
Summary Report

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

Year 2 Data Collected from Community
Partners, Caregivers, and Youth in
Residential Mental Health Treatment

July 2023

Revised: January 2024



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Introduction

Evaluation Overview

West Virginia University Health Affairs Institute is conducting a longitudinal evaluation of the West Virginia Department of Health and Human Resources (WV DHHR) Children’s In-Home and Community-Based Services Improvement Project. The mixed method evaluation was designed to provide information about the perspectives and experiences of people and partners at all levels of the youth mental and behavioral health system: organizations and facilities; providers, including cross-sector partners; caregivers; and youth with mental and/or behavioral health needs.

Data collection methods include:



SURVEYS



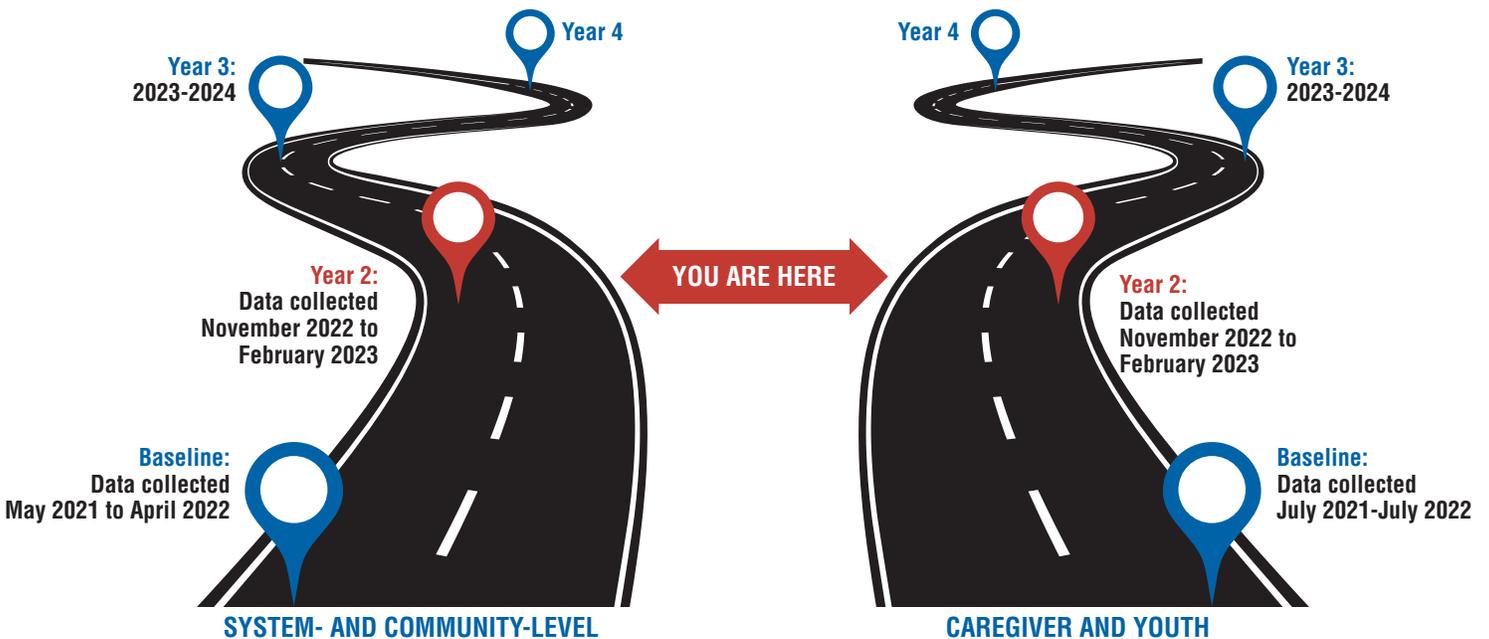
INTERVIEWS



SECONDARY DATA

Data collected during each year of the Evaluation are intended to provide a snapshot of the experiences of people in the field, as well as youth receiving mental and behavioral health services and their families. During and after data collection, WV DHHR and stakeholders across the system are actively engaged in making changes to policies and practices that are not reflected in the presented data. As part of a longitudinal evaluation, future reporting will provide additional insight into the cumulative work over the course of the project.

4-YEAR EVALUATION



Report Overview

This report is a supplement to the July 2023 Evaluation Report which includes data collected at the system-level, community partners, youth in residential mental health treatment (RMHT) and their caregivers. The report is focused on Year 2 data collected between November 2022 and February 2023, and also includes comparisons to Baseline data from 2022 reports. This supplemental report is designed to provide an overview of key findings from the first two years of data collection. For additional data and analysis, please refer to the full report; a topical index is provided in the Appendix to facilitate navigation.

Data presented in this report were collected from 1,141 providers and 52 organizations as well as 174 caregivers and 156 youth who were in residential mental health treatment on July 1, 2022. The responses provide perceptions about services being offered by:

- Children’s Mobile Crisis Response and Stabilization (CMCRS)
- Wraparound: For caregivers and youth, in this report Wraparound (WRAP) includes WV Children’s Mental Health Wraparound and the Children with Serious Emotional Disorders (CSED) Wavier Wraparound. For providers and organizations, this refers to WV Children’s Mental Health Wraparound (CMHW) unless otherwise specified.
- Behavioral Support Services (including Positive Behavior Support; PBS), referred to below as BSS
- Assertive Community Treatment (ACT)
- Residential mental health treatment (RMHT)
- Children’s Crisis and Referral Line (CCRL; 844-HELP4WV)

In this report, data are presented in the following sections: 1) access to services; 2) experiences with services; 3) statewide workforce; 4) youth and family status; and, 5) and service-level data. Readers are encouraged to access the section(s) that are most relevant to their interests and needs. Quantitative and qualitative results are highlighted to provide insight into provider and partner perspectives, share suggestions from respondents for expanding on what’s working, and to inform dialogue around opportunities for systems improvements.

In this report:

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

Overall, evaluation results were very clear: mental and behavioral health services continue to be valued and important to the wellbeing of youth in West Virginia. Year 2 evaluation data presented here are intended to capture the successes of the system to empower West Virginians to reach their potential.



Access to Services

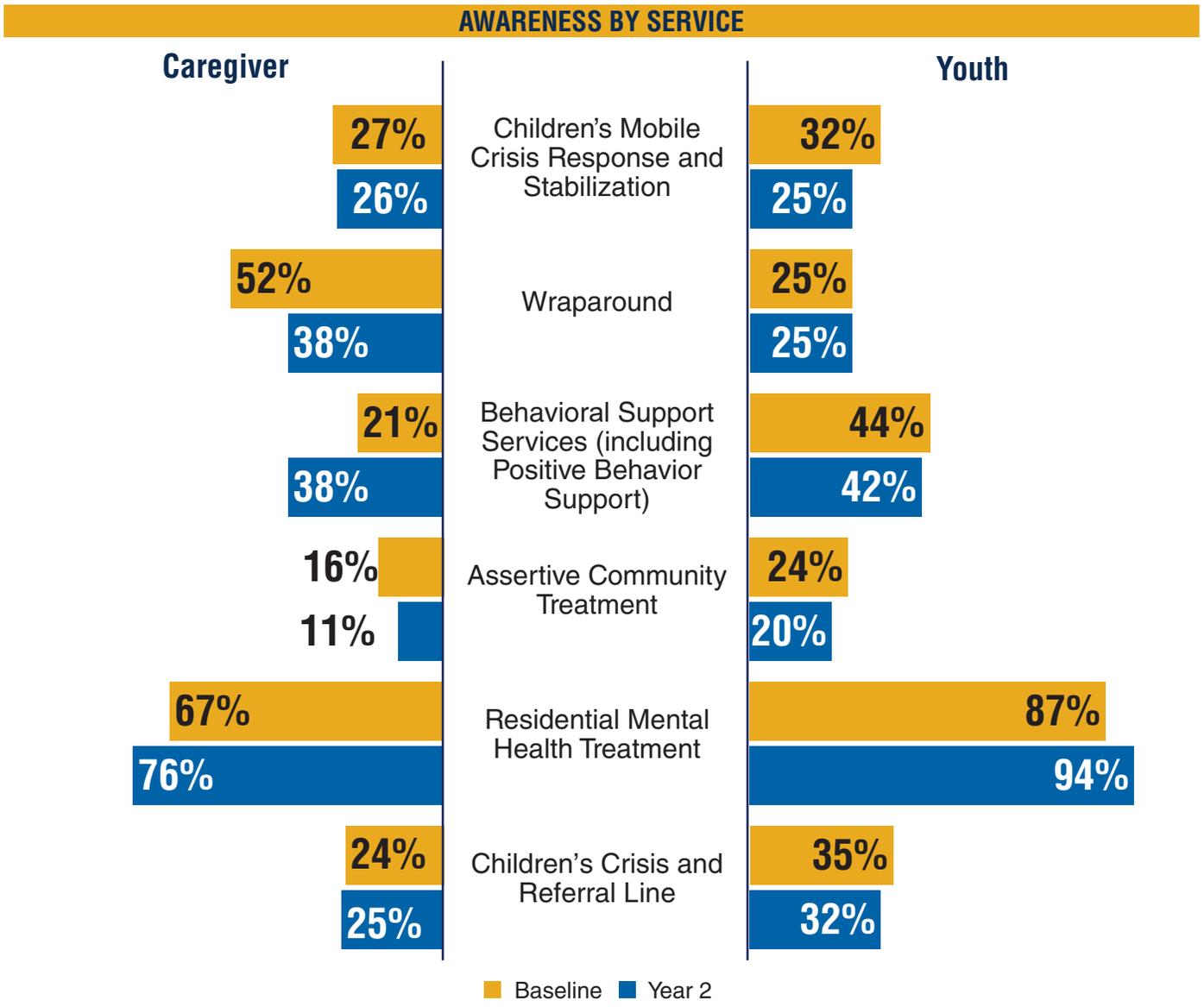
Access to Services

Delivery of mental and behavioral health care encompasses a wide range of services, treatments, and supports for youth and their families. As West Virginia has continued to prioritize community-based treatment options for youth, evaluation results indicate that providers, caregivers, and youth all value existing services and want more of them. Across all respondents, a desire for a wider variety of services that could address a broader range of needs in community-based settings was also noted.

Caregiver and Youth Awareness

Youth and caregiver awareness of community-based services remained generally the same across Baseline and Year 2. In both years, caregivers and youth were most aware of BSS including PBS and least aware of ACT.

