids, so definitely more resources in that...I think somebody should have stepped in more, been a little bit more proactive in recognizing the mental health need in [youth]. I still feel like it is being swept under, [but] if they don't get in and stop it, it's gonna be another cycle of him harming himself or harming somebody else...Get the</p>

Theme & Summary	Representative Quotes
	<p>programs in place before the child comes home. Have the parents have help.” (Caregiver 6)</p>
<p>Awareness. Some caregivers were aware of general community-based services, such as therapy, because their youth received services in the foster to adoption process. However, caregivers were less aware of the severity of their youths’ history and issues and the services available to meet those complex needs. Many relied on police and legal intervention to secure intensive services as issues escalated.</p>	<p>“In the beginning, no, we didn’t know what to do [to] keep [youth] from harming us or herself or others...‘All they need is structure.’ That’s all we were told...That was a very false statement, and we were unseasoned in children like them.” (Caregiver 2)</p> <p>"I have a lot of friends and stuff, and they've struggled with getting the services. But like I said, I'm proactive. I go out there, and I look for it. But sometimes people don't know what's all out there. They don't know what they could be getting for their kids." (Caregiver 4)</p> <p>“First of all, any parent thinks when you're having a problem with your kid, you're going to lose your kid first thing if you're asking for help.” (Caregiver 5).</p> <p>“From the beginning with adoption...I think more resources, knowing what's available, knowing what to expect from these children because they're so trauma-based sometimes.” (Caregiver 6)</p>
<p>Onset and precipitating Factors. Youths’ issues presented early on and escalated around 9-12 years old. All reference issues with anger and aggression, and most have had issues with depression, ADHD, verbal and physical violence/abuse, trauma, running away, and bullying. Most have been through foster/adoptive care and have a biological history of abuse, violence, substance use, and other mental and behavioral concerns that caregivers</p>	<p>"I can tell you exactly what happened. It was the perfect storm. [Youth] started her period and at the same time decided she wanted to see her biological [caregiver]. She asked before the adoption was final...adoption, period and visit with [caregiver]." (Caregiver 2)</p> <p>“But it's like when you're dealing with a kid's DNA and possibly [biological] parents [who] have mental health issues or something, [you're] kind of dealing with that on top of the teenage years.” (Caregiver 3)</p> <p>"At first things went really well, and he was adjusting. But especially during like COVID, when they couldn't get out and do stuff and everything, the violent behaviors started again." (Caregiver 4)</p> <p>"[Youth] wasn't being heard, she wasn't [getting] the love [and] attention she needed as a kid from me. So that's where all that came from...Not for her own reasons, because of the environments and situations I had put her in, and that was my fault." (Caregiver 5)</p> <p>“It was made a closed adoption. As far as I am aware, every time I would see [biological caregiver] and come back, I'd be like really defiant</p>

Theme & Summary	Representative Quotes
<p>felt contributed in part to youths' complex needs.</p>	<p>and disrespectful...And for about ten years there have been a bunch of issues... There was some family history of bipolar disorder and schizophrenia [and] addiction." (Youth 6)</p>
<p>Service Process. Most youth were initially connected to therapy and related services facilitated through the adoption process. As issues intensified, most caregivers relied on police and legal intervention to obtain the services needed at some point, including filing incorrigibility, state custody, and/or criminal charges. Most youth have had probation, referenced positively as a service facilitator. Several caregivers spoke to additional services set up as part of the adoption process and discharge from various out-of-home services and hospitalizations.</p>	<p>"They basically [gave] me a plea deal. If I pled guilty to one of my charges, they would like, give me a chance. Instead [of] doing a certain amount of years, they would let me go to rehab and see if I can like, turn my life around." (Youth 1)</p> <p>"How many times did we call the police on [youth] before we actually got help? It was multiple, 20 [times]?... The chief of police [said], 'Guys, you're gonna have to press charges to get any sort of help.'... And of course we were heartbroken about having to do that... And they took our rights [because] that's the only way they could get her help [and] get it paid for." (Caregiver 2)</p> <p>"After a while we started calling the police because [youth's] social worker or his probation officer would say, 'Call the police. When he runs away, call the police.'... You hate to call the police and file a report on your kid, you know. But we did...it wasn't until the very last time that the police called that we said, 'He cannot come home... No way. This is it. You need some help.'" (Caregiver 3)</p> <p>"Things were a little better than when he became on the incorrigibility." (Caregiver 4)</p> <p>"Whenever [youth] decided to get mad and run away from home, authorities were called, and all kinds of attention happened. And they went ahead and took her," (Caregiver 5).</p> <p>"So I went back to the courthouse [and] filled out another set of incorrigibility papers. And at the direction of [worker] from the CSED program, too, because there's just no managing him." (Caregiver 6)</p>
<p>Barriers. Caregivers referenced challenges to availability and continuity of tailored community-based services, including specialized therapy and psychiatric care as well as services in school and in emergency/crisis</p>	<p>"Things now are much slower, [and] when everything really started getting bad and escalating, [the process took] forever... [Youth] would come home [for] maybe two, four weeks, and then it would start all over again. And waiting on facilities to get her in. Trying to find facilities...Every time we've had to send her to a facility, we have to go to the local hospital and she has to lay in that ER anywhere from 8 to 24 hours for them to get the facility." (Caregiver 2)"</p>

Theme & Summary	Representative Quotes
<p>response. Participants also referenced some issues with wait times and abrupt discharges, medications, delayed evaluations and a high threshold of severity to obtain help. Communication was a major underlying barrier to services. Youth reported that their own resistance to engage was a key barrier.</p>	<p>“[DHHR worker] was their number one contact because the State had custody, [and] she failed at times...There were things that happened [that] weren't being dealt with; and as parents, we could say how we felt, but it had to be the case worker that dealt with them,” (Caregiver 2).</p> <p>“That's what it was like, prisoners in my own home, [which] is a level zero facility, [where] I have a zero backup... And I can't count on 911 because [they] can't really do anything [if] he's trying to knock down my door to get to me [but] hasn't [yet] hurt anybody...I tried to protect me and my family.” (Caregiver 6)</p>
<p>Hope for the future. Most youth were currently receiving community-based services and open and willing for future services. Youth wished to sustain progress in their mental and behavioral health and relationships with their families and communities. This included completing probation and achieving a “clean record,” employment, and vocational training. Caregivers also hoped for continued progress and a community-based service continuum that provided routine and structure to deter problematic patterns.</p>	<p>“I wish [youth] could see what we see in him. He needs some better self-confidence... He's got a couple of classes [like] budgeting [and] computers [that] will help him a lot” (Caregiver 1)</p> <p>“It's small town, [and] I'd want to do mechanics or welding, [and] I'm trying to get a job.” (Youth 1)</p> <p>“Honestly, [probation] does help. There have been times I wanted to fight. But I'm like, [you] can't do that. You want to be home.” (Youth 2)</p> <p>“We tried to take [youth] and do what's best for them, even though they don't want it. So just make them a productive person.” (Caregiver 3)</p> <p>“I hope that [I] am able to handle my anger and my anxiety better [and] meet my several siblings that I haven't met.” (Youth 5)</p> <p>“I am hoping [my record] is resolved before I turn 18 because there is certain jobs and stuff that I want that I can't exactly do...I really want to know [higher] education that's available for my career choice...I want to be on better terms with my mom, [and] I don't like holding grudges. It's very stressful. It's very debilitating. I just end up suffering because of it.” (Youth 6)</p>

15.5.2 Engagement

When asked about engagement, caregivers and youth discussed experiences with their involvement and inclusion in their youth's service trajectory. Caregivers generally felt engaged in

services but all desired more consistent and meaningful involvement. They felt that experiences of thorough, regular communication with providers, staff, and affiliates across the service continuum fostered their engagement. They desired more active and comprehensive involvement, where they felt their voices were trusted and valued as collaborators in their youth’s care. Several caregivers reported not receiving timely information or updates and/or feeling that they were not included or listened to regarding service planning and decision-making. In many instances, caregivers referenced advocates across the system who helped increase their involvement and influence, such as community-based providers, probation officers, and staff of DHHR and affiliate programs. Youth generally described more engagement in their services, though some discussed wanting more say in decision-making and more involvement of their caregivers. Youth engagement was also a major factor in caregiver engagement. Youth resistance or refusal to participate in services limited the extent to which caregivers could engage, particularly in instances of state custody and incorrigibility. However, youth engagement improved with time and exposure on all accounts. Table 35 provides an illustrative summary of the Service Engagement domain.

