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HEALTH AFFAIRS

Youth and Family-level Evaluation Report

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

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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
AAPOR	American Association of Public Opinion Research
ADHD	Attention Deficit Hyperactivity Disorder
BBH	Bureau of Behavioral Health
BMS	WV Bureau for Medical Services
CAFAS	Child and Adolescent Functional Assessment Scale
CANS	Child and Adolescent Assessment of Needs and Strengths
CATI	Computer Assisted Telephone Interview
CPS	Child Protective Services
DHHR	West Virginia Department of Health and Human Resources
KMO	The Kaiser-Meyer-Olkin
ODD	Oppositional Defiant Disorder
PCA	Principal Component Factor analysis
PTSD	Post-Traumatic Stress Disorder
RAD	Reactive Attachment Disorder
RMHTF	Residential Mental Health Treatment Facility
SCCRL	Statewide Children's Crisis and Referral Line
SFTP	Secure File Transfer Protocol
WV	West Virginia
WVU	West Virginia University
WVU OHA	West Virginia University Office of Health Affairs
YSS	Youth Services Survey
YSSF	Youth Services Survey for Families

1 Executive Summary

This report presents baseline findings for the first year of data collection for the West Virginia Department of Health and Human Resources (WV DHHR) Children's In-Home and Community-Based Services Improvement Evaluation Project (the Evaluation). Evaluation findings outlined in this report focus on data collected from children, youth, and young adults residing in residential treatment (hereafter referred to as youth), as well as their caregivers. Data collection activities included:

Caregivers

- Administering surveys to West Virginia (WV) caregivers of youth who received residential treatment in 2021.
- Conducting 12 independent caregiver interviews with at least one caregiver from each of the six regions defined by the WV DHHR Bureau for Behavioral Health (BBH).
- Conducting nine caregiver interviews as part of a case series design that pairs caregiver data to the youth in their care who received residential treatment in 2021.

Youth

- Administering surveys to WV youth who received residential treatment in 2021.
- Conducting 10 youth interviews as part of a case series design that pairs data from nine youth who received residential treatment in 2021 with their caregivers and also includes one Ward of the State.
- Analyzing statewide Medicaid data to focus on youth with claims for residential treatment between 2019 and 2020.
- Linking and analyzing client-level data collected by BBH to describe use of Children's Mobile Crisis Response and Stabilization and Children's Mental Health Wraparound.

Details of the population and study design are provided in Section 7. Key findings from the data collection activities are outlined below.

1.1 Summary of Key Findings and Recommendations

The findings in this section are organized by areas of agreement across caregivers and youth, findings specific to caregivers, and findings specific to youth.

1.1.1 Caregivers and Youth

Most of the youth in residential treatment were reported by caregivers and self-reported by youth as moderate to high functioning. Additional data, such as Child and Adolescent Functional Assessment Scale (CAFAS) scores, are needed to help determine whether it might be clinically feasible and safe to care for some of these youth in their homes and communities, if the necessary services are available.

Awareness and usage of community-based services was low. Caregivers were most aware of Children's Mental Health Wraparound, and youth were most aware of Behavioral Support Services, specifically Positive Behavior Support; both were least aware of Assertive Community Treatment. Over the last 12 months, less than half of youth had used any community-based services included in this evaluation.

Few youths were waiting for services at the time of data collection; youth and caregivers targeted for this phase of the evaluation were in residential treatment as of October 2021. However, both caregivers and youth felt that long wait times had been a barrier to initiating and continuing services in the past.

Both caregivers and youth reported positive behavior changes during and/or after residential treatment. Youth were more optimistic about reaching their treatment goals and about their post-treatment outcomes than their caregivers. Caregivers were more likely to report the need for ongoing services, including services to help transition youth back into their homes and communities.

Attendance and school performance improved as a result of receiving mental and behavioral health services. However, more than a third of youth were suspended in the last 12 months.

More mental and behavioral health services are needed. Both caregivers and youth said additional psychiatric and therapeutic services were needed, as well as alternative providers and recreational activities. Caregivers want more residential services, and home- and community-based specialty services such as therapy and counseling services of varying intensity and duration that focus on keeping youth in their homes or helping reintegrate them after placement in a Residential Mental Health Treatment Facility (RMHTF). Youth expressed the need for activities that help maintain the progress they made during residential treatment.

More than a third of youth reported having an encounter with the police in the last 12 months. Caregivers reported through survey responses that 39% of youth had an encounter with police in the last 12 months, 43% of whom had been arrested. Youth self-reported that 35% had an encounter with police in the last 12 months, 30% of whom had been arrested.

Many caregivers and youth rely on the police and hospitals to gain access to mental and behavioral health services in an emergency. Few caregivers or youth used crisis services such as the Statewide Children's Crisis and Referral Line or Children's Mobile Crisis Response and Stabilization in the last 12 months. However, both are confident that youth can access mental and behavioral health services outside of a hospital setting if said services are needed again in the future.

Some caregivers and youth had difficulty recognizing the services by the service name. For example, they did not always recognize that the youth had received "residential treatment" but could identify the facility in which a youth had received services (e.g., Chestnut Ridge).

Caregivers and youth felt that providers respected their cultural, religious, and spiritual beliefs. Both had moderate to high scores on survey questions measuring engagement and respect from providers.

1.1.2 Caregivers

Caregivers in interviews viewed residential mental health treatment as a last resort, only to be used if community-based services were inadequate or unavailable. They viewed the legal system as a gateway to residential placement but indicated that youth are sometimes held in detention centers if beds are not available.

Among the caregivers interviewed, most felt that residential treatment was appropriate for their youth. However, caregivers also expressed concerns that youth were not properly diagnosed, that there was a lack of communication with service providers, and that service providers were not always responsive to the family's needs, sometimes resulting in unanticipated and/or early discharges with little transition planning or reintegration support.

Caregivers felt that the wait times for residential treatment were significantly longer for in-state facilities than for out-of-state facilities. Caregivers reported that some youths were waiting up to 36 months for placement at an in-state facility, whereas the wait for out-of-state facilities was just a few weeks.

Many youths reported having stayed in RMHTF more than once. In fact, caregivers reported via survey responses that 44% of the youth sample had been placed in residential treatment three or more times in their lifetime. Additionally, most youth involved in the case series study reported multiple placements in RMHTFs.

Before residential treatment, caregivers had difficulty knowing what services were available to their youth, or who to contact to receive services. During residential treatment, caregivers became aware of how to start and use community-based treatment options for their youth in the future. Of note, caregivers had low confidence that these and other critical services would be available in their communities.

Caregiver satisfaction is closely tied to engagement and accessibility of specialized services for youth with complex needs. Some caregivers felt removed from decision-making processes and desired more participation in discussions about changes to youth's treatment or discharge planning. Satisfaction was found to be higher in instances where caregivers were able to access and sustain the needed specialized services both in the community and residential settings.

1.1.3 Youth

Discharges more than doubled and youth are staying in residential treatment for shorter periods of time compared to May 2019. Between May 2019 and the end of 2020, there were fewer Medicaid claims submitted for residential treatment per youth, there were more discharges from residential treatment, and there was a decrease in the average length of stay.

Many youths felt engaged in treatment planning and goal setting. Youth agreed that they received services that were right for them, and that their family got the help they wanted.

Youth were confident about maintaining the positive behavior changes achieved during residential treatment once they returned to their homes and communities. In fact, youth were less likely than caregivers to identify the need for transitional mental and behavioral health services, and/or the need for long-term services.

Youth reported a number of improvements as a result of residential treatment, including enhanced communication skills, anger management and coping skills, as well as behavioral awareness and empathy.

1.1.4 Additional Key Findings and Recommendations

A significant finding that was not anticipated based on the evaluation questions or plan involves the name recognition of services. Throughout the case series and caregiver interview process, participants made little reference to specific programs and services outlined in this evaluation. For instance, Positive Behavior Support was not mentioned in case series interviews, though supplemental data showed that three of ten youth participants had received the service. Similarly, only one caregiver disclosed the use of Children's Mobile Crisis Response and Stabilization, while records showed that eight of ten had received the service. Several participants reported use of "therapy" and "counseling" indiscriminately, without detailing which specific service was being provided by whom. Many participants reported utilizing services but had difficulty distinguishing which provided a particular service received.

Overall, both caregivers and youth referred to RMHTFs as "placement," but also used the term to refer to stays in shelters, hospitals, and juvenile detention centers. Three of ten youth participants did not recognize the term "Residential Mental Health Treatment Facility," when asked at interview, despite the fact that they were currently or had recently been in a RMHTF:

> *Interviewer: Okay. Have you been in residential placement before this time?*
>
> *Youth: What's that?*
>
> *Interviewer: So this is a residential facility. Have you been taken out of your home before?*
>
> *Youth: Mhm (Affirmative).*

Disparate reference to specific services and programs throughout qualitative interviews may convey a lack of use, awareness, and/or name recall of services received in the past. As one caregiver illustrated, "I feel like they were very poorly explained," when asked whether they became aware of other services during residential placement.

These findings suggest the need for strategic marketing campaigns and outreach as programs and services evolve in brand and nature. Amid the volume, variety, and complexity of social service programs across WV, comprehensive marketing strategies are critical to effective services access and delivery. As program branding evolves, it must be clearly and consistently communicated to recruit and retain stakeholders, evaluate and improve services, and continue to meet the needs of West Virginians.

Specifically, the following recommendations should be considered:

Specific strategic marketing campaigns and materials for each current and new program and service should be created and disseminated among provider and stakeholder communities throughout the state. As neither caregivers nor youth are consistently using the naming conventions established by WV DHHR, further rebranding may present a challenge for stakeholders to find and access specific services. This also poses a challenge for service providers who promote, provide, and refer to these services. The combination of these factors could result in decreased service utilization for those in need in WV. Additionally, rebranding impacts the ability to effectively evaluate and improve service experiences among stakeholders.