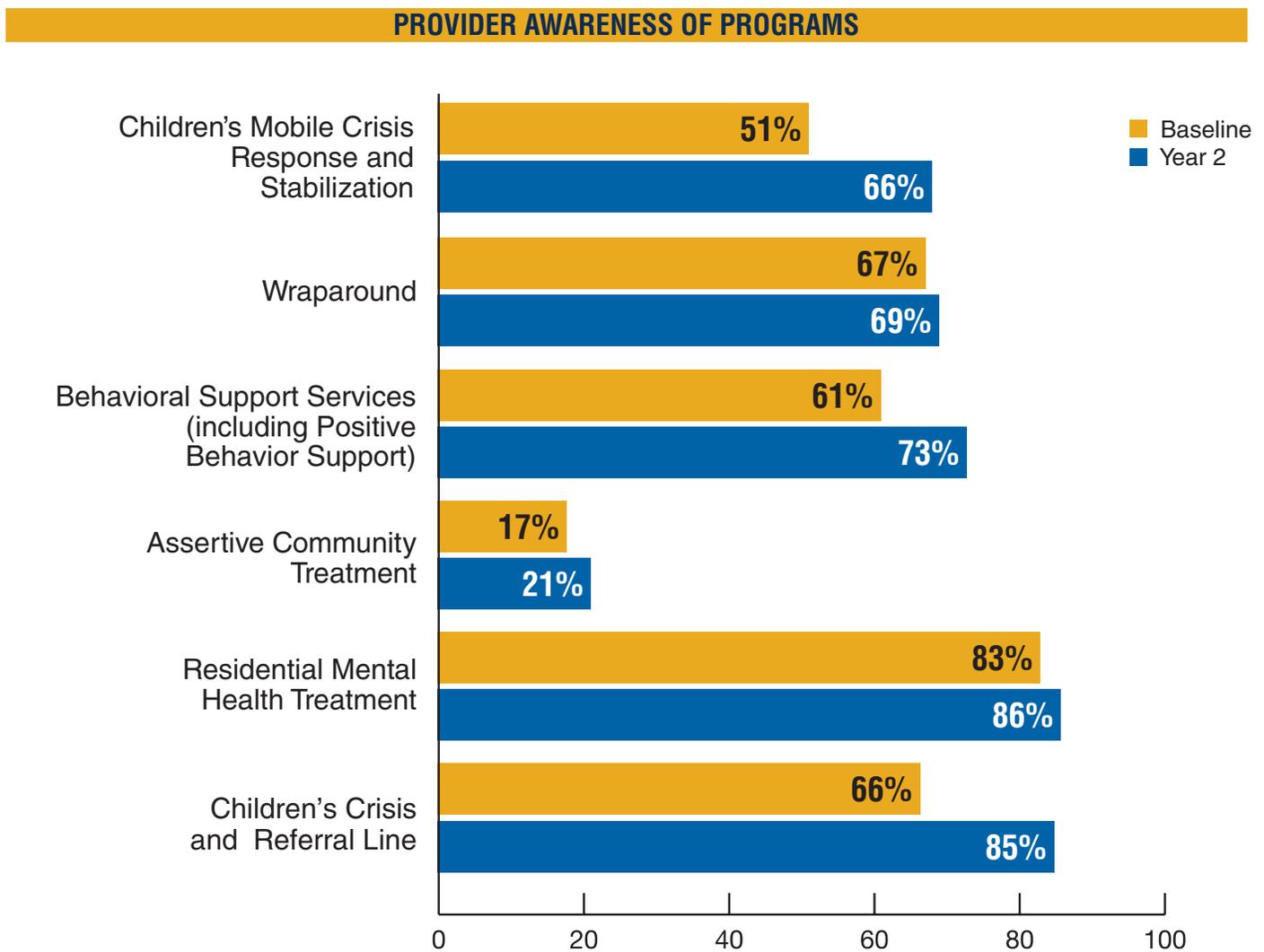
Caregivers agreed that they had the knowledge to start and use all of the services being evaluated. Youth in RMHT in Year 2 agreed that they had the knowledge to start and use CCRL and Wraparound, but neither agreed nor disagreed for the other services.



Similar to findings at Baseline, youth and caregivers do not always share the same language as providers relating to services. Examples of this include: which program a client is enrolled in and receives services under, titles of staff involved with the program, and what types of services are delivered by programs. In Year 2 data collection, for example, youth regularly identified Behavioral Support Services including PBS with the Behavioral Support Specialist position who often work with youth in RMHT settings.

Provider Awareness

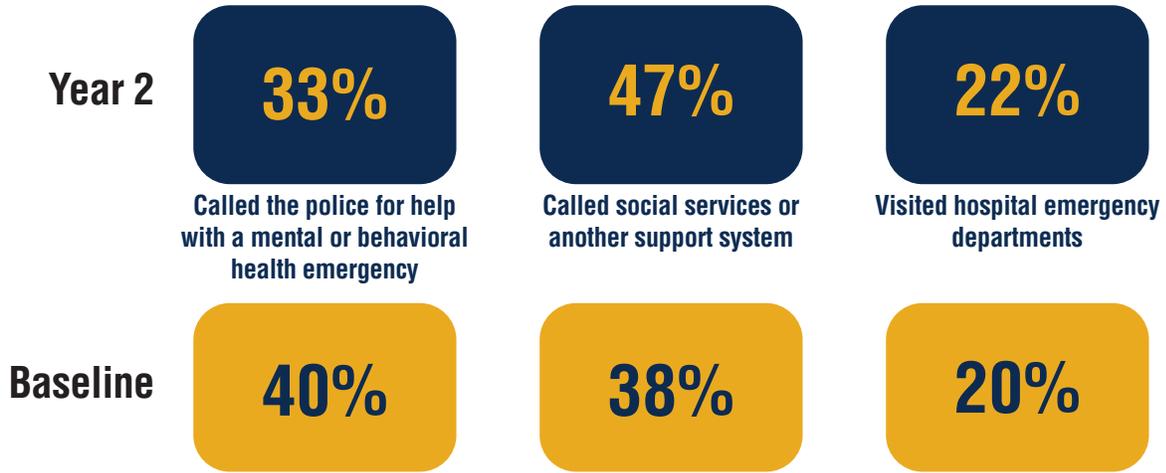
Providers play a critical role in connecting youth and caregivers to mental and behavioral health services. During the Year 2 data collection period, DHHR was actively engaged in providing information and resources to providers across the state. As such, results may not reflect the level of change that has been achieved since Baseline. Even so, there was a 19% increase in awareness of the Children’s Crisis and Referral Line, a 15% increase in awareness of Children’s Mobile Crisis Response and Stabilization, and a 12% increase in awareness of BSS (including PBS). Additionally, provider awareness of others who work across the child welfare system to provide youth a continuum of care increased.



Crisis and Emergency Services

Youth and their families continue to access crisis and emergency services, including going to hospital emergency departments, calling the police, or reaching out to other social supports for mental and behavioral health needs.

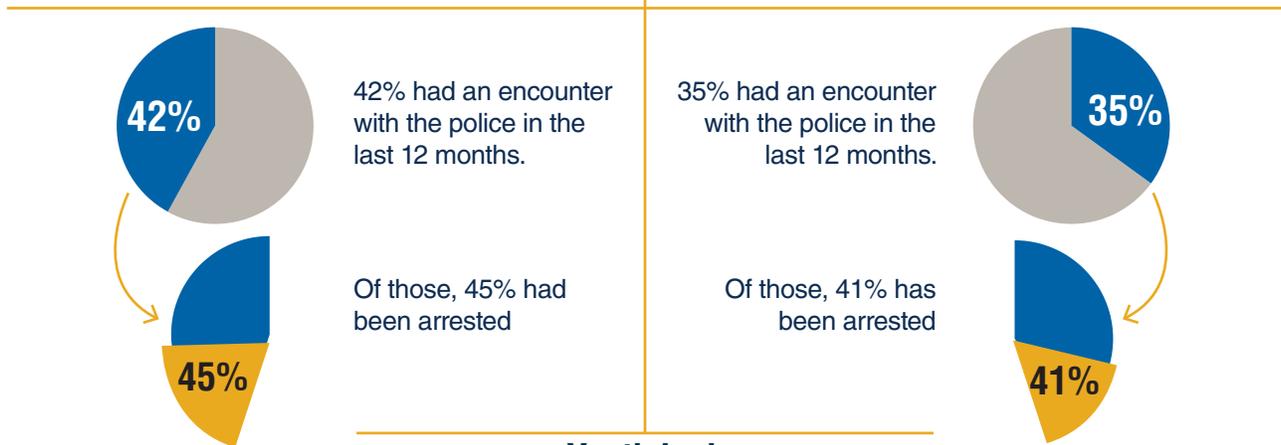
In response to youth needs, over the last 12 months, Caregivers:



Overall there was a decrease in the number of youth who reported encounters with police in the last 12 months. While youth were in RMHT at the time the sample was identified, fewer police encounters and arrests in Year 2 may indicate a positive trend.

Caregivers of youth in RMHT reported that:

Youth in RMHT reported that:

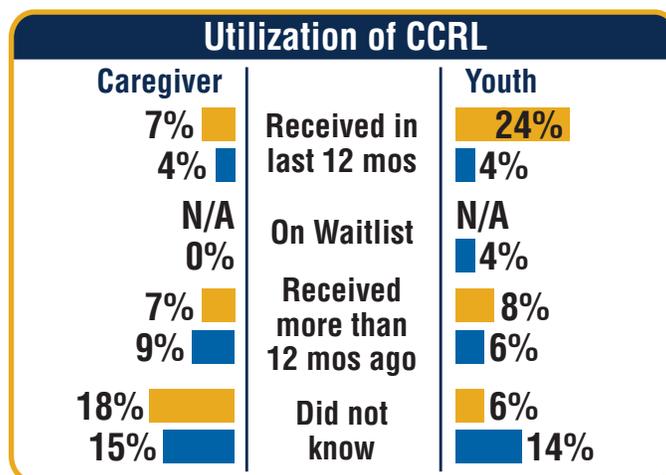
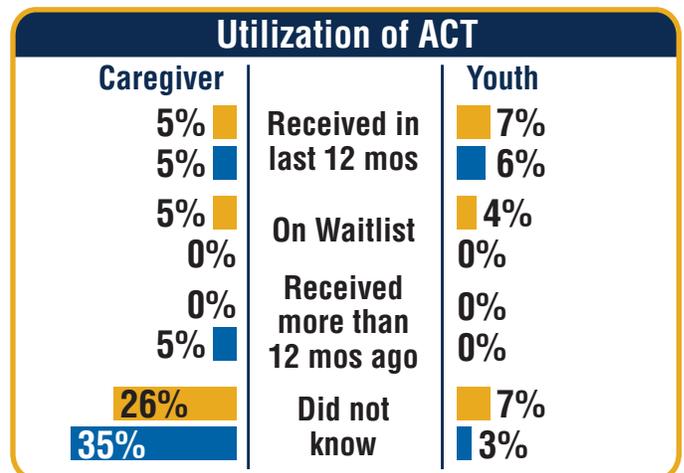
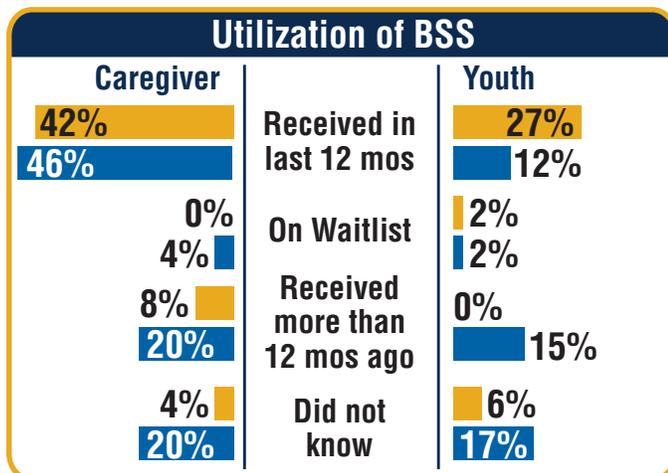
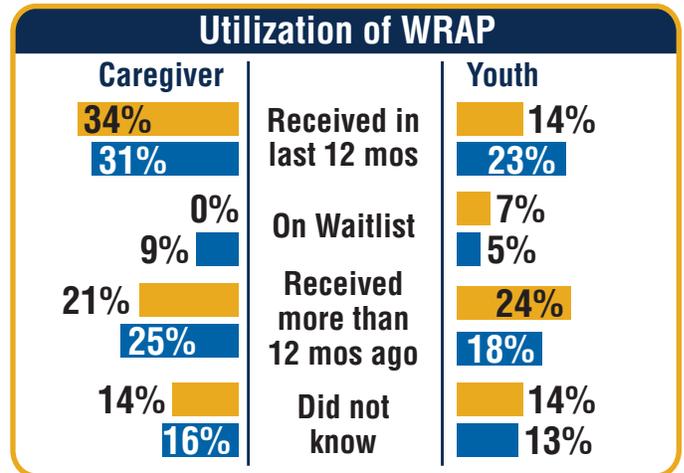
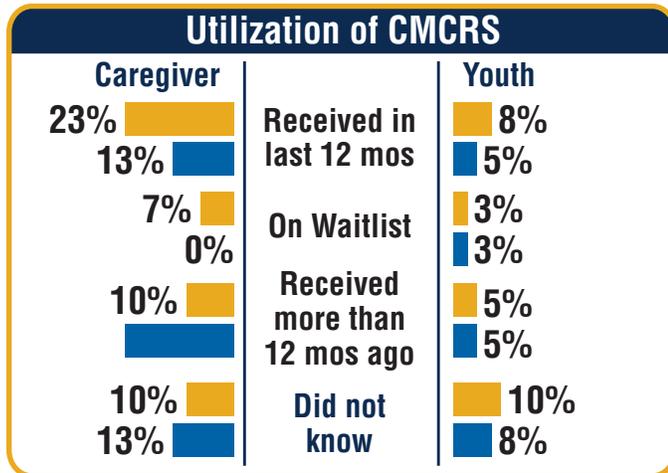