Table 35: Youth and Caregiver Service Engagement

Theme and Summary	Representative Quotes
<p>Communication: Consistency and Inclusivity. Caregivers generally felt involved in their youth’s services early on and shared both positive and negative experiences. They felt engaged with more consistent, thorough communication throughout, including timely information and updates. They felt most engaged as part of an inclusive, collaborative team, where their voices were trusted and valued in service planning and decision-making. Most wanted more engagement. Some caregivers shared less positive experiences where they felt their concerns were</p>	<p>“Anytime that we needed [or] wanted anything, we would call his probation officer [if] we ever had like questions about what’s happening [with] court cases or anything, she was always telling us everything, and in the loop really well...She had connections with social workers, police courts, everything, [and] she knew what was going on with that. So she was kind of our go to.” (Caregiver 3)</p> <p>“[Services] started a few months in because I didn’t know where and when or anything I was supposed to do...And I’m coming up to court hearings, I just kept bringing up the charges, [and] no one directed me [or] would answer me...Communication is the bottom line of everything...Understanding how I can articulate things I need to say or think or do. As a family, as a single [caregiver]... Anyone that was involved that actually took the time to [care] and listen. That’s what helped.” (Caregiver 5)</p>

Theme and Summary	Representative Quotes
<p>not accounted for, including abrupt discharges, medication issues, delayed evaluations, as well as inadequate response during crisis and emergency situations. Probation officers were champions in communication and advocacy.</p>	
<p>Advocacy. Most caregivers found an advocate within the system to help navigate and secure greater engagement and support for their youth and family’s service needs. Caregivers referenced advocates including adoption workers, probation officers and legal agents, staff of DHHR and affiliate programs, as well as community-based providers. They also spoke to employing their own self-advocacy and agency for more inclusion and say in services and priorities.</p>	<p>"Other than just being me [and] outspoken and letting them know that I will be a part of it...It's maybe a little better, but I think that's because I speak my mind. And I don't just agree, and that I advocate for my child more." (Caregiver 1)</p> <p>"All starting with his adoption worker. She was very involved if we had issues. She was right there, and she would connect us to people. We've been blessed that we've always had someone somewhere that was able to connect us to somewhere else when we need it, [and] we've had people that have been able to point us in the right direction." (Caregiver 4)</p> <p>"I have no qualms with changing doctors [who] won't listen to me. I come from a history myself, [and] we've learned things over the years, and I will not work with someone that won't trust me as a parent...If there was a problem, [I'm] proactive. I go out there, and I look for it" (Caregiver 4)</p> <p>"I begged the court, [and] they finally appointed me another lawyer, who gave me the skills and tools, [and] directed me everywhere I had to go [and] everything I had to do...If it wasn't for my attorney at the time, I wouldn't of got through all that." (Caregiver 5)</p>
<p>Service Capacity. Several caregivers conveyed a lack of service capacity to adequately respond to their family’s needs at home, school, and in crisis. They perceived that capacity issues in part undermined</p>	<p>"I don't think that West Virginia has [a] lot of places for the kids to talk to the counselors... I know that [teachers] are overwhelmed, and I just don't think that there is enough support in the school for the teachers to give to the kids... Then outside of school we don't have very many options for therapy [or] mental health in our area." (Caregiver 1)</p>

Theme and Summary	Representative Quotes
<p>their continued engagement and progress within the community-based service continuum and contributed to perceptions that their needs were not being heard or met.</p>	<p>“[Youth] would come home [for] maybe two, four weeks, and then it would start all over again. And waiting on facilities to get her in. Trying to find facilities...Every time we've had to send her to a facility we have to go to the local hospital and she has to lay in that ER anywhere from 8 to 24 hours for them to get the facility.” (Caregiver 2)</p> <p>“I thought, maybe [youth] can go to some kind of [camp] and do fun kid activities...I didn't know what the heck to do [because] nothing was available.” (Caregiver 5)</p> <p>“I'm sure the [workers] did have busy schedules [and] a lot on their plates. So I mean some of my frustration with them might be unfounded [or] unwarranted, [but] just taking time [to] really assess the situation, what the family actually needs. And help them in the home first if you can.” (Caregiver 5)</p> <p>“The psychologist [went] over a few things, but not much was accomplished, and then he wanted him to see a child psychiatrist. But the one in the area was [going] to resign his contract. He said, ‘So you could just continue the counseling, for now.’ I think that was really bad advice. Had I had it to do over again, I probably would have driven [youth] to the next state had I had the knowledge of what I would have to go through. But you know hindsight is always 20/20.” (Caregiver 6)</p>
<p>Youth Participation. Several youth and one caregiver were initially resistant to services, which particularly limited caregiver engagement where state custody and incorrigibility were involved. Multiple youth reported improvements in engagement with services when structure was enforced (e.g., RMHT), and some youth wanted greater say in planning and decision-making as well as caregiver involvement in their services. Some mentioned that the label associated with</p>	<p>“I have problems with wanting to go. But that was about it...I remember I got therapy, and I had a really good bond with the worker. She helped me through a lot of stuff...One of the best places I was at... I really liked it...It was strict with the structure, but I [that] worked [because] you couldn't really get away with stuff, so you kind of had to be good and learn stuff...The therapy was like amazing.” (Youth 1)</p> <p>“[WV facility] was helpful there at the end, and, like once I actually started doing what I needed to do: talking. Yes, it was helpful. But if you don't talk, you're not going to get help...But in the beginning no, I was not [engaged] because I was not in the right mental state,” (Youth 2).</p> <p>“At the time I thought [that] maybe we just need to go talk to someone, and I didn't believe in therapy or counseling at the time...Nothing was available, and I didn't want to go to [therapy].” (Caregiver 5)</p>

Theme and Summary	Representative Quotes
<p>services was a deterrent to service engagement.</p>	<p>"I've been in counseling, therapy for [over] five years... Honestly, a lot of it was rubbish in my opinion, [and] I wasn't very honest with them all the time...But more recently I've been trying to talk about it with staff, for when I get mad or when I feel myself getting mad. So yeah, there's a lot of talking to people who I consider to be a worthwhile mentor [and] understand me...people that I love and that love me. It's weird how that happens." (Youth 6)</p>
<p>Caregiver Resources and Support. Several caregivers reported needing their own knowledge, skills, and support to adequately engage and address youths' needs, including education, training, and support groups. Those provided were insufficient and/or untimely for the level needed, and many caregivers pursued resources independent of the system.</p>	<p>"We've done everything we humanly possible can do, [but] we were unseasoned in children like them... That's another one of my big frustrations. Nobody. We reached out to probably twenty different professionals and couldn't get any help. I'm like you give us these parenting classes for foster care, [but] I could teach them. I've already raised a typical developing child. I've already raised a special needs child. I have not raised a child with behavioral mental health problems. This is what I need, and I looked all over for it. So [second caregiver] and I bought books and did webinars. Self-taught." (Caregiver 2)</p> <p>"We're not trained psychologists [or] trained therapists. It's hard like sometimes being an adoptive parent, and just trying to do the right thing...I wish they had foster parent/adoptive parent, like a support group." (Caregiver 3)</p> <p>"Understanding how I can articulate things I need to say or think or do, as a single [caregiver] ...Adults and children both have needs, [but] instead of helping me in the home, instead of advising who and where to go...Instead of giving me guidance...No one bothered to do that." (Caregiver 5)</p> <p>"[Community-based therapist] definitely helped me as a parent. You know, it's my first child with mental health issues that there was just a lot, I just pour myself into him, and I would just sometimes be there [like] I just can't do another day with this child. [Therapist] would encourage me, encourage [youth], and then so that was just very helpful to us, making it through the next week, the next week... I just really needed that. 'You can do this. How about you try this this week?'...Those methods they teach you, they work." (Caregiver 6)</p>

15.5.3 Changes in Youth and Family Functioning

When asked about changes in functioning, caregivers and youth largely agreed that services, and therapy in particular, have had a positive impact on youth and family functioning and wellbeing. Some behaviors continued to vary and/or return, but to a lesser extent than prior. Youth were generally demonstrating more mental and behavioral stability and management at home and in the community, and caregivers had expanded their own knowledge and skill base to better address youths’ ongoing needs. At the same time, caregivers relayed the need for a strong service continuum providing routine, structure, and accountability both in and out-of-home, which some youth reiterated. Caregivers also spoke to their need for more resources to grow their own capacity as well as responsive services and support in school and during crises. Most youth shared improvements in relationships, school performance, and outlook and were involved in extracurricular activities. Most continued community-based therapy and counseling which they both liked and valued, and some received psychiatric medicine with mixed perceptions as well. Though they hoped to continue a positive, productive track, some youth spoke to the associated label that impacted their life and community pursuit, such as employment. Caregivers were generally pleased with youth progress amid the services received at Round 1 but expressed uncertainty in continued progress and stability as youth approach adult independence. Table 36 provides an illustrative summary of the Changes in Functioning domain.