Any program or service rebranded from one naming convention to another should explicitly be stated in marketing materials for those familiar with programs or services they have used prior. Information should include the nature and quality of service offered, distinctions and relations to other services, eligibility and how to access, and the use and benefit to stakeholder needs. For caregivers and youth to adopt new branding, and for providers to effectively promote, refer to, and evaluate these services, stakeholders must be able to assign a name to specific services and clearly identify and distinguish among them.

1.2 Concluding Summary

Evidence suggests that fewer youth are being placed in RMHTFs and they are being placed for shorter periods of time than in May 2019. Caregivers and youth recognized the value of residential mental health treatment and observed improvements in youth's functional wellbeing as a result. Many caregivers felt that residential treatment was the appropriate level of care needed for their youth at the time of their placement. Yet, it should be noted that at the time of data collection caregivers reported, and youth self-reported, moderate to high levels of youth functioning. Caregivers felt that residential services as well as home- and community-based services lacked capacity, especially for youth with complex needs. For instance, many caregivers and youth reported relying on the police and hospitals to gain access to mental and behavioral health services in an emergency.

Overall, the findings were clear: caregivers and youth need more accessible mental and behavioral health services that vary in duration and intensity to meet the various and complex needs of youth. Access, inclusion, and engagement with services were closely tied to both caregiver and youth satisfaction. Areas of opportunity exist to increase awareness, capacity, usage, and engagement with community-based services that delay or reduce the need for residential treatment, or that can help transition youth back into their homes and communities. Caregivers also desired more frequent and higher quality communication with service providers, especially when it comes to treatment and discharge planning, goal setting, and changes to their youth's care plans.

2 Introduction

2.1 Project Overview

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

- Assertive Community Treatment (ACT)
- Children's Mobile Crisis Response and Stabilization (CMCRS)
- Wraparound Facilitation Services: West Virginia Children's Mental Health Wraparound and Children with Serious Emotional Disorders Waiver Wraparound
- Positive Behavior Support, which is now a part of Behavioral Support Services (PBS)
- Residential mental health treatment facilities (RMHTF)
- Statewide Children's Crisis and Referral Line

Therapeutic Foster Care was included in data collection, analysis, and overall reporting, although Therapeutic Foster Care-specific findings are not presented in this report. During the data collection and reporting period, WV DHHR shifted strategy from Therapeutic Foster Care to the Stabilization and Treatment Home Model, which is currently being developed and will likely begin in early 2023.

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

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

2.2 Workgroup Achievements

The workgroups have achieved numerous accomplishments since initiating the work in 2019, while overcoming many adversities associated with responding to a pandemic. The most recent highlights of these accomplishments are as follows:

2.2.1 Year 2022

- Established an Office of Quality Assurance for Children's Programs and have hired a director to lead that office.
- Developed and implemented a Continuous Quality Improvement Plan.

- A Quality Committee was established with representatives across all three bureaus.
- The first semiannual Quality and Outcomes report for Children's Mental Health and Behavioral Health services was published on January 31, 2022.
- Developed Stabilization and Treatment homes as a new model of care for foster children.
- The Bureau for Social Services implemented the Assessment Pathway process across all counties.
- The Bureau for Juvenile Services and Probation Services began making referrals to the Assessment Pathway.
- The KEPRO contract was approved to begin providing Qualified Individual Assessments to recommend the appropriate level of residential treatment.
- Rebranded the Child Welfare Collaborative website to the Kids Thrive Collaborative to provide families with additional resources and updated information.

2.2.2 Evaluation Background

As a part of this work, WV DHHR engaged West Virginia University Office of Health Affairs (WVU OHA) in 2020 to conduct an outcome evaluation of the State's expansion of in-home and community-based services for children. 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), WVU OHA developed an outcome evaluation plan that provided the overarching evaluation framework, including evaluation questions for both the initiative and the workgroups, which is being assessed at three levels:

- ***System-level:*** an examination focused on statewide trends and collaborations.
- ***Community and provider-level:*** an examination of organizations, agencies, mental health providers, and other providers delivering services or collaborating with service providers within the continuum of care for children's mental health services in WV.
- ***Youth and caregiver-level:*** an examination of child- and family-level information within and across programs of interest to the evaluation over time.

The Evaluation is currently in the second phase (5/1/2021 – 7/31/2022), the baseline data collection phase, which began with collecting data for the system-, and community and provider-levels of the Evaluation and ended with collecting data for the youth and caregiver-level. The findings from system- and community and provider-level were presented in the System and Community-Level Evaluation Report dated March 31, 2022. **The Evaluation activities for this current report include mixed methods findings, resulting from quantitative and qualitative data collection strategies at the youth and caregiver-levels.** This stage of data collection focused on youth up to age 21 receiving care in RMHTFs in WV or other states, as well as their caregivers. The quantitative work included developing, administering, and analyzing two surveys: one for youth currently in RMHTFs and another for caregivers with children in RMHTFs. The purpose of these surveys was to understand youth and caregivers' perspectives in navigating and accessing mental health services in WV. The qualitative work included developing interview guides and protocols for qualitative data collection followed by 12 standalone caregiver interviews and 19 interviews with pairs of youth and their caregivers participating in a case series study.

Data collection methods include:

Surveys
Caregiver Interviews
Case Series Study
Secondary Data Analysis

The purpose of this report is to provide a detailed description of the baseline findings from the youth and caregiver-level. Since this is the first year of data collection for the Evaluation, only baseline data are being reported, and assessments of change will occur in subsequent years. This report only includes data collected from youth currently in or recently discharged form RMHTFs and their caregivers as of October 2021. Recruiting and collecting data from youth at risk of placement in RMHTFs is planned for the next phase of the Evaluation.

It is important to recognize the potential that social desirability bias—or the tendency for participants to answer questions in ways that will be seen favorably—may be present in the data collected from youth and caregivers. 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 both youth and caregivers, providing confidence that participants were generally forthcoming with sharing information honestly.

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

This report starts with an overview for the youth and caregiver assessment level and briefly describes the data collection, analysis, and descriptive findings. Next, the synthesized quantitative and qualitative findings for all high priority initiative and workgroup-specific evaluation questions are presented. Finally, the appendices contain quantitative findings for the medium and low priority initiative- and workgroup-specific evaluation questions, detailed quantitative data collection, analytic methods, table indices, and detailed qualitative data collection analytic methods and case series profiles.

2.3 Youth and Caregiver Level Overview

The purpose of the youth and caregiver-level assessment is to assess (1) caregivers' and youth's awareness of mental health services in WV, (2) youth and family participation and engagement in mental health services, and (3) youth functioning while receiving mental health services. This assessment was achieved through quantitative primary data collection and analysis from two statewide surveys, youth and caregiver interviews, and secondary data analysis via Medicaid data, and Epi Info data.

2.3.1 Caregiver Survey

The purpose of the Caregiver Survey was to collect information from caregivers (i.e., biological parents, foster parents, adoptive parents, or kinship care providers) about their perspectives on and experiences with children's mental health services in WV. Participants were contacted using computer-assisted telephone interviewing software and given the option to participate online or via phone. Data were collected between October 28, 2021, and February 17, 2022. There were 104 completed surveys (total sample completion rate of 30.9%) from caregivers whose youth under the age of 21 were receiving care at a RMHTF in WV or other states on October 1, 2021.

The Caregiver Survey contained multiple items about service experiences and treatment outcomes. Exploratory factor analysis was performed to determine the extent to which these items clustered together to accurately measure the constructs of interest to the Evaluation. The factor analysis resulted in the creation of five scales. Items in each scale were also analyzed for internal consistency using Cronbach's alpha coefficient to determine the stability of each scale. These scales were:

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

2.3.2 Caregiver Survey Respondent Descriptive Findings

Caregiver reports about their youth's demographics and residential history can be found in Appendix D, Demographics and Awareness, Table 1. The demographics for respondents completing the Caregiver Survey can be found in Appendix D, Demographics and Awareness, Table 2. The respondents to the Caregiver Survey included 13 (13%) males, 87 (84%) females, and four (4%) missing gender. A majority of the respondents were white (92%) and non-Hispanic (92%). In addition, five respondents described their race as Black and one described their race as American Indian. There was variation in employment status, with most respondents employed for wages (38%); nearly one in five (19%) were unable to work and 15% were retired. Respondents were employed in a variety of professions, with the most respondents employed in health care (24%) and the least respondents employed in manufacturing, education, financial services, and transportation (<5% respectively). An additional 33% of the respondents identified their industry of employment as "Other." Most respondents (82%) had a combined household income above $75,000; the state's median household income is estimated at $48,037 (Census QuickFacts, 2021).

The respondents to the Caregiver Survey reporting being the caregivers of 108 youth receiving care in RMHTFs on October 1, 2021 (Appendix D, Demographics & Awareness, Table 1). A majority of the youth (64%) were between 15 – 17 years old. Their current stay in residential care ranged from one to over 12 months, with most youth staying in residential care between four and six months (40%). Before their current entry into residential care, most of the youth reported having previously been in residential care once (40%) while 27% of them had been in residential care more than three times.

2.3.3 Youth Survey

The purpose of the Youth Survey was to collect data from youth under the age of 21 about their awareness of and experiences with mental health services in WV and the outcomes associated with receiving services. Data were collected via teleconference calls and in-person at RMHTFs between November 16, 2021, and April 18, 2022. Caregiver consent to contact youth was obtained during the Caregiver Survey for youth between the ages of 12 and 17. Additionally, the Bureau of Social Services provided a blanket consent to contact youth between the ages of 12 and 17 considered to be Wards of the State. Youth between the ages of 18 and 21 were able to provide their own consent as adults. There were 115 completed surveys (total sample completion rate of 47.9 %) from youth under the age of 21 who were receiving care at RMHTFs in WV or other states during the specified times for inclusion in the survey sample.