Youth had:



Utilization of Services

At least one youth reported receiving each of the services in the last 12 months with utilization of community-based services across Baseline and Year 2 remaining similar. Consistent with the goal of Wraparound serving as a core service in the system, youth reported a 9% increase in utilization of Wraparound. There were notable decreases in youth-reported utilization of CMCRS, Behavioral Support Services (including PBS), and the CCRL.



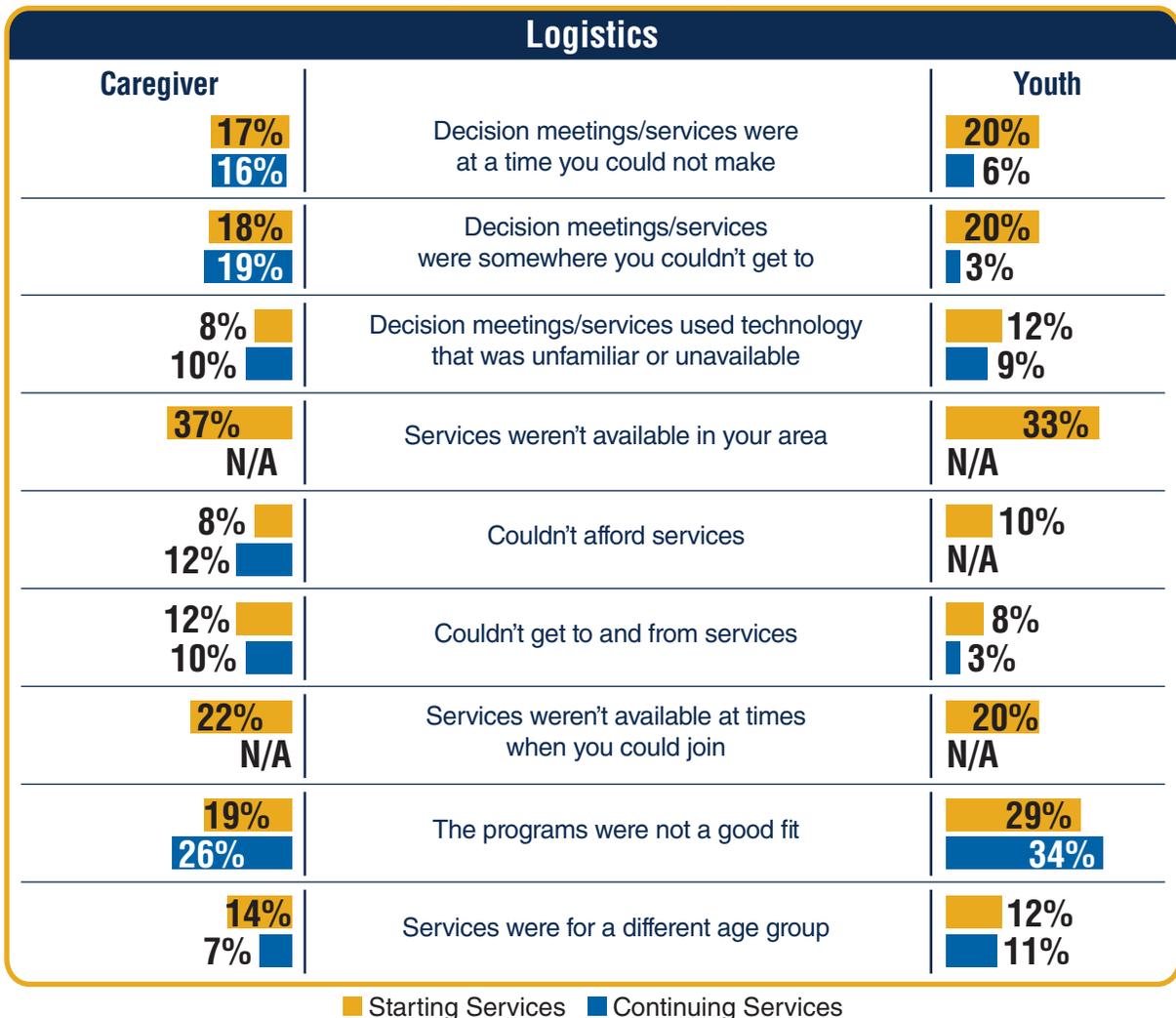
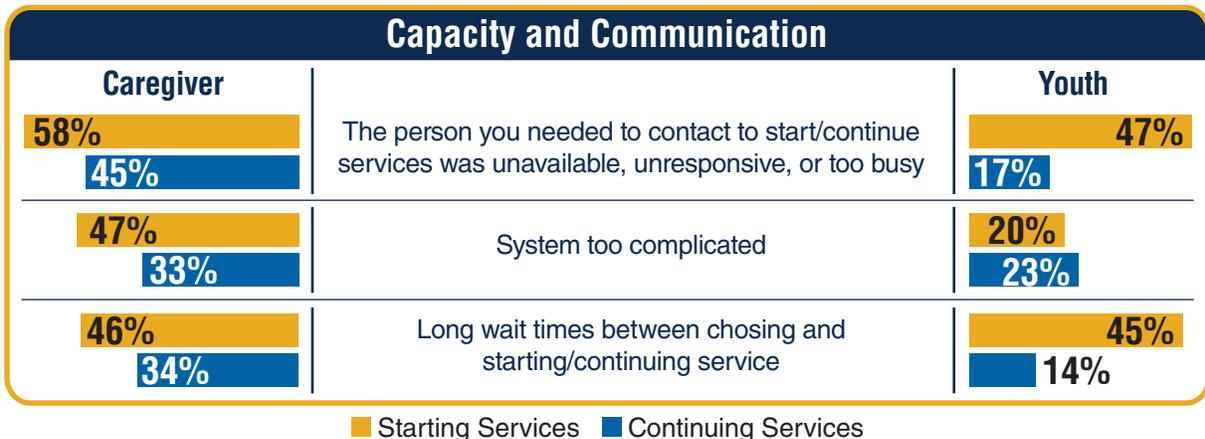
■ Baseline ■ Year 2

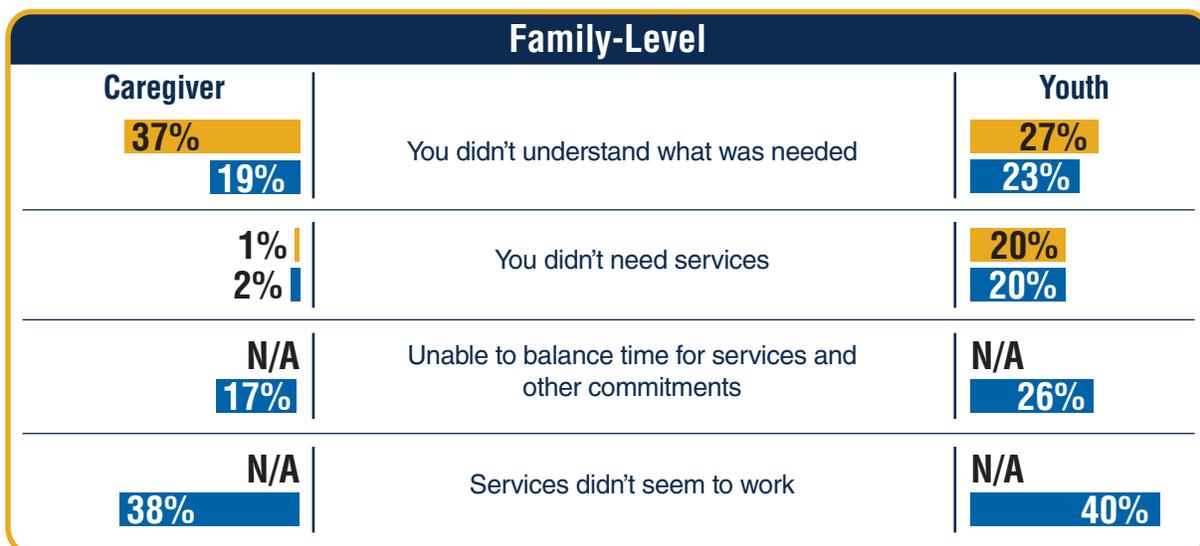
Barriers

Mental and behavioral health systems and providers are actively working to remove barriers faced by youth and caregivers to access quality services. Caregivers and youth were asked about specific barriers that they have experienced. Results fall into three major categories: Capacity and Communication, Logistics, and Family-level.

Overall, 34% of youth and 54% of caregivers reported barriers to starting services once the need was identified and 24% of youth and 41% of caregivers reported barriers continuing services after they started.

While both youth and caregivers reported difficulty reaching a person to start services and long wait times before starting services, caregivers also saw this as a problem to continue services once they started.





■ Starting Services ■ Continuing Services



■ Starting Services ■ Continuing Services

Outside of response options in the survey, over one-third of caregivers described other challenges to start services and nearly half described challenges continuing services.

Other challenges faced described **capacity** issues such as:

- Programs didn't have enough staffing and had high turnover
- Programs had no availability or space
- Programs initiated/responded too late to help
- Programs treated you poorly (e.g. "DHHR made me feel inadequate")

...or **family-level** issues such as:

- Family separation was too difficult for youth/family
- Youth were tired of programs/treatment/medication
- Services conflicted with school or other priorities (e.g. transferring credits)
- Youth/family worried about consequences or repercussions, such as CPS involvement



Statewide Workforce

Statewide Workforce

Over 1,100 providers in West Virginia responded to the survey. This includes health care professionals, attorneys, social service providers, school counselors, probation officers, program staff, and other youth-facing professionals.