Table 36: Changes in Youth and Family Functioning

Theme and Summary	Representative Quotes
<p>Youth Progress. Most dyads felt that youth were doing better at home and with family, friends, and community members since starting services. With ongoing and structured therapy, medication, and activity, youth demonstrated greater mental and behavioral stability and management. They exhibited less anxiety, anger and aggression, fighting, self-harm, and run-away attempts, as well as improved communication, relationships, and performance. Some issues varied and/or returned,</p>	<p>“It was all [youth]. I mean his program at [WV facility] was to be nine months, and he was one of the first kids to ever make it through in six months and do everything he was supposed to and get out of there. [We] just support him, [but] it was all on him. He did wonderful.” (Caregiver 1)</p> <p>“Trying to think of all the positives, because there are some negatives, [but] no suicide thoughts. No self-harming. No voices.” (Caregiver 2)</p> <p>“I’m actually doing really well. I came a long way from where I was when this all first started... Probation is good, [and] I'm not really struggling like I was.” (Youth 2)</p> <p>“[Youth’s] doing better, you know she talks about everything, and she’s not, you know, as emotional...[She’s] stable and safe, and feeling that she can talk and express herself the way she wants to.” (Caregiver 5)</p>

Theme and Summary	Representative Quotes
but to a lesser extent than prior.	
<p>Caregiver Capacity. Most caregivers also reported improving their own knowledge, skills, and techniques to better address youth’s needs at home. They also learned more self-advocacy and agency skills to secure those needs and priorities for their families. However, they called for more targeted caregiver services and support early on, such as education, training, and support groups.</p>	<p>“I have not raised a child with behavioral mental health problems. This is what I need, and I looked all over for it. So [second caregiver] and I bought books and did webinars. Self-taught... We are parenting her different. We have different expectations from her than we would another child.” (Caregiver 2)</p> <p>"You have to learn to deal with kids' DNA, [and] biological parents [who] possibly have mental health issues... But we're just hanging in there...We try to almost separate ourselves from them because of their DNA...The decisions that they make are not the decisions we would make, but that's based on their history, [so] we're doing the best we can...We just have to accept them and try to support them." (Caregiver 3)</p> <p>"We have [several] adopted children, [and] we've dealt with ADHD, depression all that stuff with all my other kids too pretty much...We've learned things over the years, and I will not work with someone that won't trust me as a parent. I know what [I'm] talking about, [and] I'm proactive. I go out there, and I look for it." (Caregiver 4)</p> <p>"We learned a lot...I had to do research and do homework because I've done online classes, too, for parenting, and that kind of helps, too... We don't really need any services, we just know that we can ask for it when we need to and find the proper people." (Caregiver 5)</p>
<p>Youth and Caregiver Relationships. Relationships between youth and their caregivers had improved in Round 1, which participants attributed to individual and family therapy, medication and psychiatric medicine, and related services both prior and current. They also felt this was due to maturity on both ends of the dyad. Youth grew with services and</p>	<p>"It's good. It's going better now, [and] I feel like I can talk to them more now." (Youth 1)</p> <p>"I used to not tell them anything, [but] now I pretty much tell them everything....It makes me feel better like somebody's actually listening....They think I'm doing a lot better, [and] since I've been home, I have a good relationship with them... I feel like my parents understand me more [and] better than like what they had in the past." (Youth 2)</p> <p>"[Youth's] very pleasant. Before we couldn't tell her no to anything [that] would equal a meltdown of breaking. Now, she says, 'Okay, I've got it.' She's very polite. She's very helpful....It was another perfect storm that they got her on the right</p>

Theme and Summary	Representative Quotes
<p>exposure, and caregivers learned service agency and better parenting of their youth's complex needs.</p>	<p>medications [and] proper therapy. We learned to parent different. She matured." (Caregiver 2)</p> <p>"[Youth] knows that she can openly, you know, talk to [me] or somebody else...So far, things are going pretty good. We know how to work through problems. I mean, life's not going to be perfect, obviously." (Caregiver 5)</p>
<p>School Performance. Most youth demonstrated better school performance, relationships, and experiences. Though some reported recent declines in grades amid lifelong learning difficulties, their ability to cope had improved on all accounts. Youth generally reported positive relationships with peers and school staff. Notably, most youth had been either the perpetrator or target of bullying in the past, of which only one continued to deal with.</p>	<p>"School [is] a little bit worse [and] stressful... But I don't really have that long till I graduate, so I'm not really worried about that much...School's always been a problem." (Youth 1)</p> <p>"Right now, I'm doing okay, but [I've] struggled in [school] my entire life...So my [caregivers] don't expect me to get straights A's." (Youth 2)</p> <p>"Other school years, [I've] been bullied and picked on and like I wanted to quit twice. But now I'm enjoying life. I have a whole bunch of friends that don't argue with me. And I am just so much better than, especially, last year at my old school because none of the kids accepted me for me." (Youth 5)</p> <p>"My grades are pretty good, [and] I'm actually very far ahead in my credits...So if I go back to public school, which I'm hoping I will... senior year will [be] good...Actually, I love the teachers, they love me." (Youth 6)</p>
<p>Caregiver Outlook. While most caregivers felt confident in services now, they also expressed uncertainty in continued progress and stability as youth approach adulthood and independence from the structure, authority, and accountability of services and home. Several caregivers cited concerns that their youth may emulate a biological history of harmful behaviors and predispositions. They reiterated the need for a</p>	<p>"Support with him for school. Just maybe tutoring, or a mentor, or [help] through school. And I just don't think that there is enough support in the school for the teachers to give to the kids...School is what really has been our nemesis." (Caregiver 1)</p> <p>"Recently [youth] has gone back to his biological [caregiver]... I said, 'I am gonna talk to you and you need to tell me you're okay [because] we're still your guardians until you're 18. You need to talk to me,' ... He seems safe enough and not willing to let anybody else kind of set rules at this point... He's ready to move on [and] that DNA comes through." (Caregiver 3)</p> <p>"Definitely [between] now and 18, I feel confident. After that, you know, I have a lot of concerns...Then he's off probation [and] free to be able to contact bio family...He has this fantasy idea of his [biological caregiver], that he's going to go live with</p>

Theme and Summary	Representative Quotes
<p>stronger service continuum providing routine, structure, and accountability as well as responsive services and support at home, in school, and in crises.</p>	<p>her, [and] we're dealing with it with his therapist right now." (Caregiver 4)</p> <p>"I'm more concerned about what's going to happen to him after 18... [He] has this long history of issues [and] family history of bipolar schizophrenia...Who's going to take care of him then? He needs a family. We want to be there for him... Get the programs in place [at] home. Have the parents have help." (Caregiver 6)</p>
<p>Youth Outlook. Most youth were positive in outlook and wanted to continue progress in their mental and behavioral health and positive relationships with their families, friends, and communities. Many hoped to complete probation and remain on good terms into adulthood, naming aspirations of a clean record, employment, and training. Some referenced their service history as a label that impacted them in their community and life pursuits.</p>	<p>"I'm doing really good right now, [and] getting really good therapy." (Youth 1)</p> <p>"Probation is good...Honestly, it does help. There have been times I wanted to fight. But I'm like, [you] can't do that. You want to be home." (Youth 2)</p> <p>"So I decided [to] start [therapy] again because my anxiety was getting bad again just from being in a whole new school [where] I knew nobody...Therapy and counseling [helps] me calm down." (Youth 5)</p> <p>"I do need [services]. I may not want them, but I know I do need them...I still haven't really worked anything out, and I would rather not repeat the same mistakes." (Youth 6)</p> <p>"More recently I've been trying to talk [to] staff, for when I get mad [or] feel myself getting mad. So yeah, there's a lot of talking to people who I consider to be a worthwhile mentor, [and] I look for somebody that I can talk to, who will understand me...I am hoping [this] is resolved before I turn 18 because there is certain jobs [that] I can't exactly do [if] the records are continued....I want to be on better terms with my [caregiver]. I don't like holding grudges. It's very stressful. It's very debilitating. I just end up suffering because of it." (Youth 6)</p>

15.5.4 Satisfaction with Mental and Behavioral Health Services

When asked about satisfaction with services, most caregivers reported satisfaction overall, as they've observed positive changes in their youth and have found strong formal and informal advocacy and support along the way. However, most reported mixed experiences with specific services, facilities, and providers. Consistent, inclusive communication and engagement were key to perceptions of satisfaction. This included regular, informed contact with information and updates, as well as caregiver perceptions of feeling heard, trusted, and valued as collaborators

in service planning and decision-making. Awareness, access, and availability of intensive, specialized services that were tailored, engaging, and responsive to youth and family needs were also major factors associated with satisfaction. Caregivers continued to call for a stronger service continuum providing such services at home, in school, during crisis and emergency, as well as in transition among services and into adulthood. Caregivers further reiterated a need for earlier evaluation and intervention of youths' complex, deep-rooted issues as well as more targeted resources and support for caregivers and families through the trajectory. Caregivers spoke to perceptions of limitations in workforce capacity that also underscored factors of satisfaction. Table 37 provides an illustrative summary of the Service Satisfaction domain.