The Youth Survey contained multiple items about service experiences and treatment outcomes. To determine whether these items clustered together to accurately measure the constructs of interest to the Evaluation, exploratory factor analysis was performed. The analysis resulted in the creation of three scales. Items in each scale were also analyzed for internal consistency using Cronbach's alpha coefficient to determine the stability of each scale. These scales were:

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

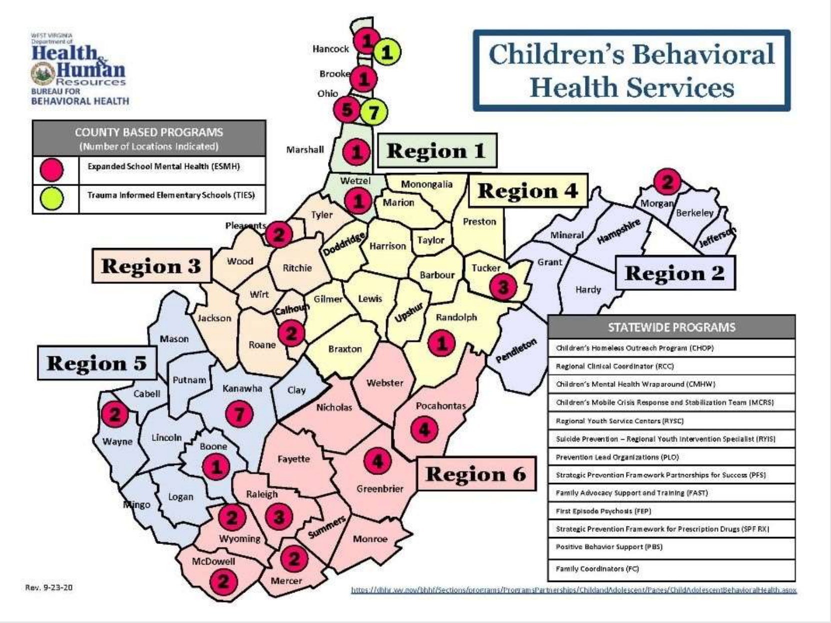
2.3.4 Youth Survey Respondent Descriptive Findings

Youth Survey Respondent percentages information can be found in Appendix E, Demographics and Awareness Tab, Table 1. The respondents to the Youth Survey included 81 males assigned at birth and 32 females assigned at birth. An additional two youth chose "I don't know" when asked about their sex assigned at birth. Over half of the respondents (n=69) were Wards of the State. A majority of the respondents were White (85%). Other races represented by respondents included multiple races (19%), African American/Black (14%), Native American/Alaskan Native (13%), other (9%), Asian American/Asian (5%), and Native Hawaiian/other Pacific Islander (3%). In addition, 13 respondents identified as Hispanic, Latino/a, or of Spanish origin. A majority of the respondents were between 15-17 (61%). There were 27 respondents between 12-14 (24%) and 18 respondents between 18-21 (16%). Their current stay in residential care ranged from one to over 12 months, with most respondents staying in residential care between four and six months (35%) and 10% staying between one and three months. Prior to their current entry into residential care, most of the respondents reported having been in residential care at least three times (49%).

2.3.5 Standalone Caregiver Interviews

The purpose of the Caregiver Interviews was to understand caregivers' awareness of WV mental health resources and DHHR programs within and across BBH regions as well as information on barriers and facilitators to receiving care, as well as quality of and satisfaction with mental health services. Participants were recruited from the Caregiver Survey and purposively selected to achieve representation across BBH regions. In total, 12 caregivers with youth receiving care in RMHTFs participated in Caregiver Interviews, with at least one participant from each BBH region (see Figure 1: BBH Region and Service Locations).

Figure 2-1: BBH Region and Service Locations



COUNTY BASED PROGRAMS (Number of Locations Indicated)	
🟥	Expanded School Mental Health (ESMH)
🟩	Trauma Informed Elementary Schools (TIES)

STATEWIDE PROGRAMS
Children's Homeless Outreach Program (CHOP)
Regional Clinical Coordinator (RCC)
Children's Mental Health Wraparound (CMHW)
Children's Mobile Crisis Response and Stabilization Team (MCRS)
Regional Youth Service Centers (RYSC)
Suicide Prevention – Regional Youth Intervention Specialist (RYIS)
Prevention Lead Organizations (PLO)
Strategic Prevention Framework Partnerships for Success (PFS)
Family Advocacy Support and Training (FAST)
First Episode Psychosis (FEP)
Strategic Prevention Framework for Prescription Drugs (SPF RX)
Positive Behavior Support (PBS)
Family Coordinators (FC)

https://dhhr.wv.gov/bbh/Sections/programs/ProgramsPartnerships/ChildandAdolescent/Pages/ChildAdolescentBehavioralHealth.aspx

2.3.6 Case Series Youth and Caregiver Interviews

The longitudinal mixed methods case series aims to gain an in-depth understanding of individual and family experiences with children's mental health services in WV over time. Case series participants were recruited purposefully from the Youth and Caregiver Surveys and include nine youth receiving care in a RMHTF and their caregivers, as well as one youth considered a Ward of the State who did not have a corresponding caregiver (n = 19 total participants). Data included in the case series includes in-depth qualitative interviews with youth and their caregivers (at baseline and every six months for the duration of the Evaluation period) as well as Medicaid claims and survey data to explore program-specific changes over time. Data from baseline interviews from youth and caregivers involved in the case series are included in this report.

2.3.7 Secondary Analysis of Medicaid Data

WV Bureau for Medical Services (BMS) collects comprehensive data about Medicaid claims in an in-house database that was accessible for the purpose of this evaluation. Medicaid claim data were available for almost all (97%) youths residing in residential mental health facilities in WV. The purpose of the secondary analysis of Medicaid claims data was to provide important information on diagnosed mental health conditions and treatment received among youth residing at RMHTFs in WV, beyond the sample of youth who responded to the survey. WV Medicaid claims data from 2009 through 2020 were accessed, and data from 2019 through 2020 were used in a longitudinal design to identify temporal trends of various mental health treatments received, and to compare health outcomes by treatment type. In total, 777 (96.9%) WV youth who reside in RMHTFs were identified in the WV Medicaid claim data.

2.3.8 Secondary Analysis of Epi Info Data

Epi Info is a DHHR-administered database that is used to collect and securely store sensitive health information from children and families receiving services from the Bureau for Behavioral Health's System of Care grant recipients. The purpose of the secondary analysis of Epi Info data was to identify the most recent Children’s Mobile Crisis Response and Stabilization and Children’s Mental Health Wraparound service history for youth residing at RMHTFs in WV. Epi Info data from October 2021 through April 2022 were used in a longitudinal design to examine the changes in Children’s Mobile Crisis Response and Stabilization and Children’s Mental Health Wraparound services reported by providers. Proportions of services provided and declined were calculated and temporal trend in month was identified.

3 High-Priority Initiative – Specific Evaluation Questions-Baseline Findings

This section of the report presents the baseline findings for evaluation questions that are related to the overall Initiative and ranked as a high priority by the WV DHHR Steering Committee and workgroups. Evaluation questions are organized by question, expected outcomes identified during the evaluation plan development, synthesis of quantitative and qualitative baseline findings, followed by a summary of WV DHHR reported progress. Each evaluation question is noted with the intended assessment level (System, Community/Provider, and Youth and Caregiver) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term) (Table 3-1).

Table 3-1: Evaluation Question Symbols and Definitions for Assessment Levels and Outcomes

Symbol	Definition
§	System-level Outcome
‡	Community/Provider-level Outcome
†	Youth and Caregiver-level Outcome
Ⓢ	Short-term Outcome (Year 1)
Ⓘ	Intermediate Outcome (Years 2 – 3)
Ⓛ	Long-term Outcome (Years 4 – 5)

3.1 Initiative – Specific Evaluation Questions and Baseline Findings

3.1.1 How has awareness of mental health services for children changed (families, mental health providers, medical providers, Department of Education staff, courts, police)?

Expected Outcome:

- Increased family awareness of youth mental health treatment services and supports among families receiving services Ⓢ Ⓘ Ⓛ

This report includes baseline data collected through March 2022. Change will be assessed and reported in 2023.

Baseline Findings:

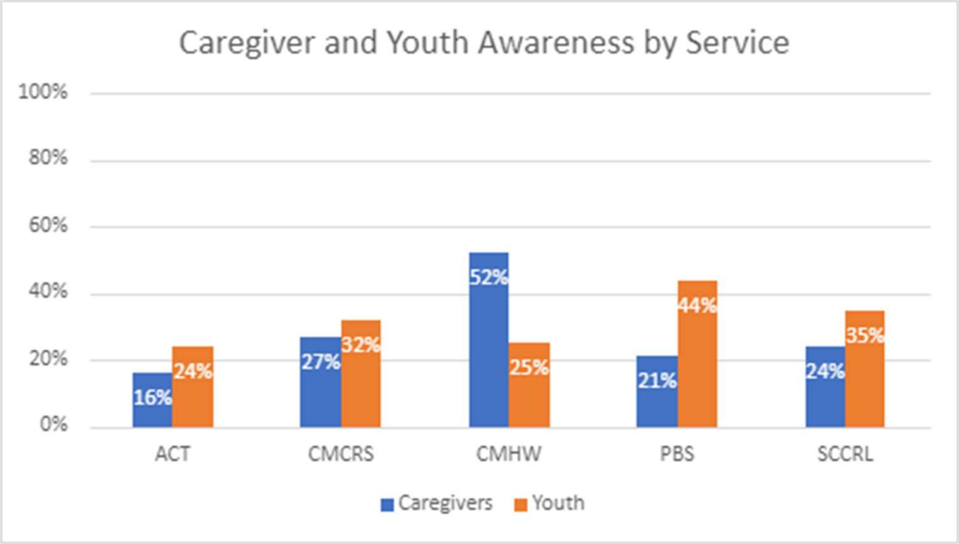
Caregivers and youth were asked whether they are aware of the community-based services included in the Evaluation. The greatest percentage of caregivers were aware of Children's Mental Health Wraparound (52%), and the greatest percentage of youth were aware of Positive Behavior Support (44%); both caregivers and youth were least aware of Assertive Community Treatment (16% and 24% respectively; Appendix D, Demographics & Awareness, Table 4; Appendix E, Demographics & Awareness, Table 3).