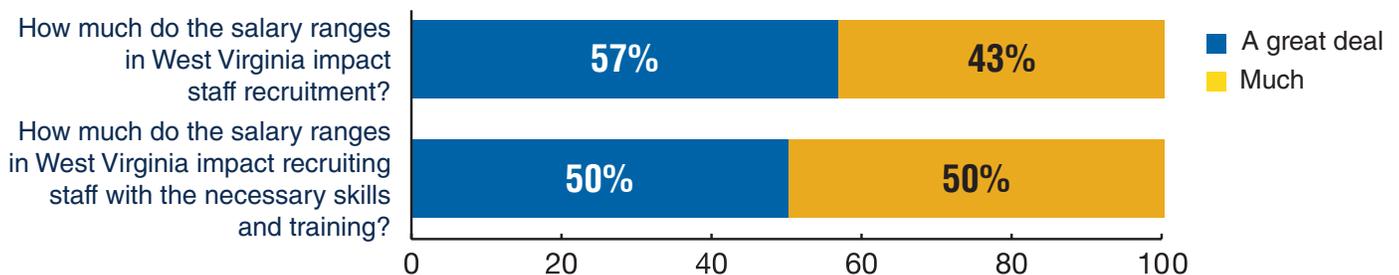
Workforce Capacity

Workforce capacity continued to be a challenge for organizations in the mental and behavioral health system. However, there were improvements in perceptions of organizations when it came to:

- Having adequate staff to meet demand (62% in Year 2, 41% at Baseline)
- Having staff with the necessary skills and training (73% in Year 2, 53% at Baseline)
- Over half (57%) of organizations at Baseline and 35% in Year 2 had the capacity to serve the youth receiving referrals to obtain mental and behavioral health services. Of those who said they could not meet demands, 24% said other providers in their region can meet youth needs.

Workforce Salary

Salary continued to be an important factor that impacts recruitment, especially recruitment of staff with particular skillsets and training needed to meet the needs of the organization and/or the service.



Administrative or legal processes such as MOUs or contracts did not contribute to lack of workforce capacity for the majority of organizations.

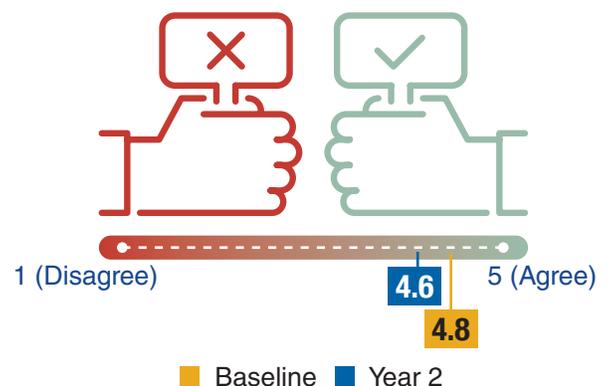
Provider Self-Reported Competency/Training

Training continued to be a bright spot for providers in the youth mental and behavioral health system. Similar to Baseline, most providers feel that they have the necessary training to function in their current role.

Providers agreed at Baseline (4.8) and in Year 2 (4.6) they have the necessary training to function in their current role. There was agreement that staff have the training and skills needed to deliver evidence-based practices, and to deliver interventions effectively.

In Year 2 more than half of providers expressed interest in trainings focused on specific services and interventions. Law enforcement officers also expressed the desire for additional training with juveniles experiencing acute mental health crises (43% at Baseline and 44% in Year 2) and more training with CMCRS teams (67% at Baseline and 70% in Year 2).

I have the necessary training to function in my current role:



Staff Turnover

Most of the existing providers in WV remain committed to their positions and organizations. Most providers intended to stay not only in their current role, but also in their current organization for the foreseeable future.

Do you agree or disagree with the following:

I have plans to stay in my current role for the foreseeable future.



I have plans to stay at my current organization for the foreseeable future.

Key Partners

This section describes findings related to several key partners that operate within and across systems and sectors to support support West Virginia youth with mental and behavioral health needs.

Children's Crisis and Referral Line



The Children's Crisis and Referral Line (844-HELP4WV) is toll-free and available 24/7 statewide. The hotline is a key access point that connects youth and families to mental and behavioral health services across the state. Eighty-five percent of providers in Year 2 reported that they were aware of the CCRL, a **19% increase** over Baseline.

Law Enforcement Officers



Law enforcement officers in Year 2 reported a **7% increase** in awareness of Children's Mobile Crisis Response and Stabilization (18% vs 11%) and a **5% increase** in knowledge of how to access Children's Mobile Crisis Response and Stabilization teams from Baseline (84% vs 79%) among those that were aware. However, few law enforcement officers reported working directly with Children's Mobile Crisis Response teams in the past year when asked at Baseline and in Year 2.

Attorneys and Guardians ad Litem



Attorneys and guardians ad litem represent the interests of youth involved in the juvenile justice system.

When asked if they were aware of services that can meet the diverse needs of youth, attorneys/guardians ad litem somewhat disagreed. Attorneys/guardians ad litem neither agreed nor disagreed both at Baseline and in Year 2 that the protocols for working with youth with mental and behavioral health needs are clear.

Attorneys/guardians ad litem and law enforcement officers expressed the desire for additional trainings focused on best practices for helping youth with mental and behavioral health needs, especially youth in crisis situations.

Education System and Schools



Schools continue to be identified across the state as key partners in the mental and behavioral health system. **Many youth and caregivers reported they found out about services from teachers.** Provider survey responses support this as school counselors and educators reported higher-than-state averages around encouraging collaboration with mental and behavioral health-related youth-serving organizations. (4.5, 4.8, 4.4 respectively).

Additionally, school counselors are more aware of the CCRL than the average provider awareness of CCRL (91% vs state 85%) and the greatest percentage of organizations that offered CMCRS in Year 2 (88%) received referrals from DHHR and local school districts or county Departments of Education.

Agency Collaboration



Referrals are an important part of the youth mental and behavioral health system. Youth have differing needs over time and often require coordinated, supportive services during treatment. Most providers reported knowing their organization's policies and procedures for making and following up on referrals for youth with mental and behavioral health needs.

Statewide in Year 2, organizations received referrals from DHHR (63%) more than other organizations, and the greatest percentage of referrals were made to community-based health centers (including FQHCs).



*Experience With
Services*

Experience with Services

Baseline and Year 2 surveys asked caregivers and youth to report on their experiences participating in mental and behavioral health services in West Virginia. Caregiver and youth service experiences included perspectives on services, staff, and overall satisfaction. Overall, experiences with services have improved since Baseline. Wait times are perceived to be shorter, engagement and respect has improved, and satisfaction with services has increased. Consistent with Baseline findings, caregivers and youth in Year 2 value the mental and behavioral health services in West Virginia.

Waitlist

Organizations and facilities reported a 10% increase in waitlists (40% in Year 2 vs 30% at Baseline). However, fewer caregivers and youth reported challenges with wait times for services. Youth agreed that over the last 12 months they were able to access services without having to wait too long. As expected for youth currently in RMHT, few were waiting for additional mental and behavioral health services at the time of the survey.

Caregiver and Youth Engagement, Involvement and Participation

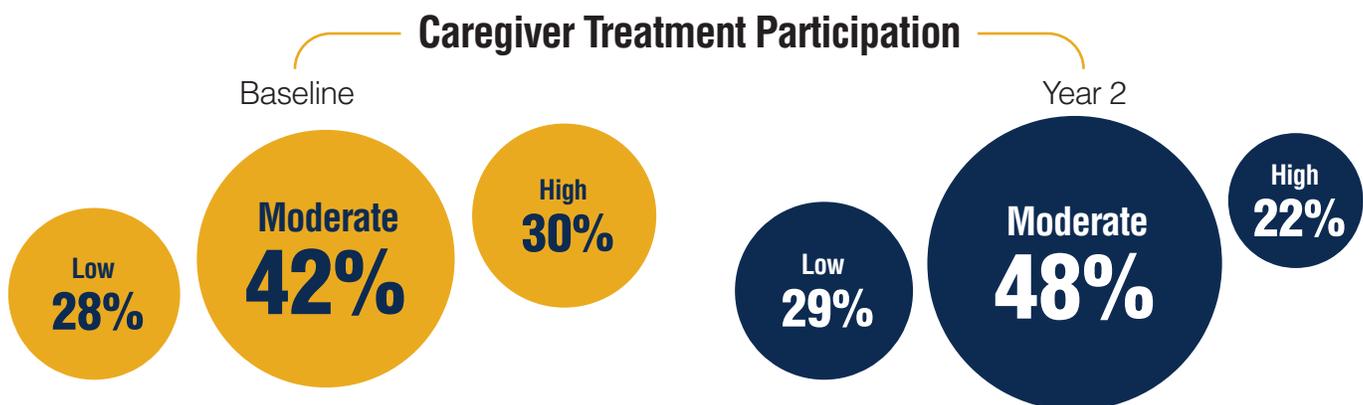
In general, youth feel included in selecting the right services for them and feel involved in changes to care. Providers report making efforts to include caregivers and youth in treatment. Caregivers and youth reported that they are engaged in treatment, although they do not feel as included in discharge planning.

Engagement

Providers indicated in the Year 2 survey that they value family and caregiver involvement in youth's treatment. There was no change from Baseline to Year 2 in the level of agreement providers had about caregivers being an essential part of the planning of mental and behavioral health services for their youth. In addition, providers agreed across timepoints that:

- Caregiver opinions are considered during treatment planning for their youth.
- Caregiver opinions are considered in the delivery of mental and behavioral health services for their youth.

Caregiver and provider perspectives were aligned around engagement in treatment: Most caregivers felt moderate to high levels of participation in the treatment of their youth in RMHTs at Baseline and Year 2.



Survey findings indicate that youth in RMHT continue to feel engaged in their treatment, with modest increase in perception since last year.

On a scale from 1 (Strongly Disagree) to 5 (Strongly Agree), youth felt they helped choose their treatment goals (3.7 at Baseline and 3.8 in Year 2), and participated in their own treatment (4.1 at Baseline and 4.2 in Year 2).

Do youth agree or disagree with the following:

I helped to choose my own treatment goals



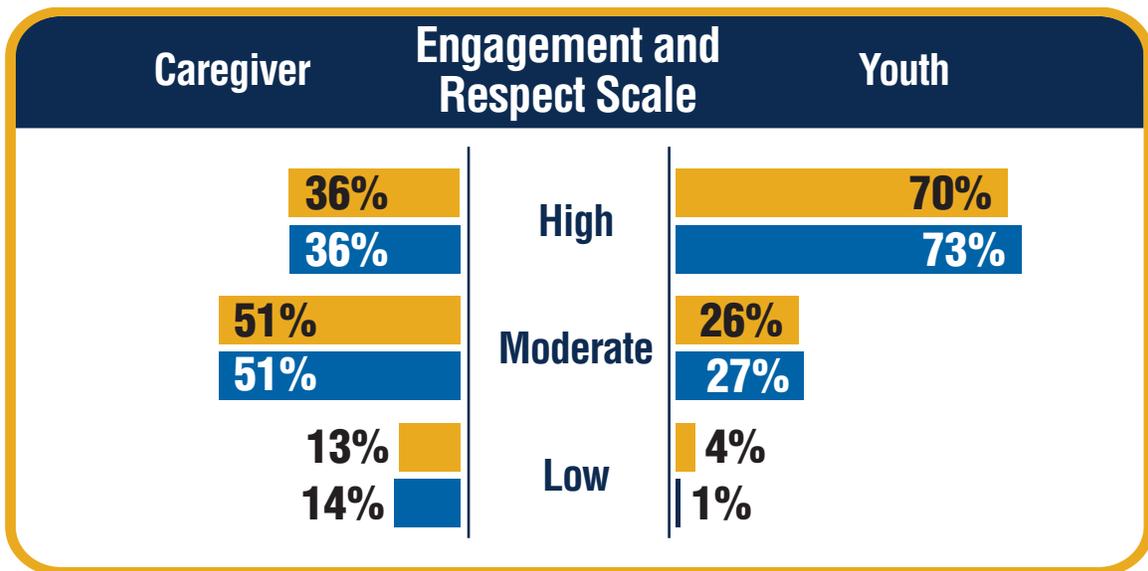
I participated in my own treatment



■ Baseline ■ Year 2

Respect

Both caregivers and youth were asked about their experiences with staff and providers specifically related to cultural competence, connectedness, respect, and communication. Questions explored engagement in treatment and whether caregivers and youth felt that providers respected their cultural and spiritual or religious beliefs. Both caregivers and youth felt like staff treated them with respect and generally engaged them in care delivery for Year 2. Specifically, most caregivers and youth reported moderate to high levels of treatment engagement and respect from staff, with little variation between Baseline and Year 2 data.