Table 37: Satisfaction with Mental and Behavioral Health Services

Theme and Summary	Representative Quotes
<p>Communication. Perceptions of communication and engagement are key factors in satisfaction. Several caregivers shared perceived deficiencies encountered within the service spectrum, including services, DHHR, and various providers and staff. Caregivers were more satisfied with those providers and workers who were thorough, consistent, and responsive to their service needs and priorities. This included receiving regular, detailed information and updates on services, processes, and changes impacting their youth and family.</p>	<p>“[Probation officer] was really good [if] we ever have like questions about what's you know what's happening with [his] court cases or anything, she was always telling us everything, and in the loop really well....Anytime that we needed anything or wanted anything, [she] could get us what we needed...She had connections with social workers, police courts, everything so, [she] our go to.” (Caregiver 3)</p> <p>“Just someone actually listening to us, you know. Anyone that was involved that actually took the time to [care] and listen. That's what helped. Whether it be [CSED], a counselor, even the lawyer, I mean, those are the three things that really stood out.” (Caregiver 5)</p>
<p>Engagement and Advocacy. Perceptions of advocates within the system who helped promote, navigate, and secure dyad service access and engagement were also key to satisfaction. Those who went above and beyond to ensure that caregivers were equipped</p>	<p>“We [were] extremely involved [and] had input on where she should go and what help she needed, which was nice...Everything went through our local judge for like for final approval of what we come up with as a team. And he was wonderful! He was very helpful. He listened and cared about our concerns and our thoughts and not just the professionals'...Our best contact was her probation officer.” (Caregiver 2)</p> <p>"I think we were pretty involved [and] wanted everything to work, [so] we did whatever they asked us to do, [and] they always were</p>

Theme and Summary	Representative Quotes
<p>and supported to meet youths' needs at home were highlighted. Several caregivers shared instances where they felt their needs and priorities weren't heard or accounted for. They were more satisfied when they felt meaningfully involved throughout the service spectrum from planning to decision-making as valued, trusted collaborators in their youths' care. Probation officers were noted as exceptional in communication, engagement, and advocacy.</p>	<p>there to help us do those things...All starting with his adoption worker. She was very involved if we had issues. She was right there, and she would connect us to people. We've been blessed that we've always had someone somewhere that was able to connect us to somewhere else when we need it. And like I said, I go out there, and you know, if I need it I'm like help, somebody. And usually we've had people that have been able to point us in the right direction." (Caregiver 3)</p> <p>"The support. The overall support for not just [youth], but us as parents. Sometimes we'd come up with things like now what do we do? Our support system has been very good [with] people that were in the know that could say, 'Well, let's try this.'...Both [community-based providers] are good listeners [who] hear me as a parent [and] trust me... I'm very involved." (Caregiver 4)</p> <p>"[Community-based therapist] was really awesome. She listened to everything I needed to say [and] wanted to talk about...Any kind of pointers or strategies for stuff she was really good about." (Caregiver 5)</p>
<p>Access and Awareness. Most caregivers felt that they had ultimately been able to access the services needed. Yet, several caregivers shared concerns with service awareness that impacts access. They had experienced difficulties in accessing responsive services at the intensity, specialization, and continuity needed to maintain positive gains amid complex and comorbid issues. This continuum included services in home and school, during crisis and emergency, as well as in transition among services and adulthood. Some spoke to deficiencies in psychiatric care, evaluations, and medications, as well as specialized</p>	<p>"I really don't know what's out there to know what I could have had, [but] we don't have very many options for therapy [or] mental health in our area...I don't think that West Virginia has [a] lot of places for the kids to talk to the counselors... I know [teachers] are overwhelmed, and I just don't think that there is enough support in the school for the teachers to give to the kids," (Caregiver 1).</p> <p>"When everything really started getting bad and escalating, [the process took] forever... She would come home [for] maybe two, four weeks, and then it would start all over again. And waiting on facilities to get her in. Trying to find facilities...Every time we've had to send her to a facility we have to go to the local hospital and she has to lay in that ER anywhere from 8 to 24 hours for them to get the facility," (Caregiver 2).</p> <p>"We did have all the services that I felt that we needed to help him, you know, be successful when he came home, [including] Safe at Home, his social worker, [and] probation officer." (Caregiver 3)</p> <p>"I have a lot of friends [who have] struggled with getting services. But like I said, I'm proactive. I go out there, and I look for it. But sometimes people don't know what's out there [or] what they</p>

Theme and Summary	Representative Quotes
<p>therapies and interventions with adequate capacity to meet those needs. Caregivers also wanted access to their own services and support to meet their youths' needs at home.</p>	<p>could be getting for their kids...There are so many more services out there for their children, [so] making it more public, [for] those that haven't had the experience." (Caregiver 4)</p> <p>"Well, I used to think that you couldn't get your kids back once they were taken. So that was something that no one made clear to me, [and] I've never seen [it]...I'm grateful that it's possible...You gotta do everything, [but] you can, [and] I didn't believe it until she actually got to come home...And it just needs to be heard." (Caregiver 5)</p>
<p>Family-Centered Service Continuum. Some caregivers perceived instances of premature discharge and/or inadequate services when youth demonstrated elevated need. Caregivers sometimes did not feel their concerns were adequately accounted for, particularly for the safety of their youth, family and community. They wanted greater in-home services and support for intensified needs and emergency situations. They also wanted a structured community continuum that could reinforce positive transition. They also wanted providers and staff to work thoroughly and holistically with the family to address complex, deep-rooted needs and equip caregivers with the knowledge, skills, and resources to benefit their family.</p>	<p>"[Youth] told her case manager on the way home that she [was] still suicidal [with] thoughts and voices in her head...We said, 'We're not ready for her to come home. She's not ready to come home.' The case worker reported us to CPS [who] said, 'Well, when you adopted her, you signed up for that.' Yeah, I signed up to be her parent, but I can't do 24/7 with a child that has high needs, and high risk. We'd already been to the ER you know several times with attempts." (Caregiver 2)</p> <p>"Instead of getting help, I lost my kid during an event...Instead of helping me in the home, instead of advising who and where to go...Instead of giving me guidance... No one bothered...completely evaluating [and] assessing the situation [and] what the family actually needs [to] give them the proper help...The environments and the situations I had put her in [were] my fault, [but] adults and children both have needs." (Caregiver 5)</p> <p>"I was almost, you know, assaulted, [and] they had us in prison in our own home. I had a CPS worker call me from [school] saying, 'I fear for you and your family's safety when [youth] gets home, [but] I'm not recommending that you take him to the ER because I know that if he doesn't say that he's going to harm somebody or something they'll just discharge him, and he'll be more angry.'...Get the programs in place before the child comes home. Have the parents have help." (Caregiver 6)</p>
<p>Satisfaction with Services. Though experiences were mixed, most dyads were satisfied with services received in WV. They've seen positive</p>	<p>"I just don't feel like they listen to [youth]. [Psychiatrist] just wants to put him on medication.... He was on so many meds in placement, and he said, like every month they'd switch them... So he just has a bad taste in his mouth for taking medication," (Caregiver 1)</p>

Theme and Summary	Representative Quotes
<p>changes in their youth and have found advocacy and support along the way. Satisfaction was dependent upon perceptions that youth had obtained the intensive, specialized, and tailored services needed with efficacy and utility. Again, perceived service engagement, communication, and responsiveness throughout planning and decision-making were critical to satisfaction. Providers and staff who worked within the system to secure family needs and priorities and equip caregivers with resources and support were also key. Additional factors included staff capacity, medication management, timely service entry and discharge. Youth are generally satisfied with services, particularly therapy, but less satisfied with medications.</p>	<p>"One of the best places I was at... I really liked it...It was strict with the structure, but I [that] worked [because] you couldn't really get away with stuff, so you kind of had to be good and learn stuff...The therapy was like amazing. I mean you got therapy every single day because of like group therapy, [so] I had kids that I could talk to, too, [about] like substance, or like trauma and stuff like that. So I talked about stuff that more like bothered me... And now [providers] just talk about like, am I okay with like meds?...They know I don't really like meds. They had me on so many in placement." (Youth 1)</p> <p>"Once I actually started doing what I needed to do: talking. Yes, it was helpful. But if you don't talk you're not going to get help... I [liked] that they actually did therapy [that] focused on my [disorder] because a lot of the kids there had it...We would do like group therapy [but] it wasn't really helpful [because] they didn't really like cover like specific topics." (Youth 2)</p> <p>"Yeah, I had a lot of fun [in therapy]... Still really fun... We play like fun therapy-based games...Therapy and counseling keeps me calmed down." (Youth 5)</p> <p>"[Therapist] definitely helped me as a parent. You know, it's my first child with mental health issues and there was just a lot, I just pour myself into him...[Therapist] would encourage me, encourage [youth], and then so that was just very helpful to us, making it through the next week, the next week...I just really needed that, [and] those methods they teach you, they work...Another positive through this whole thing...[Therapist] really tried his hardest to help [youth], but some kids need counseling, some kids need medication, [and] then some kids need placement, [and] some kids need all three... And that's where [youth] and eventually ended up with his continued needs." (Caregiver 6)</p>
<p>Satisfaction with DHHR. Most caregivers expressed mixed satisfaction with DHHR workers in Round 1. Such experiences were largely based upon perceptions of how prior and current workers engaged and involved the</p>	<p>"[Youth] had a [DHHR] worker that we never talked to. I meant there was not very good communication from her...We got another [DHHR] worker, and then she was absolutely great...She came [for] home visits [and] called...She was just very, very open with what was going on, and how she felt with what should be happening...She just really, really involved me and [second caregiver] in everything." (Caregiver 1)</p>