Youth were generally more aware of community-based services, except for Children's Mental Health Wraparound; approximately half of caregivers were aware of this service but only 25% of youth reported awareness.

Caregiver and youth awareness of mental health services for children is displayed in Appendix D, Demographics & Awareness, Table 4 and Appendix E, Demographics & Awareness, Table 3. In summary, baseline awareness of community-based services included in this evaluation were as follows:

- ***Assertive Community Treatment***: 16% of caregivers and 24% of youth were aware of Assertive Community Treatment.
- ***Children's Mobile Crisis Response and Stabilization***: 27% of caregivers and 32% of youth were aware of Children's Mobile Crisis Response and Stabilization.
- ***Children's Mental Health Wraparound***: 52% of caregivers and 25% of youth were aware of Children's Mental Health Wraparound.
- ***Positive Behavior Support***: 21% of caregivers and 44% of youth were aware of Positive Behavior Support.
- ***Statewide Children's Crisis and Referral Line***: 24% of caregivers and 35% of youth were aware of the Statewide Children's Crisis and Referral Line.

Figure 3-1: Caregiver and Youth Awareness by Service



Among all youth and caregivers participating in interviews (n = 31 total), 10 used Wraparound services and two reported use of mobile crisis services. Behavioral Support Services (such as Positive Behavior Support) and Assertive Community Treatment were not specifically referenced in qualitative interviews.

The Caregiver Survey was sent to those caring for one or more youths who were in residential care on October 1st, 2021 as recorded in the WV DHHR Families and Children Tracking System (FACTS) data system. FACTS is the statewide system most utilized for the administration of Title IV-E Child Welfare Programs (www.wvfacts.org). Similarly, the Youth Survey was sent to youth who resided in a RMHTF on October 1st, 2021. However only 67% of caregivers and 87% of youth reported awareness of residential mental health treatment (Appendix D, Demographics & Awareness, Table 4; Appendix E, Demographics & Awareness, Table 3). It could be that participants do not recognize the nomenclature of “residential mental health treatment facility.” It is also possible that some survey respondents were mistaken because the youth stayed at a facility that offered multiple services or held misperceptions about the services provided as part of residential care. During youth and caregiver interviews, several participants indiscriminately used the term “placement” to reference RMHTFs as well as stays in shelters, juvenile detention, and other centers. Youth generally referred to RMHTFs by their proper names, and three did not recognize the term “residential placement” when asked about their experiences. Several participants also had difficulty differentiating the different services and programs. This might imply a lack of awareness, utilization, and/or name recall. One caregiver stated, “I feel like they were very poorly explained,” when asked whether they became aware of other services that could be helpful while the youth was in RMTHF.

Caregivers reported difficulties knowing which services were available for their youth or who to contact for help. They neither agreed nor disagreed that they knew which types of services might have been available to help their youth (Appendix D, Crisis Support and Access, Table 2) or knew who to contact for services (Appendix D, Experiences with Mental Health Services, Table 1). All caregiver participants participating in qualitative interviews discussed challenges pursuing needed services throughout their treatment journey, and conveyed a consensus that WV has a deficit of specialized mental health services for youth. Caregivers frequently reported obtaining resources and referrals from current providers (i.e., WV DHHR, behavioral/medical) who helped them to navigate and secure services. They also reported relying on social networks (e.g., friends, school) and their own "research," which they described as overall inadequate. Several caregivers described challenges with accessing critical services, noting that sometimes DHHR was perceived as a gatekeeper and that the legal system was the only gateway to getting help. One caregiver noted that working through the legal system added complexity due to the risk of losing custody in the process of getting mental or behavioral health care. Several also noted youth being sent to detention facilities via court order while awaiting an available RMHTF placement amid long waitlists. Others reported youth's circumstances being too mild or severe to meet service criteria.

Perceived barriers to access included service compatibility (e.g., youth does not meet criteria/has specialized needs), capacity (e.g., waitlists, high caseloads, turnover), policy (e.g., age, diagnosis, out of state coverage restrictions), distance/geographical limitations (e.g., transportation, work, travel costs), and COVID, resulting in significantly limited availability and coverage for youth mental health services in WV. Many caregivers perceived RMHTFs as a last but necessary resort after exhausting all other known options, which were often reported to be inaccessible and/or inadequate to meet youths' specialized needs.

Caregivers were asked about changes in their understanding of how to access services over the last 12 months. Approximately half (47%) reported that their understanding has improved (Appendix D, Crisis Support and Access, Table 3). Of those reporting that their understanding improved over the last 12 months:

- 55% said it made them more likely to access services in the future
- 28% said it made them equally likely to access services in the future
- 4% said their increased understanding made them less likely to access youth services in the future.

An additional 17% said that they do not expect to need additional services in the future (Appendix D, Crisis Support and Access, Table 3). Moreover, caregivers agreed that should youth need mental and behavioral health support in the future, they know who to contact (Appendix D, Crisis Support & Access, Table 4) and have the knowledge necessary to start and use each of the following services, with mean scores based on a 5-point agreement scale ranging from 3.7 to 4.0 (Appendix D, Future Service Needs, Table 1):

- Assertive Community Treatment (3.7)
- Children's Mobile Crisis Response and Stabilization (3.8)
- Children's Mental Health Wraparound (3.7)
- Positive Behavior Support (3.7)
- Statewide Children's Crisis and Referral Line (4.0)

While most caregivers participating in qualitative interviews expressed the need and desire for future services, they generally conveyed low confidence that critical services would be available in their communities and accessible to meet youths' complex and ongoing needs. Caregivers shared a desire and need for more specialized service options in WV, notably in-home therapy/counseling and shorter-term, median-tier options that would allow youth to receive more intensive care in their homes and communities. Many caregivers also noted the need for greater post-treatment and reintegration engagement and support to facilitate a sustainable transition back home and to school, maintain progress, and deter future residential placement. In interviews, youth expressed less perceived need for future services and were more confident they could maintain positive mental and behavioral health upon returning home. However, one youth indicated a desire to receive Safe at Home support post-treatment, even after refusing the support prior to residential placement. Such a desire speaks to the potential of better understanding of services and more willingness to receive them.

3.1.2 How has functioning changed for children receiving mental health services?

Expected Outcome:

- Improved child functioning Ⓘ Ⓛ

Baseline Findings:

The baseline for youth functioning for the residential population was captured in several ways. The Caregiver Survey captured their perceptions of youth functioning as of Spring 2022. The Youth Survey captured self-reports of functioning also as of Spring 2022. Youth and caregiver interview participants discussed youth maintenance of positive mental and behavioral health after treatment. In future evaluation reports, Child and Adolescent Functional Assessment Scale (CAFAS) scores will also be obtained from DHHR. During the data collection and reporting period, WV DHHR selected the CAFAS to distinguish youth who are eligible for residential mental health treatment from those who are at-risk of placement. Since the CAFAS process and data collection were being implemented at the same time as the evaluation, scores were not available for this report. **For this report, youth functioning was measured through caregiver and youth surveys that include questions about daily life, social, school, and family connections, and life satisfaction.**

Caregiver perceptions of youth functioning and youth self-reported functioning were measured by the Caregiver-Child Functioning Scale and Youth-Child Functioning Scale, respectively. According to caregiver reports and youth self-report, most youth in residential care were moderate to high functioning at the time of survey administration. More than half of youth self-reported as high functioning. In summary, baseline child functioning was reported as follows:

- Caregivers reported that 17% of youth were low functioning, and 2% of youth self-reported as low functioning
- Caregivers reported that 45% of youth had moderate functioning, and 41% of youth self-reported as moderate functioning
- Caregivers reported that 38% of youth were high functioning, and 57% of youth self-reported as high functioning

The majority of caregivers and youth participating in interviews reported positive behavioral health changes with residential treatment, though youth were notably more optimistic in their treatment outcomes and post-treatment outlook. Several youth reported improved anger management and coping skills, family relationships and communication, and behavior awareness and empathy. Most reported improved grades, school experiences, and appetite. Several youth reported less contact with friends outside of residential placement generally, and a few conveyed that they would think twice about hanging around the external friend group they had once they leave. Two youth spoke to seeing and participating in more conflict inside RMHTFs, as their peers were generally more aggressive. While some youth conveyed lower levels of perceived need and were non-committal to future services, about half expressed interest and consideration for continued therapy or counseling as well as extracurricular activities post-treatment to maintain progress.

In interviews, caregivers reported that they generally do not trust that what they see or hear related to their youth's progress during residential placement will continue once they are discharged. Many caregivers report that they have not been able to be as engaged as they would like and have not received much information on their youth's treatment. Additionally, they reported abrupt discharges from residential placement with little discharge planning. Many caregivers perceive their youth were discharged too soon and express doubts they will be able to access services needed outside of residential treatment. While caregivers report improvements seen in youth *now*, the majority were skeptical about whether those improvements would sustain. Residential placement has been cyclic for many families; youth are discharged, initiate community services if they can find them, and are frequently placed in residential treatment again. Caregivers expressed that they are often in "wait and see mode" and are uncertain the positive changes are real.