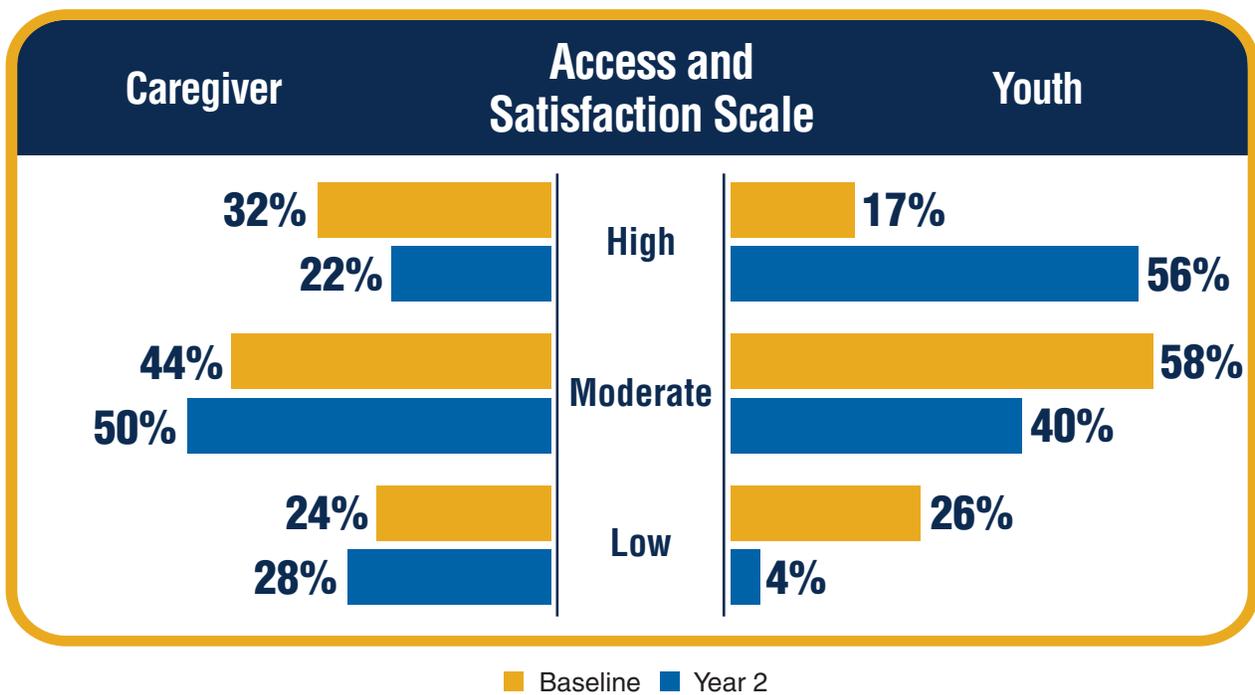
■ Baseline ■ Year 2

Caregiver and Youth Perception of Services

Most caregivers (72%) and youth in RMHT (80%) in Year 2 who were between the ages of 18-21 felt that the value of mental and behavioral health services stayed the same or got better over the last 12 months. Caregivers and youth expressed during interviews that they value community-based mental and behavioral health services; however, they want more of them, especially services with varying and higher levels of intensity.

Caregiver and Youth Satisfaction with Services

Satisfaction with mental and behavioral health services may lead to greater intentions to use mental and behavioral health services if they are needed again in the future. Responses to the Satisfaction with Services scale indicated that most of the caregivers and their youth in RMHT had moderate to high levels of satisfaction with accessibility and quality of mental and behavioral health services in Year 2. There was a considerable increase in youth satisfaction compared to Baseline.



Caregiver and Youth System Awareness

Youth in RMHT were generally more aware than their caregivers of the community-based mental and behavioral health services included in this evaluation at Baseline and in Year 2, whereas caregivers felt more knowledgeable about how to start and use services.

Caregivers and their youth in RMHT continued to report improvements in their understanding of how to access mental and behavioral health services over the last 12 months.

In Year 2, caregivers and youth were asked about how they heard about mental and behavioral health services. Most reported that they learned about services during interactions with juvenile justice, at school, from DHHR, from their close social network, or from providers. Teachers, doctors, or other trusted adults in youth lives were also reported as important resources to help caregivers recognize that their youth have mental and behavioral health needs.



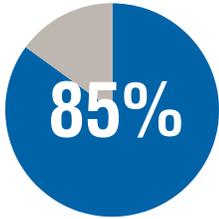
Youth and Family Status

Youth and Family Status

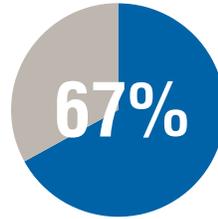
This evaluation addresses several elements of youth and family status including social support, school attendance, and caregiver- and youth-reported youth functioning. At Baseline, most of the caregivers rated their youth in RMHT as moderate to high functioning, and youth self-reported slightly higher functioning than their caregivers. Little variation was observed over time.

Caregiver Support & Involvement

Social supports are vital to caregiver and family wellbeing.



Most caregivers reported having support from family or friends in a crisis.

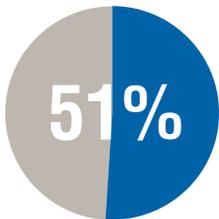


Caregivers felt respected by staff and agreed that staff were thoughtful of their backgrounds, cultures, and beliefs.

However, caregivers neither agreed nor disagreed about being involved in: creating treatment plans and goals, choosing services, and discharge planning for their youth.

Youth Attendance in School

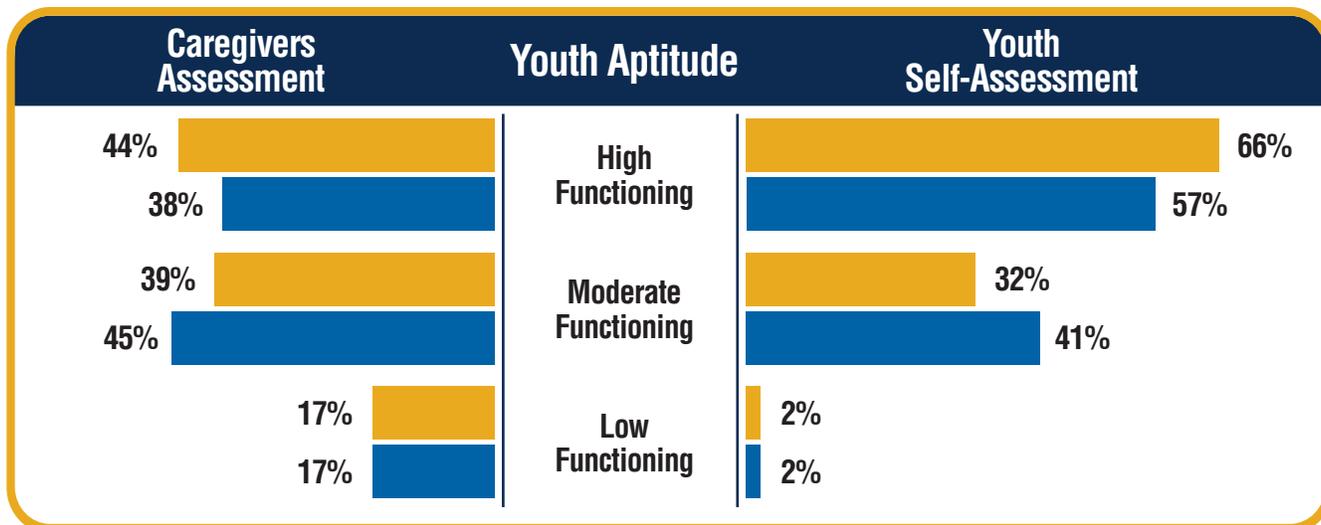
Youth in RMHT and their caregivers were asked about school attendance. Over half of youth and their caregivers report youth attending public school at some point in the last 12 months. According to caregivers, less than 1% of youth in RMHT dropped out of school. Lastly, suspensions and expulsions are a proxy for how well youth function in school settings. Caregivers and youth reported a slight decrease in suspensions and expulsions compared to Baseline.



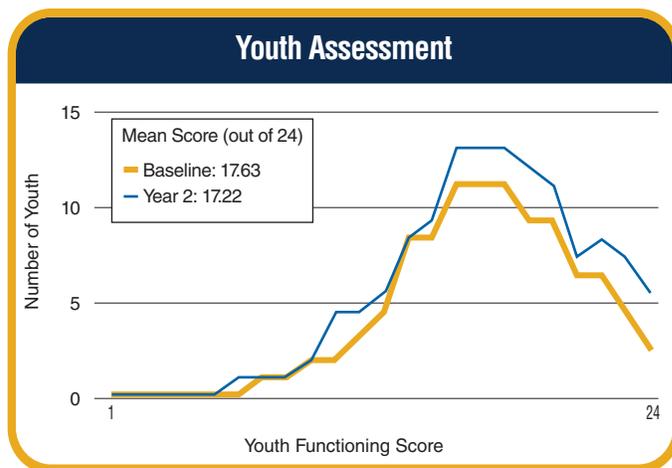
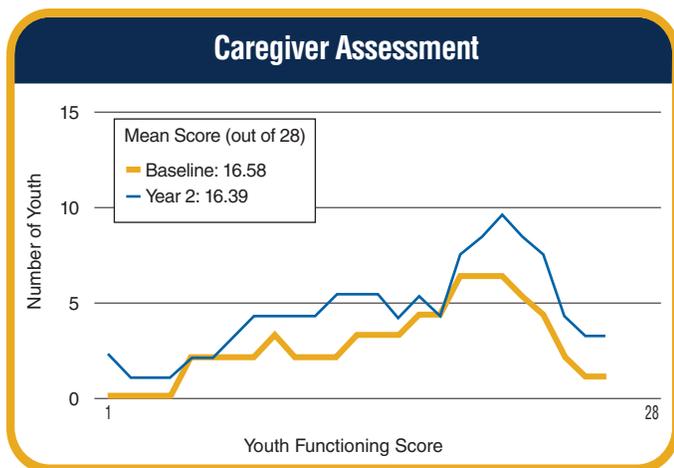
Youth and caregivers were asked to respond to a statement about how starting mental or behavioral health services has impacted their youth's school attendance, and 43% of caregivers and 51% of youth reported attendance has gone up since starting services. School performance improved over time among youth who were interviewed. Caregivers and youth reported they were either improving or consistently performing in school, with almost all youth either on track to graduate or performing well.