Theme and Summary	Representative Quotes
<p>caregiver in the process, from meeting times and process updates to ensuring the family's needs were heard and met. Less positive experiences with DHHR included perceptions of inconsistent communication and involvement, including not hearing their safety and security concerns during crises. Most caregivers attributed such barriers in part to capacity limitations and turned to other supports, namely probation officers, to get the information needed. Of note, issues encountered throughout the system tended to fall back on DHHR, including the perceived lack of resources and support, as well as engagement and capacity. One caregiver who shared her distinct prior distrust of the state system and services now perceived DHHR as a key resource for help and support.</p>	<p>"[DHHR] were involved during the whole process that she was in juvenile detention. And they took our rights. They said, not because anything we'd done wrong but because that's the only way they could get her help [and] get it paid for...So then they became strongly involved at that point." (Caregiver 2)</p> <p>"I don't think that we really call DHHR very often, but I know that here, [DHHR] were down to like two people," (Caregiver 3).</p> <p>"We don't really need any services, we just know that we can call DHHR [and] ask for it when we need to and find the proper people." (Caregiver 5)</p> <p>"I called [DHHR worker] really upset because I was almost, you know, assaulted. I said, 'I got to get him in there. If you guys don't help me, I'm going to bring him to the DHHR.'... Well, that got changed to, 'Oh, you can't do that, that's not legal.'...What do people do when they feel threatened? What? What's the normal response? They had us in prison in our own home....I can tell you what the pattern is with [youth]. If they don't get in and stop it, it's gonna be another cycle of him harming himself or harming somebody else." (Caregiver 6)</p>

16 Appendix G: Evaluation Questions and Indicators

Tables 38-46 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 38: 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?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ Medicaid ▪ KEPRO ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of youth who left RMHTF for a permanent reason, and did not return within 14 days³ 	<ul style="list-style-type: none"> ▪ High
How has length of stay in RMHTFs and PRTF changed since the agreement?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) 	<ul style="list-style-type: none"> ▪ Number of days in RMHTFs⁴ 	<ul style="list-style-type: none"> ▪ High

³ 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

⁴ 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) =

	<ul style="list-style-type: none"> ▪ Medicaid ▪ KEPRO ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of days in PRTF 	
Were fewer children with serious MH conditions needlessly removed from their family homes (after the Agreement)?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ Medicaid ▪ KEPRO ▪ DHHR records 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High
Can WV families with children who need MH services access those services in a reasonable period of time?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series ▪ Provider Focus Groups ▪ Key informant interviews ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

$$\frac{\sum_m^n (\text{exit date} - \text{entry date})}{n}$$

<p>How has the length of time to access services changed?</p>	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Case Series ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Length of time to service receipt (after identification or referral of service needs) ▪ Caregiver agreement on reasonableness of wait time 	<ul style="list-style-type: none"> ▪ High
<p>Can WV families with children who need MH services access those services in their communities?</p>	<ul style="list-style-type: none"> ▪ DHHR reports ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Surveillance Data 	<ul style="list-style-type: none"> ▪ 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 related ICD-10 codes 	<ul style="list-style-type: none"> ▪ High
<p>How has awareness of MH services for children changed among (families, MH providers, medical providers, partner organizations)?⁵</p>	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Change in level of awareness of available MH services ▪ Awareness of newly available MH 	<ul style="list-style-type: none"> ▪ Medium

⁵ 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.

	<ul style="list-style-type: none"> ▪ Case Series ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key informant Interviews ▪ System-level focus groups ▪ Surveillance Data 	<p>services (crisis line, mobile crisis) and processes for access</p> <ul style="list-style-type: none"> ▪ Use of WV emergency department for MH related ICD-10 codes ▪ Volume of calls to law enforcement related to juvenile cases 	
How has functioning changed for children receiving MH services?	<ul style="list-style-type: none"> ▪ DHHR records (Juvenile Justice, criminal justice, education) ▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ Caregiver Survey ▪ Caregiver Interviews ▪ Youth Survey ▪ Case Series ▪ Surveillance Data ▪ WV CANS 	<ul style="list-style-type: none"> ▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning (self-report by Caregivers and Youth) ▪ Educational involvement ▪ Hospitalizations and PRTF stays ▪ Use of WV emergency department for MH related ICD-10 codes 	<ul style="list-style-type: none"> ▪ High

<p>How has the use of community-based MH services changed?</p>	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Organization and Facility Survey ▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ System-level focus groups ▪ Surveillance data 	<ul style="list-style-type: none"> ▪ Number and type of services accessed ▪ Change in referral pathways ▪ Use of WV emergency department for MH related ICD-10 codes 	<ul style="list-style-type: none"> ▪ High
<p>Did fewer children with serious MH conditions unnecessarily enter RMHTF (after the agreement)? ⁴⁴</p>	<ul style="list-style-type: none"> ▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ Number of children in RMHTF ▪ Previous MH-related diagnoses ▪ Use of a validated and timely assessment ▪ Attitudes/philosophy toward referrals for RMHTF 	<ul style="list-style-type: none"> ▪ High
<p>How engaged are WV families in the MH treatment services for their children?</p>	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview 	<ul style="list-style-type: none"> ▪ Caregiver and youth self-reported involvement with treatment planning, goal setting and 	<ul style="list-style-type: none"> ▪ Medium

	<ul style="list-style-type: none"> ▪ Case Series ▪ Youth Survey ▪ Provider Survey 	<ul style="list-style-type: none"> 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 family satisfaction with children’s MH treatments and supports changed?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Case Series ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Caregiver and youth satisfaction with treatment ▪ Caregiver and youth experience with service delivery 	<ul style="list-style-type: none"> ▪ Medium
What proportion of children were appropriately assessed and placed in RMHTF or PRTF?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ KEPRO ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of youth in RMHTF/PRTF ▪ Number of youth with placement assessments ▪ Length of time between referral and assessment 	<ul style="list-style-type: none"> ▪ Medium
How many children have entered the juvenile justice system when they would have been better served in the MH system?	<ul style="list-style-type: none"> ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of DHHR youth entering juvenile and criminal justice system(s) ▪ Number of DHHR youth with petitions 	<ul style="list-style-type: none"> ▪ Medium

		<ul style="list-style-type: none"> Number of youth in Juvenile Services with previous Medicaid claims with MH related diagnosis codes 	
<p>How has the philosophy/attitude toward use of community-based services changed among youth/caregivers, providers, and partner organizations?⁶ (understanding the continuum of services)</p>	<ul style="list-style-type: none"> Caregiver Survey Case Series Provider Survey Provider Focus Groups Organization and Facility Survey Key Informant Interviews System- Level Focus Groups 	<ul style="list-style-type: none"> Agreement with prioritization of in-home and community-based service Perception of conditions for necessary residential placement 	<ul style="list-style-type: none"> High
<p>How well-integrated are MH services with community healthcare organizations?</p>	<ul style="list-style-type: none"> FACTS (PATH as of 1/2023) Provider Survey Provider Focus Groups Organization and Facility Survey Key Informant Interviews 	<ul style="list-style-type: none"> Referral pathways Proportion of referral completed Awareness of referrals across agencies Engagement of multidisciplinary team Barriers to integration 	<ul style="list-style-type: none"> Medium

⁶ 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.

	<ul style="list-style-type: none"> ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ Level of communication among organizations ▪ Number of MH provider organizations with processes for data sharing 	
How have referral pathways changed? ⁷	<ul style="list-style-type: none"> ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ Number of youth referred to community-based programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types 	<ul style="list-style-type: none"> ▪ Low
How has capacity of the MH workforce changed?	<ul style="list-style-type: none"> ▪ DHHR reports ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

⁷ This question is at the provider- and system-level. It was rated low as a provider-level outcome but medium as a system-level.