3.1.3 How has the use of community-based mental health services changed?

Expected Outcome:

- Increased usage of family-based placements with supportive mental health services Ⓛ

Baseline Findings:

When asked about their awareness and usage of community-based mental health services, caregivers and youth reported similar usage of Assertive Community Treatment, Children's Mobile Crisis and Stabilization, and the Statewide Children's Crisis and Referral Line in the last 12 months. However, fewer youth "didn't know" about their use of the Statewide Crisis and Referral Line. A greater percentage of youth said they called the hotline in previous years when compared to caregivers (Appendix D, Demographics & Awareness, Table 4 and Appendix E, Demographics & Service Awareness, Table 3). The percentage of youth who received Assertive Community Treatment, Children's Mobile Crisis and Referral Line, and RMHTF according to Medicaid claims were not significantly different than what was reported in the Caregiver Survey data and Youth Survey data.

Caregiver awareness and reported service use among youth in their care was as follows (Appendix D, Demographics & Awareness, Table 4):

- ***Assertive Community Treatment***: 16% of caregivers were aware of Assertive Community Treatment, representing 19 youth, 5% of whom had participated in Assertive Community Treatment it in the last 12 months and 5% (one youth) was on the waitlist; caregivers of 26% of youth reported that they did not know. *(Due to the target population of youth in residential treatment, few would have been old enough to be eligible and/or would have used Assertive Community Treatment during the baseline year; however, a large percentage of the sample (77%) are or will be eligible within a few years and as such awareness was analyzed across all age groups.)*
- ***Children's Mobile Crisis Response and Stabilization***: 27% of caregivers were aware of Children's Mobile Crisis Response and Stabilization, representing 30 youth, 23% of whom participated in Children's Mobile Crisis and Stabilization in the last 12 months, 7% were on the waitlist, 10% had used it in previous years, and caregivers of 10% of youth reported that they did not know.
- ***Children's Mental Health Wraparound***: 53% of caregivers were aware of Children's Mental Health Wraparound, representing 56 youth, 34% of whom had participated in Children's Mental Health

Wraparound in the last 12 months, none were waiting for services, 21% had used Children's Mental Health Wraparound in previous years, and caregivers of 14% of youth did not know

- ***Positive Behavior Support:*** 21% of caregivers were aware of Positive Behavior Support, representing 24 youth, 42% of whom had participated in Positive Behavior Support in the last 12 months, none were waiting for services, 8% had used Positive Behavior Support in previous years, and caregivers of 4% of youth did not know.
- ***Statewide Children's Crisis and Referral Line***: 24% of caregivers were aware of Statewide Crisis Line and Referral Line, representing 28 youth, 7% of whom called the Statewide Crisis and Referral Line in the last 12 months, 7% had used the Statewide Crisis and Referral Line in the previous year, and caregivers of 18% of youth did not know.

Less than half of youth reported using community-based services in the last 12 months. The greatest percentage of youth used Positive Behavior Support and Children's Mental Health Wraparound in the last 12 months. Fewer youth reported that they used Children's Mental Health Wraparound however more youth also did not know. Fewer youth reported that they used Positive Behavior Support in the last 12 months, but more youth said they had in previous years. When asked about their own awareness and service use, youth reported that (Appendix E, Demographics & Service Awareness, Table 3):

- ***Assertive Community Treatment***: 24% of youth were aware of Assertive Community Treatment, 7% of whom had participated in Assertive Community Treatment it in the last 12 months and 4% were on the waitlist; 7% of youth did not know.
- ***Children's Mobile Crisis Response and Stabilization***: 32% of youth were aware of Children's Mobile Crisis Response and Stabilization, 8% of whom had participated in Children's Mobile Crisis Response and Stabilization in the last 12 months, 3% were on the waitlist, 5% had used it in previous years, and 14% did not know.
- ***Children's Mental Health Wraparound***: 25% of youth were aware of Children's Mental Health Wraparound, 14% of whom had participated in Children's Mental Health Wraparound in the last 12 months, 7% were waiting for services, 24% had used Children's Mental Health Wraparound in previous years, and 21% did not know.
- ***Positive Behavior Support***: 44% of youth were aware of Positive Behavior Support, 27% of whom had participated in Positive Behavior Support in the last 12 months, 2% were waiting for services, 24% had used Positive Behavior Support in previous years, and 6% did not know.
- ***Statewide Children's Crisis and Referral Line***: 35% of youth were aware of Statewide Crisis and Referral Line, 3% of whom called the Statewide Crisis and Referral Line in the last 12 months, 24% had used the Statewide Crisis and Referral Line in the previous year, and 6% did not know.

Throughout youth and caregiver interviews, participants made few references to evaluation-specific services and programs, which might imply a lack of awareness, use, and/or name recall. Neither Behavioral Support Services (such as Positive Behavior Support) nor Assertive Community Treatment were discussed in any of the interviews. Four caregivers reported use of Wraparound (one of Children with Serious Emotional Disorders), two reported use of Mobile Crisis, and ten reported use of Safe at Home.

Several caregivers reported positive experiences with Safe at Home and Wraparound staff and services, noting responsiveness, consistency, and expedited assistance to delay more intensive treatment. One youth notably desired Safe at Home services to check in on her progress following discharge, though she had refused participation prior to residential placement. One caregiver stated that her Wraparound worker was exceptional, working "above and beyond the call of duty." Another caregiver reported that

Safe at Home workers, “were absolutely fantastic. They really, really helped us; they did everything they could… I think it really opened [Youth’s] eyes a little bit to see like, ‘hey, there are people that care; there are people that want to help me.’”

Others reported these programs were beneficial and responsive in offers of assistance but either could not meet youth’s needs or failed to deliver on services offered. Caregivers reported utilizing a combination of these programs, though they had difficulty identifying which provided a particular service. Two caregivers described Mobile Crisis as nonresponsive; one caregiver reported the line was always out of service or no one would answer; another reported the youth was declined services for not registering following discharge from residential treatment. When services were not responsive, several caregivers reported calling the police. Difficulties encountered included service compatibility, capacity, communication, and responsiveness amid high waitlists and caseloads and inadequate fit for youth’s specialized needs. Additional services reported by all participants included prior stays in RMHTFs and individual and family therapy or counseling of varying intensity and duration.

When caregivers were asked about their understanding of how to access services over the last 12 months, 47% reported that their understanding has improved (Appendix D, Crisis Support and Access, Table 3). Of the 47% of caregivers who reported their understanding improved over the last 12 months, 55% said it made them more likely to access services in the future, 28% said equally likely and 4% said less likely; 17% said that they do not expect to need additional services in the future (Appendix D, Crisis Support and Access, Table 3). Many caregivers and youth reported relying on the police or hospitals to gain access to mental and behavioral health services (Appendix D, Crisis Support and Access, Table 1; Appendix E, Experiences with Mental Health, Table 5). However, caregivers and youth agree that if mental and behavioral health services are needed in the future, they can access those services outside of a hospital setting. Caregivers agreed that should youth need mental and behavioral health support in the future, they know who to contact (Appendix D, Crisis Support & Access, Table 4) and have the knowledge necessary to start and use Assertive Community Treatment, Children’s Mobile Crisis and Stabilization, Children’s Mental Health Wraparound, Positive Behavior Support, and Statewide Crisis and Referral Line (Appendix D, Future Service Needs, Table 1).

While most caregiver participants in youth and caregiver interviews expressed the need and desire for future services, they conveyed low confidence that critical services would be available in their communities and accessible to meet youths’ complex and ongoing needs. Caregivers shared a desire and need for more specialized service options in WV, notably in-home therapy or counseling and shorter-term, median-tier options that would allow youth to receive more intensive care in the community. Many caregivers also noted the need for greater post-treatment and reintegration engagement and support to facilitate a sustainable transition back home, maintain progress, and deter future placement. Youth expressed less perceived need for future services and were more confident of maintaining positive behavioral health practices upon return home.

3.1.4 Did fewer children with serious mental health conditions unnecessarily enter residential mental health treatment facilities or Psychiatric Residential Facility after May 2019?

Expected Outcome:

- Increased usage of family-based placements with supportive mental health treatment services and supports Ⓛ

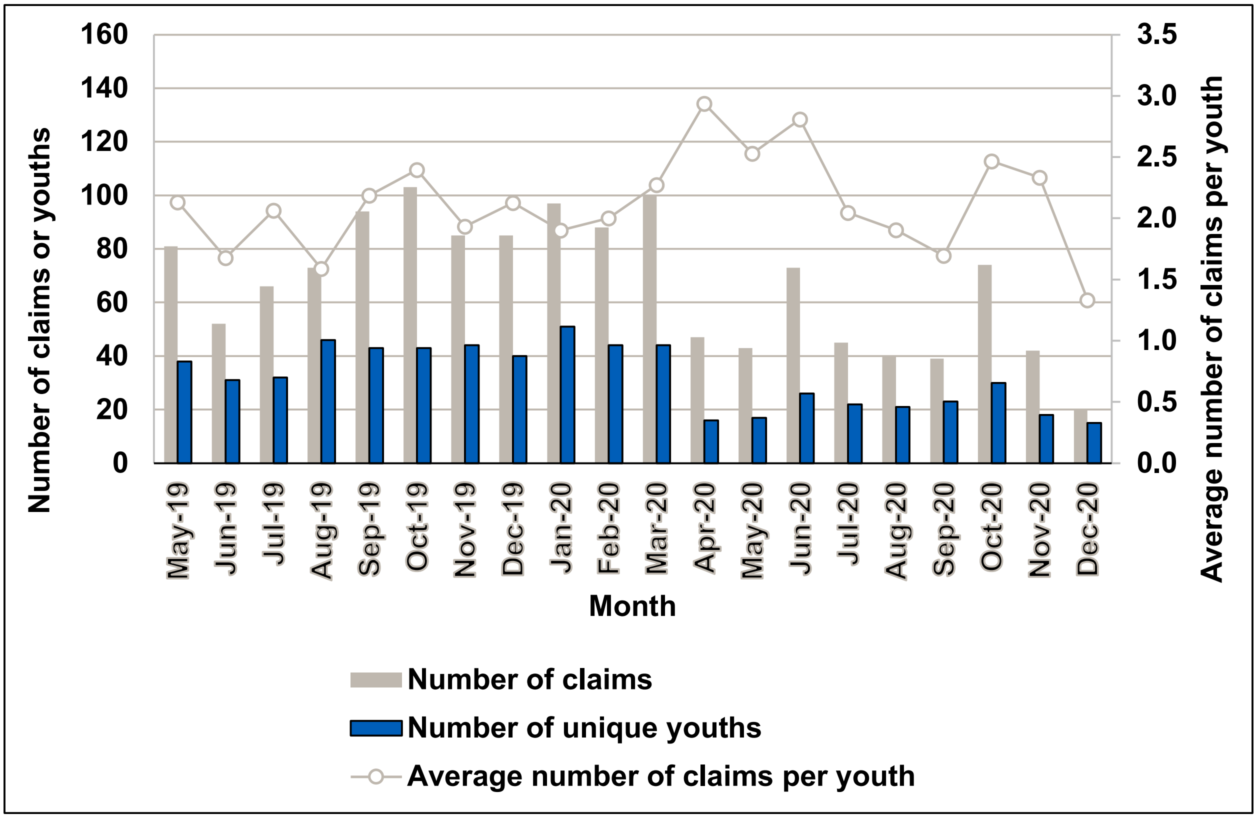
Baseline Findings:

The timeline of data review and collection for this baseline report coincided with the COVID-19 pandemic. Future trends will further the understanding of changes in the system outside of the impacts of pandemic service availability and delivery.

There were 802 WV youth under the age of 21 who were residing in RMHTFs as of October 1, 2021, according to DHHR. DHHR reports that the average census in RMHTFs was 1,096 as of June 1, 2015 and was 764 as of January 21, 2022. DHHR also reports that the average monthly RMHTF bed utilization was 1,019 in May 2019 and was 819 by June 2021.

At the time this report was generated, Medicaid claims data were available for 777 (96.9%) WV youth who reside in RMHTFs (not mutually exclusive of the sample of youth who responded to the survey) up to the end of 2020. According to Medicaid claims data, the number of claims for community-based mental and behavioral health services, number of unique youths with these claims, and average claims per youth increased between May 2019 and Spring of 2020, but then substantially decreased by the end of 2020 (see Figure 3-2).

Figure 3-2: Medicaid Claims for Community Mental Health Services



As of May 2019, there were 81 claims for community-based mental health services from 38 unique youth with an average of 2.1 claims per youth. By the end of 2020 there were fewer claims (20), fewer unique clients (15), and fewer claims per youth (1.3). In April 2020, emergency public health protocols, including national shutdown and facility closures, were implemented as a measure to combat the COVID-19 pandemic. The pandemic and subsequent changes in health care-seeking behavior should be taken into consideration when interpreting the decline of usage of community-based mental health services in 2020. It is likely that many community-based mental health services were closed or not actively accepting new clients in 2020.

Most youth were rated as moderate to high functioning by caregivers in the Caregiver Survey and by self-report in the Youth Survey at the time of data collection, indicating it might be clinically feasible to treat some of these youth in their homes and communities if needed community-based services are available. While caregivers generally agreed that residential placement was the appropriate level of care for their youth's needs at the time of interview, nearly all expressed a desire/need for more accessible and covered, community-based services and support upon discharge. Caregivers generally noted youths' positive advances with residential treatment but were apprehensive about sustaining progress without the structure and specialized services needed. Approximately half of all caregivers and youth desired more individual and family therapy/counseling tailored to their complex needs, both in behaviors and diagnoses, as well as covered in-home and virtual options. They reported the need for shorter-term, median tier options between community and residential to meet intensive needs outside of RMHTFs. Caregivers also expressed the need/desire for greater reintegration planning, service, and support among providers and facilitators, reiterating more consistent communication, coordination, and follow-up, to continue services and check in on youth/family progress as they underwent the transition home. Youth were generally more optimistic and noncommittal to future services, perceiving more positive treatment outcomes and less perceived need.

3.1.5 What proportion of children were appropriately assessed and placed in residential mental health treatment facilities or Psychiatric Residential Treatment Facility?

Expected Outcome:

- All children appropriately assessed and placed in residential mental health treatment facilities or Psychiatric Residential Treatment Facility Ⓛ

Baseline Findings:

Assessments help determine the types of services youth need and are typically conducted within 30 days of enrollment in a new service and repeated every 30-90 days. Assessment scores should allow for comparisons in functional wellbeing over time. Limited data are currently available to fully address this evaluation question. Assessment data are being developed and will be included in 2023.

Caregivers provided some insights into the appropriateness of residential placement during interviews conducted as part of baseline data collection. At the time of the interviews, caregivers generally agreed residential placement was the appropriate and necessary level of care for their youth's intensive needs. All youth reportedly had one to 10 prior residential placements, behavioral diagnoses, and therapy or counseling of varying duration and intensity. All caregivers discussed challenges pursuing residential placement. Caregivers expressed concerns youth were not properly diagnosed and that there was a lack of communication, information sharing, and caregiver involvement in treatment decision-making. Caregivers perceived service providers were not responsive to caregiver and youth needs. Several reportedly worked with providers for multiple years exhausting inadequate and/or inaccessible community options before eventually securing a placement at a RMHTF placement, either in or out of state. Several caregivers pointed to the legal system, rather than need or diagnosis, as the gateway to residential treatment. They also noted detention centers as unfit but necessary holding options while the youth awaited an available placement. One caregiver shared the challenges of pursuing residential placement for youth between emergency outlets, stating, “I believe the [WV DHHR] worker told me 112 referrals were made and [we received] 112 rejections to complex problems. He's got five or six diagnoses in combination of them. It made it very difficult to place him. Then the worker resigned.”

3.1.6 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?

Expected Outcome:

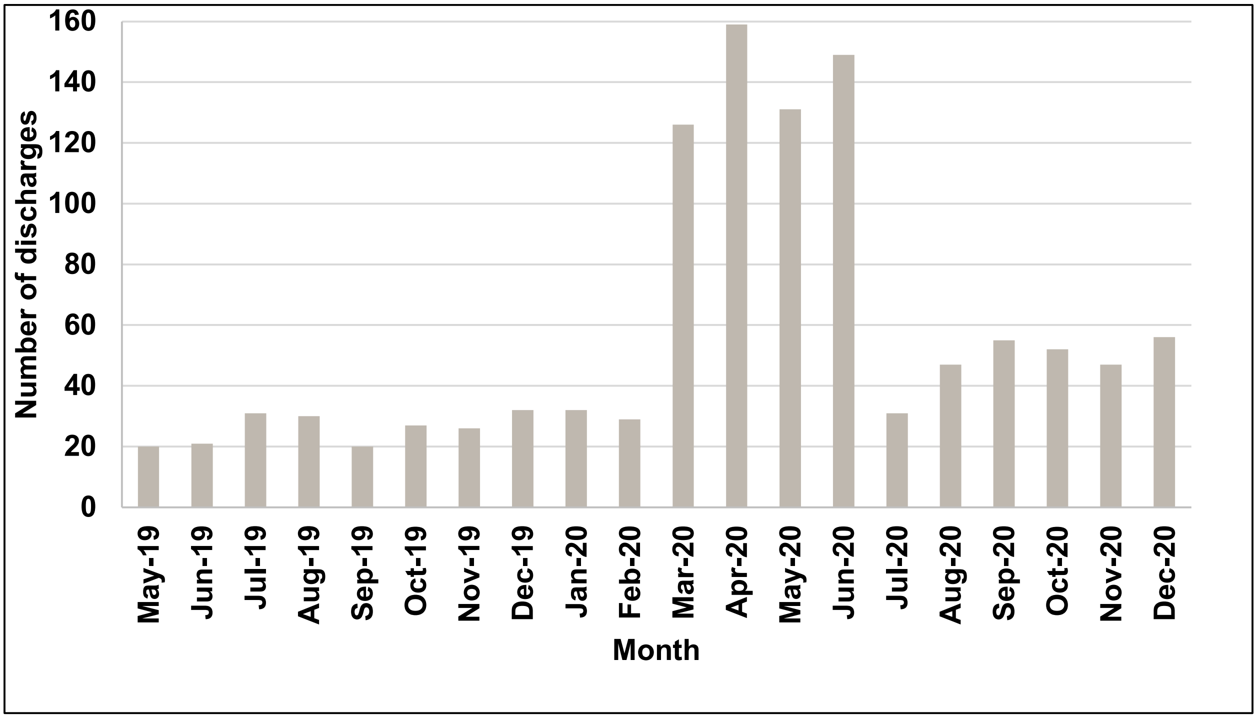
- Decreased children unnecessarily removed from the home for residential mental health treatment facilities or Psychiatric Residential Treatment Facilities Ⓢ Ⓘ Ⓛ

Baseline Findings:

According to DHHR reports, the average census in RMHTFs was 1,096 as of June 1, 2015 and was 764 as of January 21, 2022. DHHR also reports that the average monthly RMHTF bed utilization was 1,019 in May 2019 and was 819 by June 2021. DHHR reports fewer youth placements in residential treatment in recent years. Functional status reported by caregivers and youth during baseline data collection indicated that it might be clinically feasible to transition some of these youth back to their homes and communities if needed community-based services are available.

Medicaid claims data were available for 777 (96.9%) WV youth who resided in RMHTFs to track monthly discharges through the end of 2020; these findings are displayed in Figure 3-3.