Perceptions of Youth Functioning

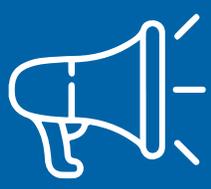
For this report, measures of youth functioning are based on caregiver and youth responses to questions about youth's daily activities and interactions in family, social, and school or work settings. Caregivers and youth responded differently on their report of youth functioning. Other measures of youth functioning include CAFAS scores, however such data were not available for this report. At Baseline, most of the caregivers rated their youth in RMHT as moderate to high functioning, and youth self-reported slightly higher functioning than their caregivers. Little variation was observed over time.



■ Baseline ■ Year 2



What they're saying



Caregivers interviewed at Baseline agree that RMHT had a positive impact on youth functioning. During interviews, half of caregivers did not observe sustained change after 6 months of being discharged from RMHT, mainly because more intensive community-based supports were needed. Nevertheless, all caregivers of youth who had been discharged from RMHT reported perceptible improvements after one year.

Several youth who were interviewed reported using coping skills and tools for managing anger and depression they learned during RMHT. Examples include deep breathing, bold and calming words, anti-anxiety and sensory fidget toys, as well as engaging in recreational activities such as drawing and basketball.

Some caregiver-youth pairs reported positive improvements in their relationships, including youth offering to help around the house and experiencing decreases in the frequency and severity of negative behaviors.

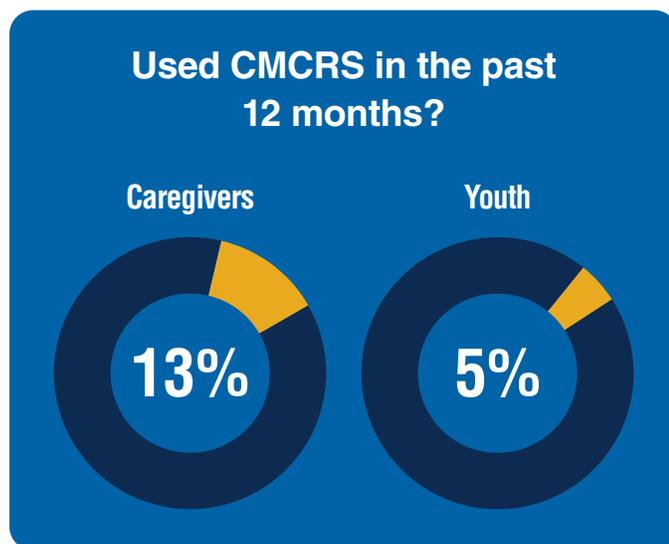


Service Profiles

Children's Mobile Crisis Response and Stabilization

Children's Mobile Crisis Response and Stabilization (CMCRS) teams provide on-demand support for families with youth ages 0-21 experiencing emotional or behavioral crises. West Virginia's Children's Crisis and Referral Line deploys CMCRS teams to provide crisis specialists in the community to support youth and family needs, and provide short-term resources and services to families to help keep youths at home. CMCRS is available statewide.

Program Availability



During Baseline, 33 organizations reported offering CMCRS services in all regions, but BBH Regions 1, 2, 4, and 6 did not have coverage in every county. Fewer organizations offering CMCRS responded to the Year 2 survey than at Baseline, and as a result, survey data were not available for Region 5 in Year 2. In Year 2, CMCRS organizations did not cover all counties in Region 2, and there were reportedly 13 counties without CMCRS coverage.

More than half (63%) of organizations that responded to the Year 2 survey reported difficulties providing CMCRS service coverage in their service areas.

Workforce and Recruitment

Skillssets

Organizations reported less difficulty with hiring and/or retaining staff with certain capabilities, skillsets, or credentials in Year 2. When asked about the most difficult positions to hire for, CMCRS-specific organizations and facilities reported the need for more licensed psychologists and traditional healthcare providers.

Salary

No organizations or facilities that reported offering CMCRS responded to questions about the impact of salary on hiring in the Year 2 survey.

What strategies has your organization implemented to overcome challenges with recruitment and capacity?

- Sought alternative grant funding
- Splitting staff across programs
- Reduced the hours that services are available during the day
- Reduced the days that services are available

Response options generated through themes found during Baseline focus groups.

Waitlist

0%

Of organizations reported having a waitlist for CMCRS

0%

Of caregivers reported their youth in RMHT on a waitlist for CMCRS

3%

Of youth in RMHT reported being on a waitlist for CMCRS

Awareness of Children's Mobile Crisis Response and Stabilization

 **Traditional Healthcare Providers**

Doctors and nurses

 **Community-Based Providers**

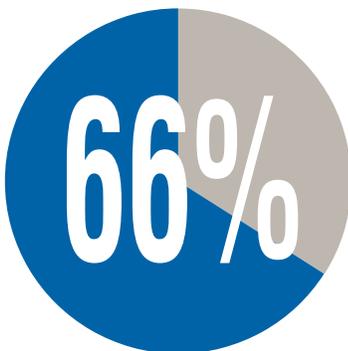
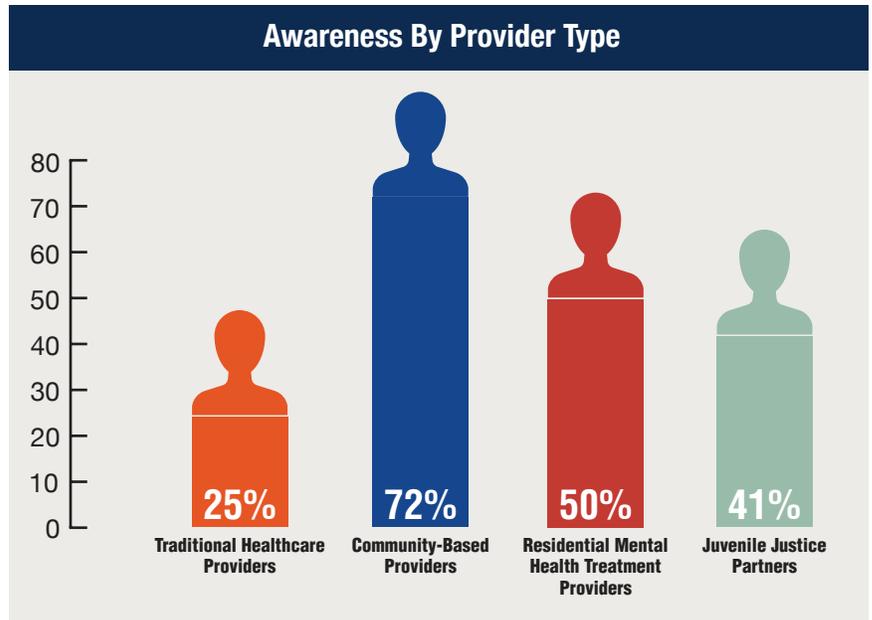
Psychiatrists/psychologists, social workers, counselors, and other social service providers

 **Residential Mental Health Treatment Providers**

RMHT staff and social workers

 **Juvenile Justice Partners**

Attorneys and probation officers



Of providers are aware of CMCRS



Up 15% from Baseline



Of caregivers are aware of CMCRS



No change from Baseline



Of youth in RMHT are aware of CMCRS



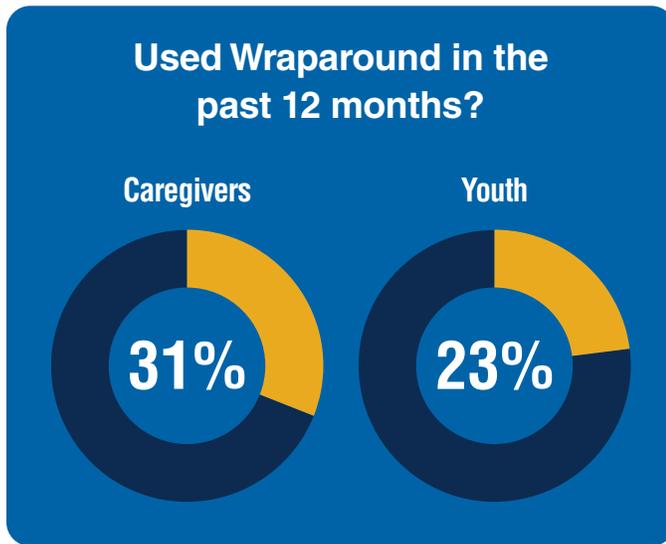
Down 7% from Baseline



Wraparound

Wraparound is a comprehensive team-based approach to developing creative and individualized strengths-based care plans that enable families to identify their own needs and work together with care providers and natural supports to meet them.

Program Availability



Year 2 data indicated that Wraparound services are available in all six BBH regions. One organization in Year 2 reported difficulties providing service coverage which impacts approximately half of the counties in Region 6.

Organizations reported needs in Wraparound workforce capacity. Forty percent of organizations offering Wraparound reported having the staff required to serve all of the youth who need services.

Additionally, 47% of Wraparound organizations indicated capacity to serve all the youth currently being referred to them, down from 62% at Baseline.

Workforce and Recruitment

Skillsets

Organizations reported a slight improvement in staff having necessary training and skills in Year 2 compared to Baseline, with 62% of organizations and facilities at Baseline indicated such compared to 67% in Year 2.

Salary

Salary continues to be a challenge in recruiting Wraparound staff. Organizations and facilities responded by saying salary ranges in WV has had much impact on staff recruitment.

What strategies has your organization implemented to overcome challenges with recruitment and capacity?

- Sought alternative grant funding
- Splitting staff across programs
- Reduced the hours that services are available during the day
- Reduced the days that services are available

Response options generated through themes found during Baseline focus groups.

Waitlist

43%

Of organizations reported having a waitlist for Wraparound

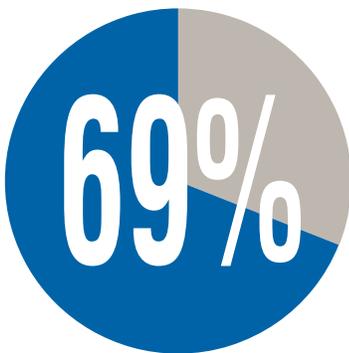
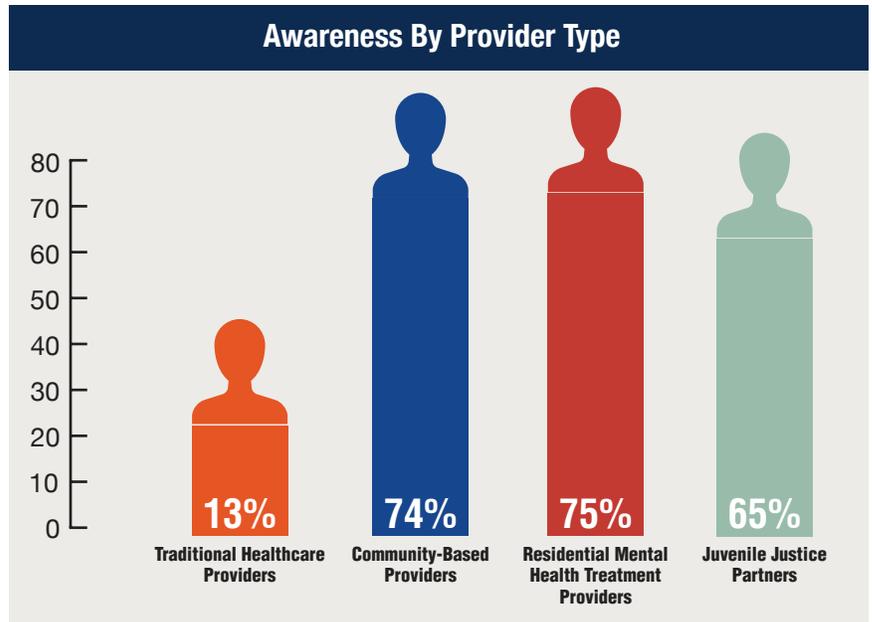
9%