	<ul style="list-style-type: none"> System-Level Focus Groups 	<ul style="list-style-type: none"> Number of providers who are able to meet need for MH services (self-report) Provider perception of workforce capacity to meet population MH needs 	
Are the community-based programs associated with the Initiative meeting their desired outcomes? ⁸	<ul style="list-style-type: none"> DHHR Reporting FACTS Provider Focus Groups 	<ul style="list-style-type: none"> Number of youth referred to RMHTF or PRTF from community-based programs Barriers and facilitators to meeting desired outcomes 	<ul style="list-style-type: none"> Medium
How have waiting periods changed for MH services? ⁹	<ul style="list-style-type: none"> DHHR reporting FACTS (PATH as of 1/2023) KEPRO Organization and Facility Survey Key Informant Interviews 	<ul style="list-style-type: none"> Organizational service capacity Workforce capacity Length of time to service receipt 	<ul style="list-style-type: none"> High
How have referral pathways changed between traditional and MH providers?	<ul style="list-style-type: none"> KEPRO 	<ul style="list-style-type: none"> Number of youth referred by provider type 	<ul style="list-style-type: none"> Low

⁸ This question is at the provider- and system-level. It was rated medium as a provider- and system-level.

⁹ This question is at the provider- and system-level. It was rated high as a provider- and system-level.

	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ Referral patterns by organization type ▪ Referral follow up practices by provider type 	
How have communication and working relationships between MH and traditional healthcare providers changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Low
How have the quality and timeliness of MH assessments/screenings changed? ¹⁰	<ul style="list-style-type: none"> ▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ Assessment tool fidelity ▪ Number of assessments ▪ Length of time between assessments ▪ Barriers and facilitators to timely assessments and screenings 	<ul style="list-style-type: none"> ▪ High

¹⁰ This question is at the provider- and system-levels. It was rated high as a provider- and system-level.

		<ul style="list-style-type: none"> ▪ Number of screenings ▪ Length of time between screenings ▪ Barriers and facilitators to timely screenings 	
How has the capacity of the MH service system workforce changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Number and location of providers ▪ Number and location of organizations ▪ Number of years of service provider experience 	<ul style="list-style-type: none"> ▪ High
Are all planned services available in each region?	<ul style="list-style-type: none"> ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number and type of service provider organizations 	<ul style="list-style-type: none"> ▪ High
How have coordination and communication among agencies and bureaus changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Low
How have crisis response times changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ KEPRO 	<ul style="list-style-type: none"> ▪ Mobile crisis response time 	<ul style="list-style-type: none"> ▪ High

How have standards changed for MH services?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System-Level Focus Groups ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Certification requirements ▪ Training requirements ▪ Barriers to achieving desired standards 	<ul style="list-style-type: none"> ▪ Low
How engaged are stakeholders with DHHR bureaus and MH programs?	<ul style="list-style-type: none"> ▪ Key Informant Interviews ▪ Provider Focus Groups ▪ System-Level Focus Groups 	<ul style="list-style-type: none"> ▪ Level of stakeholder engagement ▪ Level of stakeholder active participation 	<ul style="list-style-type: none"> ▪ Medium

Table 39: Wraparound-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How engaged are WV families in Wraparound treatment?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ *

		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?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interviews ▪ Case Series 	<ul style="list-style-type: none"> ▪ Change in level of awareness of available Wraparound services ▪ Awareness of processes for access to Wraparound services 	<ul style="list-style-type: none"> ▪ High
How did receiving Wraparound services contribute to children's ability to remain at home?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ DHHR records (juvenile justice, criminal justice, education) 	<ul style="list-style-type: none"> ▪ Caregiver and youth agreement with treatment outcomes ▪ Caregiver and youth agreement with functional outcomes ▪ Caregiver and youth rating of Wraparound's contribution ▪ Number of youth enrolled in wraparound with involvement in juvenile services 	<ul style="list-style-type: none"> ▪ High
How has the length of stay for inpatient hospitalizations changed among Wraparound participants?	<ul style="list-style-type: none"> ▪ KEPRO ▪ FACTS (PATH as of 1/2023) 	<ul style="list-style-type: none"> ▪ Length of stay 	<ul style="list-style-type: none"> ▪ Low

How has child functioning among Wraparound participants changed?	<ul style="list-style-type: none"> ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning (self-report caregiver and youth) 	<ul style="list-style-type: none"> ▪ *
How has the use of Wraparound services changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ KEPRO 	<ul style="list-style-type: none"> ▪ Number of wraparound services utilized ▪ Number of unique individuals receiving Wraparound services ▪ Number of referrals to Wraparound programs 	<ul style="list-style-type: none"> ▪ *
How have Wraparound providers' knowledge and skills changed?	<ul style="list-style-type: none"> ▪ DHHR Implementation Data ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ Level of provider knowledge of NWI ▪ Level of Wraparound skills 	<ul style="list-style-type: none"> ▪ High
How has coordination/communication between Wraparound providers and non-Wraparound providers changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ Level of provider agreement on existence of communication among wraparound providers 	<ul style="list-style-type: none"> ▪ *

		<ul style="list-style-type: none"> 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?	<ul style="list-style-type: none"> KEPRO Organization and Facility Survey 	<ul style="list-style-type: none"> Length of time to service receipt from referral 	<ul style="list-style-type: none"> *
How has capacity of the Wraparound workforce changed?	<ul style="list-style-type: none"> DHHR records Provider Survey Provider Focus Groups Organization and Facility Survey Key Informant Interviews 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> *
Can WV families with children who need MH services access Wraparound services in their communities?	<ul style="list-style-type: none"> DHHR records Caregiver Survey Caregiver Interview Case Series Youth Survey 	<ul style="list-style-type: none"> Caregiver agreement with service access and availability Barriers to access to preferred locations or services Available providers by region Caregiver agreement with 	<ul style="list-style-type: none"> *

		<p>convenient location</p> <ul style="list-style-type: none"> Youth 18-21 agreement on convenient location 	
How has fidelity to the NWI model changed?	<ul style="list-style-type: none"> DHHR Implementation Data 	<ul style="list-style-type: none"> Fidelity adherence 	<ul style="list-style-type: none"> *
How has coordination/communication between the two Wraparound programs changed?	<ul style="list-style-type: none"> DHHR records Organization and Facility Survey Key Informant Interviews Provider Survey 	<ul style="list-style-type: none"> Level of coordination Number of referrals 	<ul style="list-style-type: none"> *
How has the availability of Wraparound services changed?	<ul style="list-style-type: none"> DHHR Implementation Data DHHR records 	<ul style="list-style-type: none"> Number of NWI trained providers 	<ul style="list-style-type: none"> *
How has the quality and timeliness of CANS assessment for the Wraparound program changed?	<ul style="list-style-type: none"> DHHR implementation data DHHR records KEPRO WV CANS 	<ul style="list-style-type: none"> Length of time to first assessment Length of time between assessments Number of assessments completed by an independent trained person 	<ul style="list-style-type: none"> *
How has knowledge of the NWI model among Wraparound providers changed?	<ul style="list-style-type: none"> DHHR implementation data Provider Survey 	<ul style="list-style-type: none"> Level of knowledge of NWI model 	<ul style="list-style-type: none"> *

	<ul style="list-style-type: none"> ▪ Provider Focus Groups 		
How has awareness among professional stakeholders related to eligibility/accessibility of Wraparound services changed?	<ul style="list-style-type: none"> ▪ DHHR implementation data ▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Level of knowledge of eligibility ▪ Level of awareness of available wraparound services ▪ Level of awareness of processes for wraparound referrals and access 	<ul style="list-style-type: none"> ▪ High