Figure 3-3: Discharges from Residential Mental Health Facilities by Month



According to the Medicaid claims data, there were 20 discharges in May 2019. Monthly discharges trended up until they spiked at 159 in April 2020, and then trended down to 56 at the end of 2020. Overall, there were twice as many monthly discharges by the end of 2020 than there were in May of 2019. Given the COVID-19 pandemic and subsequent changes in health care-seeking behavior, caution should be taken when comparing statistics during the surge of the pandemic to other periods of time. For instance, April 2020 discharges were most certainly impacted by the COVID-19 pandemic.

3.1.7 How has length of stay in residential mental health treatment facilities and Psychiatric Residential Treatment Facilities changed since May 2019?

Expected Outcome:

- Decreased child length of stay in residential mental health treatment facilities and Psychiatric Residential Treatment Facilities Ⓢ

Baseline Findings:

DHHR reported a slight increase in average length of stay for RMHTFs during the data collection period; the rolling average for length of stay in July 2020 was approximately 242 days and the rolling average for length of stay as of June 2021 was 270.

According to caregivers, most youth who were in RMHTFs during the data collection period have been placed in facilities two or more times (Appendix D, Demographics & Awareness, Table 1). Caregivers reported:

- 40% of youth had one stay in RMHTF in their lifetime
- 7% had two stays
- 17% had three stays
- 27% had four or more stays in their lifetime.

Caregivers of 40% of youth that responded to the survey reported that length of stay in RMHTFs was between four and six months (120 to 180 days), but many indicated stayed longer stays. Caregivers reported that 19% percent of youth stayed in a RMHTFs for one to three months, 26% between seven and 12 months, and 8% for longer than a year (Appendix D, Demographics & Awareness, Table 1).

Medicaid claims data were available during the time period to track average length of stay by quarter; however, the nature of claim data has significant limitations to understanding stays based on continuous inpatient days. For example, a discharge to home on the weekends separates a stay into segments, leading to inconsistencies in Medicaid data and caregiver reports. For future analyses, evaluation and implementation teams will work with DHHR to confirm sensitivity analysis to determine an appropriate lag between two stays for continuity analysis.

3.1.8 Were fewer children with serious mental health conditions needlessly removed from their families' homes since May 2019?

Expected Outcome:

- Increased children leaving residential mental health treatment facilities and Psychiatric Residential Treatment Facilities for family-like settings

Baseline Findings:

Caregivers reported and youth self-reported moderate to high levels of functioning in respective surveys, but comparisons to more objective assessments (e.g., CAFAS and/or CANS) are needed to better contextualize these perceptions. CAFAS and CANS scores will be available for the 2023 report to help determine the functioning of youth in RMHTFs and, based on assessment at the time of entry into treatment, have the potential to reveal whether some youth might be able to receive the services they need in their homes and communities rather than in residential settings.

Medicaid data provides some insights into the transitioning of youth from residential to more family-like settings. Medicaid data suggests that between May 2019 and the end of 2020 discharge rates more than doubled (20 versus 56) and the average length of stay decreased (11.5 versus 6.9 days). Together these data suggest that more youth were returned to their homes and communities much faster by the end of 2020 than they were in May 2019. Future analyses might consider whether youth are able to transition to family-like settings long term as well, or whether and how frequently youth return to residential facilities for multiple stays.

In youth and caregiver interviews, all youth reportedly had one to 10 prior RMHTF placements, varying in length of stay and location (e.g., in-state and out of state). Participants largely agreed that residential placement had a positive impact on youths' needs. Caregiver participants conveyed a strong need and desire for community-based services upon discharge, particularly median-tier, and more specialized service options (namely therapy or counseling) tailored to youths' complex needs to sustain the transition home and deter future residential placement. They reiterated the structure and specialization of RMHTFs that was lacking in the community. Though greatly desired, caregivers generally perceived a deficit of such resources in WV that were accessible to youth and apprehension that they would secure the services and support necessary to adequately meet youths' needs. Many caregivers reported limited communication and engagement throughout treatment along with unanticipated/early discharges and little transition and reintegration planning and support. This lack of engagement seemingly contributed to caregiver uncertainty that behavioral improvements were genuine and sustainable in the community. Youth generally perceived less service need upon return home, though half expressed a willingness for continued therapy or counseling and extracurricular activities to maintain progress.

3.1.9 Can WV families with children who need mental health services access those services in a reasonable period of time?

Expected Outcome:

- Increased accessibility of youth and caregiver mental health treatment services and supports Ⓛ

Baseline Findings:

Both caregivers and youth indicated that few were waiting for services at the time of the survey. Caregivers who knew about and reported use of community-based services indicated that few youths were on the waitlist for services at the time of data collection (Appendix D, Demographics & Awareness, Table 4). No youth were waiting for Positive Behavior Support or Children's Mental Health Wraparound. Surveyed caregivers indicated that one youth (5%) was waiting for Assertive Community Treatment and two youths (7%) were waiting for Children's Mobile Crisis and Stabilization. (Note: the survey sample included youth who were in RMHTF on October 1, 2021, and may have remained in RMHTF or been released by the time of survey administration.) Of youth who knew about and reported use of community-based services, one was waiting for Assertive Community Treatment (5%), Children's Mobile Crisis Response and Stabilization (3%), and Positive Behavior Support (2%) respectively, and two youth were waiting for Children's Mental Health Wraparound (7%; Appendix E, Demographics & Service Awareness, Tables 3). Caregivers and youth neither agreed nor disagreed that youth could access services without having to wait too long (Appendix C, Crisis Support and Access, Table 2; Appendix E, Experiences with Mental Health, Table 1). Caregivers also neither agreed nor disagreed that their youth will be able to get access in the near future without having to wait too long (Appendix D, Future Service Needs, Table 1).

Survey responses indicated that caregivers and youth were experiencing wait times for community-based services, but none of the participants in the youth and caregiver interviews reported currently awaiting services of interest to this evaluation. Many of those interviewed were planning for their youth's transition home from residential placement at the time of data collection. Participants noted several positive prior experiences with the responsiveness and expediency of Safe at Home and Wraparound services. However, efficient access to limited specialized mental health services was of ongoing concern. Though several caregivers noted how helpful and responsive WV DHHR case workers had been throughout processes, about half noted capacity limitations (e.g., high caseloads, waitlists, turnover) experienced across DHHR and in related services and programs. These capacity issues were perceived as significant and having a negative impact on service access and engagement. Likewise, several caregivers described abrupt and/or unanticipated discharges from RMHTFs with little communication, planning, and support to set up and secure services for youth's return home. Future data collection will be important in determining the impact of COVID-related changes in service delivery related to the experiences of abrupt or unanticipated discharges. Caregivers reported feeling apprehensive that they could find adequate services that were available and covered by insurance in or near their community. Other barriers cited included policy (e.g., age, diagnosis, Medicaid coverage), geographical and logistical restrictions (e.g., distance, transport, work, travel costs, COVID).

Half of the caregivers and several youths who responded to surveys reported challenges in starting services. When challenges were encountered, long wait times were a commonly reported barrier. Many caregivers reported shorter wait times for out-of-state youth residential services. Caregivers representing 50% of youth in survey responses encountered challenges with starting services, 41% of whom said that long wait times made it challenging to start services (Appendix D, Starting Service Barriers, Table 1). Twenty-two caregivers also wrote in additional responses to the survey item asking about barriers to initiating services. Trends in write-in responses revealed additional caregiver perspectives. Caregivers described in-state services as “nonexistent,” with limited options and long wait times for access. Some caregivers reported wait times of up to 36 months for youth residential services and shared that wait times are much shorter for placement at out-of-state facilities. Four youth (22% of those asked) reported challenges in starting mental or behavioral services (Appendix E, Starting Service Barriers, Table 1). Trends in write-in responses also indicate that lack of local services was a barrier to initiating services.

While all caregivers and youth who were interviewed were in residential placements during the data collection period, they revealed similar challenges to starting services, including long waitlists amid limited specialized providers and services in WV. After applying for services, caregivers reported waiting two to four weeks for service initiation to months and years for residential placement. While awaiting residential placements, participants reported exhausting available alternatives (e.g., Safe at Home, Wraparound, stays in detention centers, emergency shelters, and other outlets) that were partially helpful, but inadequate to meet youth's complex needs. Several caregivers described challenges with accessing critical services, noting that sometimes DHHR was perceived as a gatekeeper and that the legal system was the only gateway to getting help. Barriers to starting services included compatibility, capacity, policies (e.g., age, diagnosis, coverage), and geographical/logistical issues (e.g., distance, transportation, work, travel costs) that frequently resulted in waitlists for community-based treatment and a lack of overall adequacy, availability, and access. Notably, several caregivers reflected on policy restrictions (e.g., age, diagnosis, out-of-state coverage) that prevented younger children in WV from accessing the intensive services needed prior to behaviors escalating to the point of residential care.

Fewer caregivers and youth encountered challenges with continuing services although wait times remained a commonly cited barrier. Caregivers of 24% of youth reported challenges with continuing services, 8% of which reported that the selected services were not available in their area (Appendix D, Continuing Service Barriers, Table 1). Eleven also wrote in additional responses to the survey item asking about barriers to continuing services. Trends in write-in responses revealed that some caregivers felt the system was too complicated and there was a lack of consistency in services received. In addition, out-of-state placements make family visits challenging. Three youth (17% of those asked) reported challenges with continuing services, two of whom indicated long wait times as a barrier (Appendix E, Continuing Service Barriers, Table 1).

In youth and caregiver interviews, participants further elaborated on the difficulties in continuing services following residential treatment. Barriers cited to continuing services included capacity limitations of DHHR and pertinent programs (e.g., waitlists, caseloads, turnover), communication and non-responsive/non-engaging services and providers, inadequate fit and specialization to meet need, abrupt and unanticipated discharges with limited planning, and geographical/logistical challenges of both in and out of state placements (e.g., distance, transport, work, travel costs, COVID). Notably, one caregiver reported having a strong RMHTF discharge plan, but services were not covered by WV Medicaid so they could not be pursued. Caregivers reported varied experiences with engagement, communication, responsiveness, and support throughout treatment processes, and most shared both positive and negative experiences across and within facilities and programs. Across all participants, higher satisfaction seemed to correspond with greater perceived levels of communication and engagement in conjunction with delivery of more specialized and tailored care. There was consensus among participants that communication and engagement were insufficient, needed improvement, and were strongly desired by participants. About half of all participants desired specialized therapy and counseling options upon returning home but felt apprehension that adequate services would be accessible.