Of caregivers reported their youth in RMHT on a waitlist for Wraparound

5%

Of youth in RMHT reported being on a waitlist for Wraparound

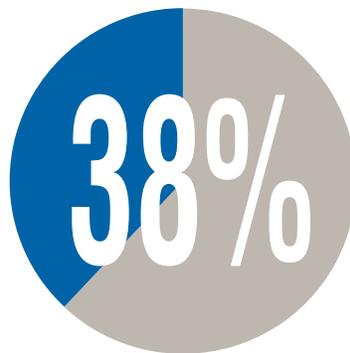
Awareness of Wraparound



Of providers, statewide, are aware of Wraparound



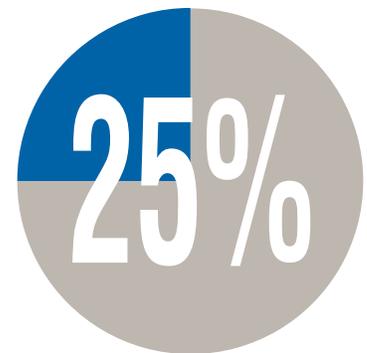
Up 2% from Baseline



Of caregivers are aware of Wraparound



Down 14% from Baseline



Of youth in RMHT are aware of Wraparound

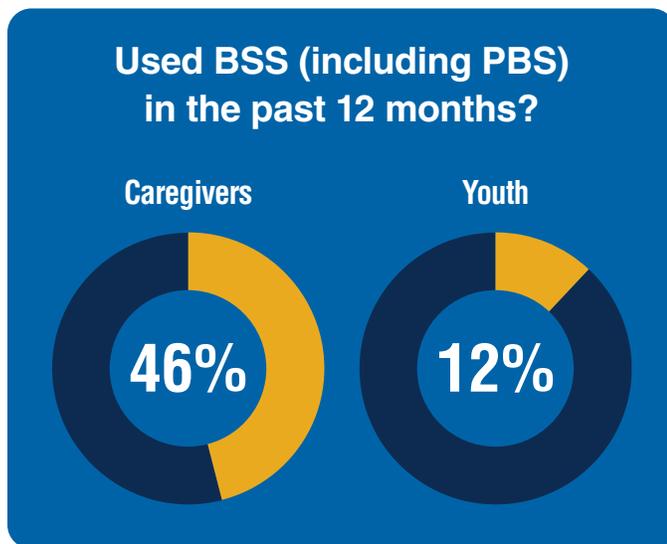


No change from Baseline

Behavioral Support Services (including Positive Behavior Support)

Behavioral Support Services (including Positive Behavior Support; PBS) is a series of services that therapists can offer to support families with youth (ages 0-21) who are demonstrating challenging behaviors and are at risk of out-of-home placement or involuntary commitment. Behavioral Support Services (including PBS) include mental health and behavioral assessments; development and implementation of person-centered treatment plans; modeling for the family and other caregivers on how to implement behavioral support plans; and skill-building services. Home-based services are available for youth with more intensive needs.

Program Availability



Behavioral Support Services (including PBS) became available statewide in October 2020 and 35 organizations offered it in all regions and counties in Year 2. However, 35% of organizations that offered Behavioral Support Services (including PBS) in Year 2 reported difficulties providing service coverage, namely in Regions 5 and 6.

Survey data indicated that capacity to provide BSS (including PBS) services has improved. Nearly half (49%) of organizations offering BSS (including PBS) reported having the number of staff required to serve all youth who need services, which was 23% at Baseline.

Workforce and Recruitment

Skillsets

Nearly two-thirds (63%) of organizations offering Behavioral Support Services (including PBS) agreed that they have staff with the necessary training and skills, as opposed to 43% at Baseline. Likewise, 46% of organizations and facilities offering BSS in Year 2 reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials, compared to 66% at Baseline.

Salary

Organizations that offered PBS at Baseline and that offered Behavioral Support Services (including PBS) in Year 2 that did not have enough staff indicated that salary ranges in WV had “much” to do with difficulties with staff recruitment.

What strategies has your organization implemented to overcome challenges with recruitment and capacity?

- Sought alternative grant funding
- Splitting staff across programs
- Reduced the hours that services are available during the day
- Reduced the days that services are available

Response options generated through themes found during Baseline focus groups.

Waitlist

26%

Of organizations reported having a waitlist for Behavioral Support Services (including PBS)

4%

Of caregivers reported their youth in RMHT on a waitlist for Behavioral Support Services (including PBS)

2%

Of youth in RMHT reported being on a waitlist for Behavioral Support Services (including PBS)

Awareness of Behavioral Support Services (including PBS)

 **Traditional Healthcare Providers**

Doctors and nurses

 **Community-Based Providers**

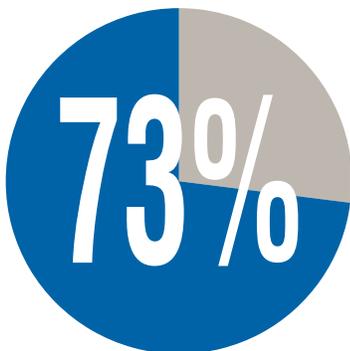
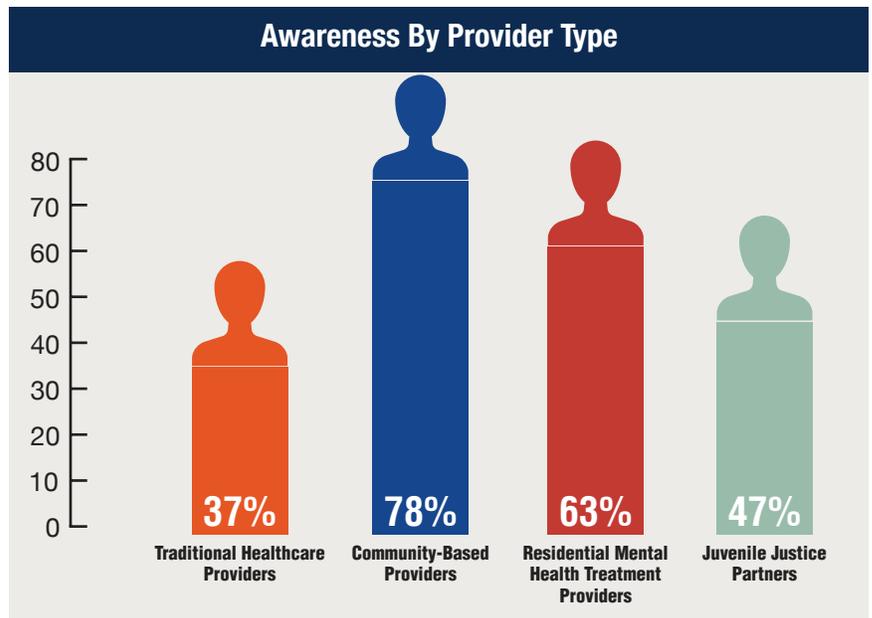
Psychiatrists/psychologists, social workers, counselors, and other social service providers

 **Residential Mental Health Treatment Providers**

RMHT staff and social workers

 **Juvenile Justice Partners**

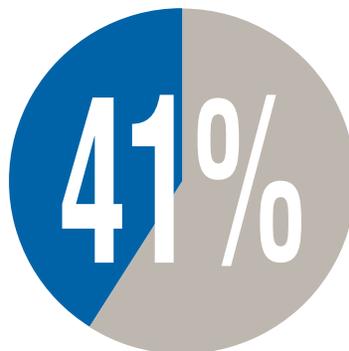
Attorneys and probation officers



Of providers, statewide, are aware of BSS



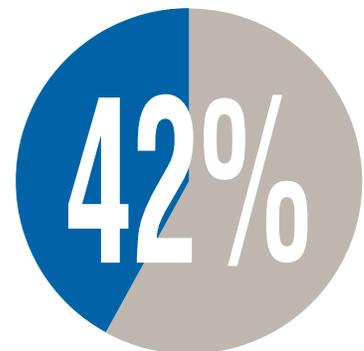
Up 12% from Baseline



Of caregivers are aware of BSS



Up 20% from Baseline



Of youth in RMHT are aware of BSS



Down 2% from Baseline



Assertive Community Treatment

Assertive Community Treatment (ACT) operates out of the Bureau for Medical Services to provide an array of inclusive community-based services for individuals 18 years of age or older with serious and persistent mental and behavioral health needs.

Program Availability



Organizational leadership identified that in each of the six BBH regions at least one organization provides ACT services, and that all WV counties have ACT services available.

More than half (60%) of organizations that offered ACT in Year 2 responded “Yes” to having staff with the necessary training and skills to serve all the youth who needed services, which is similar to Baseline (64%).

Organizations that could not meet the demand for ACT services did not have other nearby providers to whom they could refer youth for needed services.

Workforce and Recruitment

Skillssets

Staff recruitment for specific skills has improved in Year 2. Nearly two-thirds (64%) of organizations offering ACT at Baseline agreed that they have staff with the necessary training and skills to serve all youth needs, compared to 73% in Year 2. Also, 86% of organizations that offered ACT at Baseline reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials, compared to 80% in Year 2.

Salary

Many organizations that offered ACT that encountered challenges with workforce capacity and staffing attributed it to salary ranges in WV.

What strategies has your organization implemented to overcome challenges with recruitment and capacity?

- Sought alternative grant funding
- Splitting staff across programs
- Reduced the hours that services are available during the day
- Reduced the days that services are available

Response options generated through themes found during Baseline focus groups.