Table 40: 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?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Youth Surveys ▪ Caregiver Interview ▪ Case Series ▪ DHHR records (juvenile justice, criminal justice, education) 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

		mobile crisis services with involvement in juvenile services	
How has child functioning among Mobile Crisis Service participants changed?	<ul style="list-style-type: none"> ▪ FACTS (PATH as of 1/2023) ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Interview ▪ Surveillance data 	<ul style="list-style-type: none"> ▪ Level of short-term functioning (e.g., stabilization, ability to remain at home) 	<ul style="list-style-type: none"> ▪ *
What proportion of families contact the crisis line more than once?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Case series 	<ul style="list-style-type: none"> ▪ Number of repeat crisis line contacts 	<ul style="list-style-type: none"> ▪ Low
How satisfied are families with the Mobile Crisis services received?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ Caregiver level of satisfaction with service receipt ▪ Level of youth satisfaction with service receipt ▪ Caregiver and youth experience with service delivery 	<ul style="list-style-type: none"> ▪ High
How accessible are mobile crisis services to families?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Interview ▪ Case Series ▪ Organization and Facility Survey ▪ Surveillance Data 	<ul style="list-style-type: none"> ▪ Caregiver agreement with service access and availability ▪ Available providers by region ▪ Caregiver and youth perceptions of availability 	<ul style="list-style-type: none"> ▪ *

		and/or use of crisis call services	
How engaged are WV families in children mobile crisis treatment?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Surveillance data 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ *
How has the number of petitions for juvenile justice in response to a crisis situation changed?	<ul style="list-style-type: none"> ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of Juvenile Justice petitions ▪ Number of children entering Juvenile Justice system 	<ul style="list-style-type: none"> ▪ Low
What is the frequency of Mobile Crisis usage and	<ul style="list-style-type: none"> ▪ DHHR reports 	<ul style="list-style-type: none"> ▪ Number of calls to Crisis hotline 	<ul style="list-style-type: none"> ▪ Low

how has this changed over time?			
How has awareness among West Virginians related to availability of mobile crisis services/the mobile crisis hotline changed?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Youth Survey ▪ Case Series 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High
How well-integrated are Mobile Crisis services with community healthcare organizations?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Level of provider agreement on existence of coordination between Mobile Crisis teams and community healthcare organizations 	<ul style="list-style-type: none"> ▪ *
How are the working relationships between Mobile Crisis services and traditional medical providers?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ *

		treatment planning and delivery	
How is the coordination and communication between Mobile Crisis and community-based organizations?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interview ▪ System-Level Focus groups 	<ul style="list-style-type: none"> ▪ Barriers and facilitators to coordination and communication between Mobile Crisis Teams and community-based organizations 	<ul style="list-style-type: none"> ▪ *
How have the hotline staff changed?	<ul style="list-style-type: none"> ▪ DHHR reports ▪ Provider Survey 	<ul style="list-style-type: none"> ▪ Number of adequately trained workforce ▪ Number of providers who are able to meet need for MH services (self-report) 	<ul style="list-style-type: none"> ▪ *
How well do Mobile Crisis services communicate with traditional medical providers?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Provider level of agreement about communication with traditional providers 	<ul style="list-style-type: none"> ▪ *
What are the referral pathways between Mobile Crisis and other service providers?	<ul style="list-style-type: none"> ▪ Provider survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ Number and type of referrals to Mobile Crisis Response services ▪ Number of children referred to community-based programs by 	<ul style="list-style-type: none"> ▪ Medium

	<ul style="list-style-type: none"> ▪ DHHR reports 	<p>Mobile Crisis providers</p> <ul style="list-style-type: none"> ▪ Barriers to referrals to community-based programs 	
How routinely are standardized and approved assessments used by Mobile Crisis services?	<ul style="list-style-type: none"> ▪ DHHR reports ▪ KEPRO ▪ Provider Survey 	<ul style="list-style-type: none"> ▪ Type of assessment ▪ Length of time between assessments 	<ul style="list-style-type: none"> ▪ *
How have the mobile crisis teams changed?	<ul style="list-style-type: none"> ▪ DHHR reports ▪ Provider Survey ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ Number of adequately trained workforce ▪ Number of providers who are able to meet need for MH services (self-report) ▪ Provider perception of workforce capacity to meet population MH needs 	<ul style="list-style-type: none"> ▪ *
How has the length of time to respond to a child crisis situation changed?	<ul style="list-style-type: none"> ▪ DHHR reports ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ Length of Mobile Crisis response time 	<ul style="list-style-type: none"> ▪ High
How have QA/PI processes improved CMCR services?	<ul style="list-style-type: none"> ▪ DHHR Implementation data ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Use of QA/PI data 	<ul style="list-style-type: none"> ▪ High

How has the availability of Mobile Crisis services changed?	<ul style="list-style-type: none"> ▪ DHHR Implementation Data ▪ DHHR records ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Number of provider organizations and service area location ▪ Number of trained workforce and service area location 	<ul style="list-style-type: none"> ▪ *
How has the average response time for crisis response services changed?	<ul style="list-style-type: none"> ▪ DHHR Records ▪ DHHR implementation data 	<ul style="list-style-type: none"> ▪ Response time 	<ul style="list-style-type: none"> ▪ Low
How engaged are stakeholders with Mobile Crisis services?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Level of stakeholder engagement with service providers ▪ Level of capacity to engage services independently 	<ul style="list-style-type: none"> ▪ *

Table 41: Positive Behavior Support-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question	Data Source	Indicators	Priority
How has child functioning among PBS participants changed?	<ul style="list-style-type: none"> ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ DHHR records ▪ WV CANS ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High
How has academic engagement among PBS participants changed?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Educational involvement ▪ Self-report educational experiences 	<ul style="list-style-type: none"> ▪ Medium to High
How has quality of life changed for children and families following PBS intervention?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series ▪ DHHR records ▪ KEPRO ▪ FACTS ▪ WV CANS 	<ul style="list-style-type: none"> ▪ Level of clinical functioning (CANS, CAFAS) ▪ Level of overall functioning ▪ Caregiver and youth satisfaction with care ▪ Hospitalizations and PRTF stays ▪ Educational involvement 	<ul style="list-style-type: none"> ▪ Medium

<p>Can WV families with children who need MH crisis services access PBS services within their community?</p>	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Youth Survey ▪ Caregiver Interview ▪ Case Series ▪ Surveillance Data 	<ul style="list-style-type: none"> ▪ Caregiver agreement with service access and availability ▪ Available providers by region ▪ Caregiver and Youth perceptions of availability and/or use of PBS services ▪ Use of WV emergency department for MH related ICD-10 codes 	<ul style="list-style-type: none"> ▪ High
<p>How have family/caregiver knowledge and skills changed to meet youth behaviors and needs?</p>	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ Caregiver knowledge ▪ Provider perception of barriers to improved knowledge and skills ▪ Number of providers trained 	<ul style="list-style-type: none"> ▪ Medium
<p>How has family engagement with MH services changed after PBS intervention?</p>	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey 	<ul style="list-style-type: none"> ▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery ▪ Caregiver and youth reported barriers and facilitators 	<ul style="list-style-type: none"> ▪ High

How has the quality and timeliness of CANS screenings for PBS participants changed?	<ul style="list-style-type: none"> ▪ DHHR implementation data 	<ul style="list-style-type: none"> ▪ Fidelity of tool delivery ▪ Length of time to reassessment 	<ul style="list-style-type: none"> ▪ Medium
How has the capacity to provide PBS services changed at the region and state levels?	<ul style="list-style-type: none"> ▪ DHHR Implementation Data ▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ 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 ▪ Sustained delivery of PBS services to meet needs statewide ▪ Expanded workforce and system capacity to provide PBS services statewide 	<ul style="list-style-type: none"> ▪ Medium
How has the availability of PBS services changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Provider Survey ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ Number of trained PBS providers 	<ul style="list-style-type: none"> ▪ High
How has coordination/communication between PBS providers and child serving agencies changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ Level of provider agreement on existence of communication among PBS 	<ul style="list-style-type: none"> ▪ Medium to High

	<ul style="list-style-type: none"> Organization and Facility Survey 	<p>providers and partner agencies</p> <ul style="list-style-type: none"> Increased coordination/communication across child-serving agencies Increased referral pathways across child-serving MH programs and bureaus 	
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?	<ul style="list-style-type: none"> Provider Survey 	<ul style="list-style-type: none"> Level of PBS skills Experience with PBS 	<ul style="list-style-type: none"> High
How has fidelity of PBS service delivery related to standards of practice changed?	<ul style="list-style-type: none"> DHHR implementation data 	<ul style="list-style-type: none"> PBS fidelity adherence 	<ul style="list-style-type: none"> High
How has the use of PBS services changed?	<ul style="list-style-type: none"> KEPRO DHHR records Caregiver Survey Youth Survey 	<ul style="list-style-type: none"> PBS service utilization 	<ul style="list-style-type: none"> *
How has the length of time to access PBS services changed?	<ul style="list-style-type: none"> KEPRO DHHR records Caregiver Survey Youth Survey 	<ul style="list-style-type: none"> Length of time to service receipt 	<ul style="list-style-type: none"> High

	<ul style="list-style-type: none"> Organization and Facility Survey 		
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Table 42: 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?	<ul style="list-style-type: none"> FACTS (PATH as of 1/2023) KEPRO DHHR records 	<ul style="list-style-type: none"> Number of ACT referrals 	<ul style="list-style-type: none"> Medium to high priority – tied to policy change
How has involvement with the criminal justice system among ACT participants changed?	<ul style="list-style-type: none"> DHHR records 	<ul style="list-style-type: none"> Criminal justice encounters among ACT enrolled individuals 	<ul style="list-style-type: none"> Low to medium
How have referrals and orders to the criminal justice system changed for ACT eligible participants?	<ul style="list-style-type: none"> DHHR records 	<ul style="list-style-type: none"> Criminal justice encounters among ACT enrolled individuals 	<ul style="list-style-type: none"> Low to Medium
How has the length of stay for inpatient hospitalizations due to a primary MH condition changed among ACT participants?	<ul style="list-style-type: none"> KEPRO FACTS (PATH as of 1/2023) DHHR records 	<ul style="list-style-type: none"> Length of stay 	<ul style="list-style-type: none"> Medium
How has child functioning among ACT participants changed?	<ul style="list-style-type: none"> KEPRO FACTS (PATH as of 1/2023) DHHR records Caregiver Survey 	<ul style="list-style-type: none"> Level of clinical functioning (CANS, CAFAS) Level of overall functioning 	<ul style="list-style-type: none"> Medium