Waitlist

20%

Of organizations reported having a waitlist for ACT

0%

Of caregivers reported their youth in RMHT on a waitlist for ACT

0%

Of youth in RMHT reported being on a waitlist for ACT

Awareness of Assertive Community Treatment

 **Traditional Healthcare Providers**

Doctors and nurses

 **Community-Based Providers**

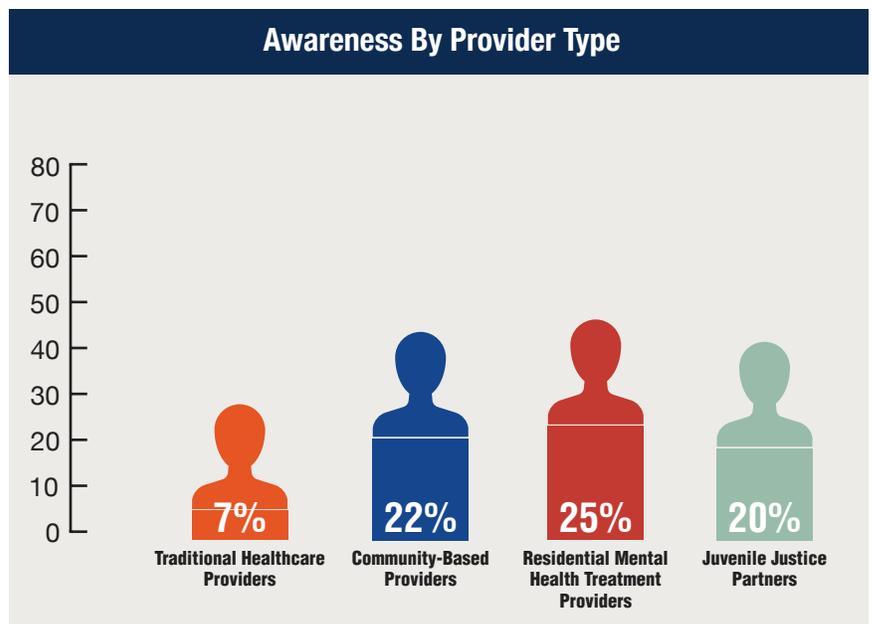
Psychiatrists/psychologists, social workers, counselors, and other social service providers

 **Residential Mental Health Treatment Providers**

RMHT staff and social workers

 **Juvenile Justice Partners**

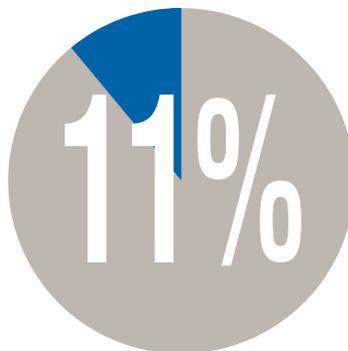
Attorneys and probation officers



Of providers, statewide, are aware of ACT



Up 4% from Baseline



Of caregivers are aware of ACT



Down 5% from Baseline



Of youth in RMHT are aware of ACT

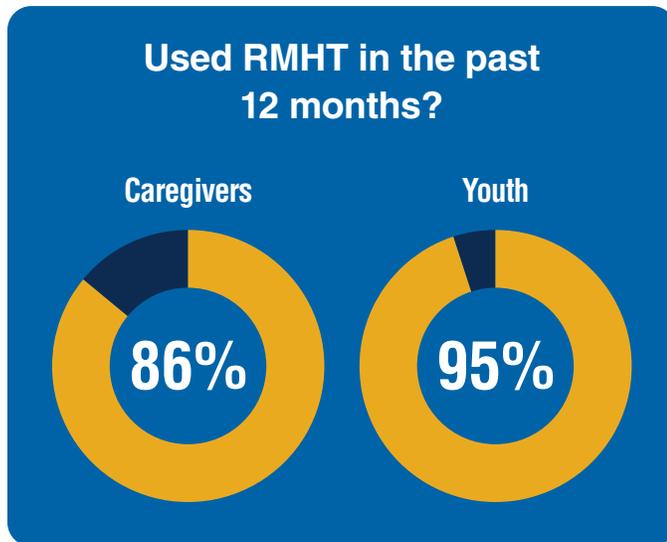


Down 4% from Baseline

Residential Mental Health Treatment Facilities

Residential mental health treatment facilities (RMHTFs) are 24-hour care settings in which youth receive structured treatments.

Program Availability



RMHT is available statewide with facilities located in every BBH region. Of the RMHTFs that responded to the survey, 33% responded “Yes” to having the capacity to serve all of the youth being referred to them, which was down considerably from Baseline (65%).

Despite the shortfall in capacity to serve referrals, 83% of RMHTFs reported having the number of staff required to serve all of the youth who needed services. This is an improvement from Baseline when only 50% had adequate staffing.

Workforce and Recruitment

Skillsets

Staff recruitment for specific skills has improved in Year 2. Fifty five percent of RMHTFs at Baseline agreed that they had staff with the necessary training and skills to serve all youth needs, compared to 83% in Year 2. Also, 75% of RMHTFs reported difficulties hiring and/or retaining staff with certain capabilities, skillsets, or credentials, compared to 50% in Year 2.

Salary

Many RMHTFs that encountered challenges with workforce capacity and staffing attribute it to salary ranges in West Virginia. Findings around the importance of salary in recruitment and retention were consistent with statewide averages.

What strategies has your organization implemented to overcome challenges with recruitment and capacity?

- Sought alternative grant funding
- Splitting staff across programs
- Reduced the hours that services are available during the day
- Reduced the days that services are available

Response options generated through themes found during Baseline focus groups.

Waitlist

67%

Of organizations reported having a waitlist for RMHT

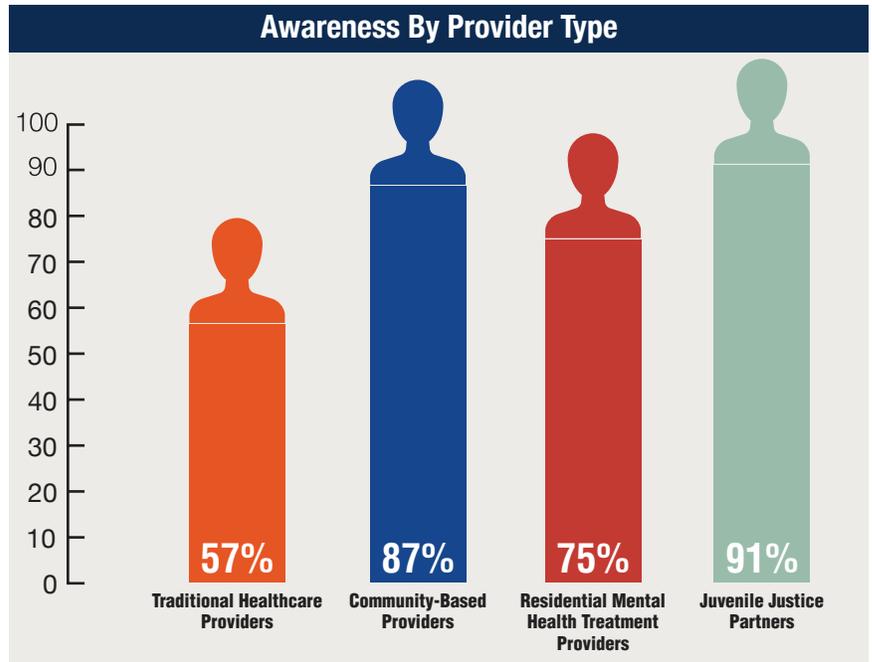
1%

Of caregivers reported their youth in RMHT were on a waitlist for more RMHT services

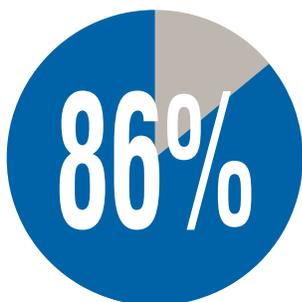
1%

Of youth in RMHT reported being on a waitlist for more RMHT services

Awareness of Residential Mental Health Treatment

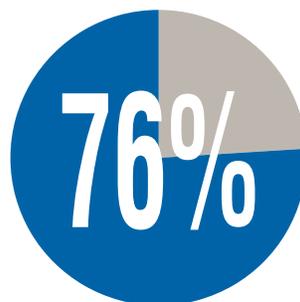


This report includes data for youth in RMHT and their caregivers; however, Baseline data indicated that caregivers and youth were more likely to identify an organization or facility where youth received services (e.g., Chestnut Ridge), but they did not always know the services or interventions that youth received. While awareness of RMHT increased, there are still some gaps that are likely related to the nomenclature—not all caregivers identify with the terminology of “residential treatment.”



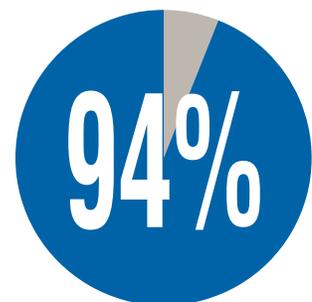
Of providers, statewide, are aware of RMHT

Up 12% from Baseline



Of caregivers are aware of RMHT

Up 9% from Baseline



Of youth are aware of RMHT

Up 7% from Baseline



Appendix: Topical Index



Topical Index

The topics covered in this Summary Report are reported in more detail in the following sections of the Children's In-Home and Community-Based Services Improvement Evaluation Project Year 2 Report.

Awareness (General)

- Assertive Community Treatment (ACT), 3.1,3.2
- Behavior Support Services including Positive Behavior Support (BSS PBS), 3.1, 3.2
- Children's Crisis and Referral Line, 3.1,3.2
- Children's Mobile Crisis Response (CMCR), 3.1, 3.2
- CSED Waiver Mobile Response, 3.1, 3.2
- CSED Waiver Wraparound, 3.1, 3.2
- Residential Mental Health Treatment (RMHT), 3.1, 3.2
- WV Children's Mental Health Wraparound (WVCMHW), 3.1, 3.2

Availability (General)

- Assertive Community Treatment (ACT), 5.1
- Behavior Support Services including Positive Behavior Support (BSS PBS), 5.1
- Children's Mobile Crisis Response (CMCR), 5.1
- CSED Waiver Mobile Response, 5.1
- CSED Waiver Wraparound, 5.1
- Residential Mental Health Treatment (RMHT), 5.1
- WV Children's Mental Health Wraparound (WVCMHW), 5.1

Experience with Services, Appendix G

- Accessibility and Satisfaction, 8.2
- Barriers to Services, 1.1, 5.2, 8.1
- Engagement and Respect in Treatment, 8.1
- Treatment Participation (Caregiver perceptions of), 8.1

Partners

- Attorneys/Guardians ad Litem, 3.1, 4.1, 5.1
- Children's Crisis and Referral Line, 4.3, 5.4
- Availability, 5.2
- Awareness, 3.1, 3.2
- Training, 3.1, 5.4
- Education System/Schools, 7.2, 7.3,
- Law Enforcement, 2.4, 4.1, 9.1
- Awareness, 3.1
- Training, 4.6, 5.4, 6.1

Provider Staff and Workforce

- Capacity, 6.1
- Salary, 6.1
- Training, 6.1
- Turnover, 1.1, 5.2, 6.1

Salary (General)

- Assertive Community Treatment (ACT), 6.1
- Behavior Support Services including Positive Behavior Support (BSS PBS), 6.1
- Children's Mobile Crisis Response (CMCR), 6.1
- Residential Mental Health Treatment (RMHT), 6.1
- WV Children's Mental Health Wraparound (WVCMHW), 6.1

Service Utilization, self-reported

- Assertive Community Treatment (ACT), 5.2
- Behavior Support Services including Positive Behavior Support (BSS PBS), 5.2
- Children's Mobile Crisis Response (CMCR), 5.2



Topical Index Continued

- Crisis and Emergency Services, 5.2
 - Encounters with Police, 9.1
 - Hospital Emergency Department Visits, 5.4
- Residential Mental Health Treatment (RMHT), 5.2
- WV Children’s Mental Health Wraparound (WVCMHW), 5.2

Training (General), 4.6, 5.4, 6.1

- Assertive Community Treatment (ACT), 6.1
- Behavior Support Services including Positive Behavior Support (BSS PBS), 4.6, 6.1
- Children’s Mobile Crisis Response (CMCR), 3.1, 6.1
- Residential Mental Health Treatment (RMHT), 6.1
- WV Children’s Mental Health Wraparound (WVCMHW), 4.6, 6.1

Waitlist (General), 5.2, 5.3, 6.1

- Assertive Community Treatment (ACT), 5.3
- Behavior Support Services including Positive Behavior Support (BSS PBS), 5.3
- Children’s Mobile Crisis Response (CMCR), 5.3
- Residential Mental Health Treatment (RMHT), 5.3
- WV Children’s Mental Health Wraparound (WVCMHW), 5.3

Youth and Family Status

- Caregiver social supports, 8.2
- School attendance, 9.1
- Youth functioning (perceptions of), 9.1