	<ul style="list-style-type: none"> Caregiver Interview Youth Survey Surveillance data 	<ul style="list-style-type: none"> Hospitalizations and RMHFT stays Educational involvement 	
How has the acceptance of community-based MH treatment (for ACT) as an alternative to RMHTF placement changed?	<ul style="list-style-type: none"> FACTS (PATH as of 1/2023) KEPRO DHHR records Provider Survey Provider Focus Groups 	<ul style="list-style-type: none"> Number of children in RMHTF Perception of criteria for placement in RMHTF 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Provider Survey Provider Focus Groups 	<ul style="list-style-type: none"> Level of provider knowledge of eligibility Level of provider awareness of available ACT services Level of awareness of processes for ACT referrals and access 	<ul style="list-style-type: none"> High
How has the availability of ACT services changed?	<ul style="list-style-type: none"> DHHR records DHHR Implementation Data Organization and Facility Survey 	<ul style="list-style-type: none"> Number of ACT provider organizations Number of counties/regions with available ACT services Number of qualified ACT team members 	<ul style="list-style-type: none"> High – need to demonstrate statewide coverage

How has the use of ACT services changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ DHHR implementation data ▪ KEPRO 	<ul style="list-style-type: none"> ▪ ACT team caseload ▪ Utilization volume of ACT services per enrolled individual ▪ Total number of unique individuals being served by ACT programs 	<ul style="list-style-type: none"> ▪ Medium, because somewhat contingent on eligibility
How many ACT team members met all of the model fidelity factors?	<ul style="list-style-type: none"> ▪ DHHR records ▪ KEPRO 	<ul style="list-style-type: none"> ▪ Statewide access to children’s MH prevention and treatment services 	<ul style="list-style-type: none"> ▪ *

Table 43: 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? ¹¹	<ul style="list-style-type: none"> ▪ KEPRO 	<ul style="list-style-type: none"> ▪ Length of time to screening ▪ Number of children being screened 	<ul style="list-style-type: none"> ▪ High
Can WV families with children who need MH services access those services in their communities?	<ul style="list-style-type: none"> ▪ KEPRO ▪ DHHR records ▪ FACTS (PATH as of 1/2023) 	<ul style="list-style-type: none"> ▪ Length of time to service receipt (after identification or referral of service needs) 	<ul style="list-style-type: none"> ▪ High

¹¹ 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.

	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ Decreased involvement with Juvenile Justice ▪ Caregiver agreement on reasonableness of wait time ▪ Barriers to access ▪ All youth are appropriately assessed and placed in RMHTFs 	
How has awareness of MH services for children changed among (families, MH providers, medical providers, partner organizations)?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Youth Survey ▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey ▪ DHHR records ▪ Surveillance data 	<ul style="list-style-type: none"> ▪ 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 ▪ Increased referrals 	<ul style="list-style-type: none"> ▪ Medium
How engaged are WV families in the MH treatment services for their children?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making 	<ul style="list-style-type: none"> ▪ High

	<ul style="list-style-type: none"> ▪ Youth Survey ▪ Provider Survey 	<p>related service delivery</p> <ul style="list-style-type: none"> ▪ Caregiver and youth self-reported barriers and facilitators ▪ Provider perception of family involvement in treatment planning, goal setting and decision making related service delivery 	
How well-integrated are MH services with community healthcare organizations?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews ▪ System Focus Groups ▪ KEPRO ▪ DHHR records 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Medium
How have referral pathways changed?	<ul style="list-style-type: none"> ▪ KEPRO ▪ Provider Survey 	<ul style="list-style-type: none"> ▪ Number of children referred to community-based 	<ul style="list-style-type: none"> ▪ Low

	<ul style="list-style-type: none"> ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System Focus Groups 	<ul style="list-style-type: none"> programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types 	
How have referral pathways changed between traditional and MH providers?	<ul style="list-style-type: none"> ▪ KEPRO ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ Number of children referred by provider type ▪ Referral patterns by organization type ▪ Referral follow-up practices by provider type 	<ul style="list-style-type: none"> ▪ Low
How have the quality and timeliness of MH assessments/screenings changed?	<ul style="list-style-type: none"> ▪ DHHR implementation data ▪ DHHR records ▪ KEPRO ▪ FACTS (PATH as of 1/2023) ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

How have coordination and communication among agencies and bureaus changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High
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Table 44: Workforce-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question ¹²	Data Source	Indicators	Priority
How many MH providers are available to treat children in WV?	<ul style="list-style-type: none"> ▪ DHHR records 	<ul style="list-style-type: none"> ▪ Number of MH providers statewide 	<ul style="list-style-type: none"> ▪ High
Can WV families with children who need MH services access those services in their communities?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Surveillance Data 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

¹² The Evaluation Questions included in this table are at the Initiative-level but are indicated within the workgroup specific logic model.

		department for MH related ICD-10 codes	
How has awareness of MH services for children changed among MH providers and medical providers?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ Key Informant Interviews ▪ Surveillance Data ▪ DHHR records 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Medium
How has capacity of the MH workforce changed?	<ul style="list-style-type: none"> ▪ DHHR records ▪ Provider Survey ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

	<ul style="list-style-type: none">▪ System-Level Focus Groups	<p>for MH services (self-report)</p> <ul style="list-style-type: none">▪ Provider perception of workforce capacity to meet population MH needs	
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Table 45: Outreach-Specific Evaluation Questions, Data Sources, and Indicators

Evaluation Question ¹³	Data Source	Indicators	Priority
Did fewer children with serious MH conditions unnecessarily enter RMHTF (after the agreement)?	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Highest
How engaged are WV families in the MH treatment services for their children?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Youth Survey ▪ Case Series ▪ Provider Survey 	<ul style="list-style-type: none"> ▪ Caregiver and youth self-report involvement with treatment planning, goal setting and decision making related service delivery 	<ul style="list-style-type: none"> ▪ High

¹³ The Evaluation Questions included in this table are at the Initiative-level but are indicated within the workgroup specific logic model.

		<ul style="list-style-type: none"> ▪ 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 MH services for children changed among (families, MH providers, medical providers, DOE staff, courts, police)?	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

How have coordination and communication among agencies and bureaus changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus Groups ▪ Organization and Facility Survey 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Medium
How have referral pathways changed?	<ul style="list-style-type: none"> ▪ Provider Survey ▪ KEPRO ▪ Provider Focus Groups ▪ Organization and Facility Survey ▪ System Focus Groups 	<ul style="list-style-type: none"> ▪ Number of children referred to community-based programs by provider type ▪ Referral patterns by organization type ▪ Barriers to referrals by provider types 	<ul style="list-style-type: none"> ▪ High

Table 46: 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? ¹⁴	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview 	<ul style="list-style-type: none"> ▪ Caregiver and youth self-report involvement with treatment planning, goal setting and 	<ul style="list-style-type: none"> ▪ High

¹⁴ New question based on workgroup feedback.

	<ul style="list-style-type: none"> ▪ Youth Survey ▪ Case Series 	<p>decision making related service delivery</p> <ul style="list-style-type: none"> ▪ Caregiver and youth reported barriers and facilitators 	
How has the philosophy/attitude toward community-based services (including residential) among families changed? (understanding the continuum of services)	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series 	<ul style="list-style-type: none"> ▪ Attitudes toward RMHTF use, in-home care 	<ul style="list-style-type: none"> ▪ High
How has family engagement in aftercare planning as a part of discharge planning changed?	<ul style="list-style-type: none"> ▪ Caregiver Survey ▪ Caregiver Interview ▪ Case Series ▪ Provider Survey 	<ul style="list-style-type: none"> ▪ Increased engagement with aftercare planning 	<ul style="list-style-type: none"> ▪ *
How has the philosophy/attitude toward community-based services (including residential) among RMHTF staff? (understanding the continuum of services)	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ High

<p>How has the philosophy/attitude toward community-based services (including residential) changed among stakeholders? (understanding the continuum of services)</p>	<ul style="list-style-type: none"> ▪ Provider Survey ▪ Provider Focus Groups ▪ System Focus groups ▪ Key Informant Interviews 	<ul style="list-style-type: none"> ▪ 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) 	<ul style="list-style-type: none"> ▪ High
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