3.1.10 Can WV families with children who need MH services access those services in their communities?

Expected Outcome:

- Increased accessibility of youth and caregiver mental health treatment services and support

Baseline Findings:

Survey results indicate that all caregivers and youth who were aware of community-based services reported using one or more in the last 12 months (Appendix D, Demographics & Awareness, Table 4; Appendix E, Demographics & Awareness, Table 3). Caregivers and youth reported similar usage of Assertive Community Treatment (5% and 7%) and the Statewide Children's Crisis and Referral Line (7% and 3%), although 18% of caregivers and 13% of youth "didn't know" whether they had called the hotline in the last 12 months. A greater percentage of caregivers reported usage of Children's Mobile Crisis Response and Stabilization than youth (23% and 8%), as well as with Children's Mental Health Wraparound (34% and 14%) and Positive Behavior Support (42% and 27%). While overall usage of community-based services was low, caregivers and youth reported an increased use of Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization and Positive Behavior Support in the last 12 months than in previous years. Caregivers also reported increased use of Children's Mental Health Wraparound, whereas youth reported less use in the last 12 months (14%) than in previous years (24%). Caregivers reported the same usage of the Statewide Children's Crisis and Referral Line in the last 12 months than in previous years, whereas youth reported slightly less usage in the last 12 months (3%) than in previous years (8%).

Many caregivers and youth rely on the police, other social services and supports (as defined by respondents), and Emergency Departments to access mental and behavioral health services in their communities. Compared to youth, caregivers were much more likely to have called the police for mental health concerns, while a similar percentage of caregivers and youth reported calling social services. A greater percentage of youth reported visiting the Emergency Department for mental health services compared to caregivers' reports of youth visiting Emergency Departments. To access support outside of the services included in this Evaluation, over the last 12 months (Appendix D, Crisis Support and Access, Table 1):

- Caregivers of 40% of youth in residential called the police for help with a mental or behavioral health emergency.
- Caregivers of 38% of youth called social services or another support system.
- Caregivers of 20% of youth visited the emergency room to get their youth mental health services.

For youth who accessed support outside of the services included in this Evaluation (Appendix E, Experiences with Mental Health, Table 5):

- 47% reported that they had visited the emergency room to get their youth mental health services; 28% of these had done so in the last 12 months.
- 26% called social services or another support system; 37% of these had done so in the last 12 months.
- 18% had called the police for help with a behavioral or mental health emergency; 10% of these had done so in the last 12 months.

In qualitative interviews, caregivers frequently reported obtaining resources and referrals from current providers (DHHR and behavioral/medical) who helped them navigate and secure services as well as relying on social networks (friends, school) and their own "research," which were overall inadequate. Several caregivers described challenges with accessing critical services, noting that sometimes DHHR was perceived as a gatekeeper and that the legal system was the only gateway to getting help. Caregivers described youths' criminal offenses and/or taking legal action against the youth themselves, at the risk of losing custody. Many also mentioned police involvement precipitating placement and/or responding when other programs did not facilitate residential service provision (i.e. Mobile Crisis, Safe at Home). Many reported stays in detention centers while waiting for an available residential placement as well as accessing Emergency Departments, inpatient hospitalizations, and emergency shelters.

Caregivers and youth were asked about their ability to access services and their interaction with those services, including wait time, service availability, and service location accessibility. Most caregivers and youth reported moderate to high levels of service accessibility and satisfaction in the respective surveys. Caregivers tended to rate accessibility and satisfaction as moderate, while youth generally rated accessibility and satisfaction as high. Specifically:

- 23% of caregivers and 9% of youth reported accessibility and satisfaction as low
- 44% of caregivers and 41% of youth reported accessibility and satisfaction as moderate
- 32% of caregivers and 50% of youth reported accessibility and satisfaction as high

Half of the caregivers and several youths reported challenges starting services. When challenges were encountered, long wait times were one of the most reported barriers. Caregivers noted shorter wait times for out-of-state youth residential services. Caregivers representing 50% of youth in the sample participating in the survey encountered challenges with starting services. Of caregivers who encountered challenges starting services, 41% said that it was long wait times that made it challenging to start services (Appendix D, Starting Service Barriers, Table 1). Twenty-two caregivers who wrote in additional responses to the survey item asking about barriers to initiating services; responses included:

- Caregivers described in-state services as “nonexistent,” with limited options and long wait times for accessing services.
- Some caregivers reported wait times of up to 36 months for youth residential services, whereas the wait times were reported as much shorter for out-of-state facilities.
- Four youth (22% of those asked) reported challenges in starting mental or behavioral services (Appendix E, Starting Service Barriers, Table 1).

Trends in write-in responses also indicate that lack of local services was a barrier to initiating services.

Qualitative interviews revealed similar challenges to starting services, including long waitlists amid limited specialized providers and services in WV. After applying for services, caregivers reported waiting two to four weeks for service initiation to months and years for residential placement. While awaiting residential placements, participants reported exhausting available alternatives (e.g., Safe at Home, Wraparound stays in detention centers, emergency shelters, and other outlets) that were partially helpful, but inadequate to meet youth’s complex needs. Barriers to starting services included compatibility, capacity, policies (e.g., age, diagnosis, coverage), and geographical/logistical issues (e.g., distance, transportation, work, travel costs) that frequently resulted in waitlists for community-based treatment and a lack of overall adequacy, availability, and access. Notably, several caregivers reflected on policy restrictions (e.g., age, diagnosis, Medicaid coverage) that prevented younger children in WV from accessing the intensive services needed prior to behaviors escalating to the point of residential care. Some caregivers and youth reported the need for additional services and support that were not available at the time of data collection. Of those seeking additional services, 27% caregivers (Appendix D, Continuing Service Barriers, Table 5) and 21% youth (Appendix E, Continuing Service Barriers, Table 3) reported the need for more mental health services, particularly psychiatric and therapeutic services, and professional services (e.g., Big Brother program, recreational activities, alternative providers). Caregivers also reported the need for more residential and in-home services. Youth reported the need for family support. When asked about future service needs, caregivers and youth agree that they can access those services outside of a hospital setting if mental and behavioral health services are needed (Appendix D, Future Service Needs, Table 1; Appendix E, Future Service Needs, Table 1). Furthermore, caregivers agreed that they know how to start and use community-based behavioral and mental health services such as Assertive Community Treatment and Children’s Mental Health Wraparound, should their youth need these services in the future (Appendix D, Future Service Needs, Table 1). Youth neither agreed nor disagreed (Appendix E, Future Needs, Table 1).

Most caregivers participating in interviews further expressed the need, desire, and pursuit of future services following residential treatment. All caregivers conveyed the need for more specialized mental health services for youth, namely intensive therapy/counseling options (in-home, virtual, school) for youth and family that are tailored to youths' complex needs and reasonably accessible and covered in WV. Many caregivers desired median tier of shorter-term intensive services between residential and community options that would permit youth to remain at home and receive services needed. Caregivers reported a need for more engaging, communicative, responsive transition and integration services and support to help check in on family/youth progress and facilitate additional services needed in the community. Caregivers who have services available and in place upon discharge will utilize them. However, half of youth conveyed willingness for continued therapy/counseling and extracurricular activities to maintain progress.

4 High-Priority Workgroups Specific Evaluation Questions: Baseline Findings

This section of the report presents the baseline findings for evaluation questions that are related to the specific workgroups and ranked as a high priority by the workgroups. Evaluation questions are organized by question, expected outcomes identified during the evaluation plan development, synthesis of quantitative and qualitative baseline findings. Each evaluation question is noted with the intended assessment level (System-, Community/Provider-, and youth and caregiver-levels) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term) (Table 3-1).

4.1 Wraparound

4.1.1 How has awareness of Wraparound services among West Virginians whose children are receiving mental health services changed?

Expected Outcome:

- Increased family awareness of children's mental health treatment services and supports among WV Medicaid families Ⓢ Ⓘ Ⓛ

Baseline Findings:

Approximately half of caregivers (52%) and 25% of youth were aware of Children's Mental Health Wraparound at the time of the survey (Appendix D, Demographics & Awareness, Table 4; Appendix E, Demographics & Service Awareness, Table 3). Of all participants in youth and caregiver interviews), four reported use of Wraparound services by youth, one of whom specified using the Children with Serious Emotional Disorder Waiver. Data are being developed to link youth in residential treatment to Medicaid data and usage of Wraparound services and will be included in the 2023 report.

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

Expected Outcomes:

- Decrease in children unnecessarily removed from the home for placement in residential mental health treatment facilities and Psychiatric Residential Treatment Facilities by 25% by 12/31/2022 Ⓢ Ⓘ Ⓛ
- All children appropriately assessed and placed in residential mental health treatment facilities Ⓢ Ⓘ Ⓛ
- Increase in children leaving residential mental health treatment facilities for family-like settings Ⓢ Ⓘ Ⓛ

Baseline Findings:

Caregivers reported of their experience with their youth who were in residential treatment that Children's Mental Health Wraparound helped delay residential mental health treatment for 25% of youth who received it in the last 12 months (Appendix D, Demographics & Awareness, Table 4). DHHR reported data trending in the right direction in that the average monthly RMHTF bed utilization in in-state facilities dropped from more than 700 in May 2019 to less than 600 in June 2021. Medicaid claims data show that there were similar numbers of unique youths with claims for residential mental health treatment in May 2019 and at the end of 2020. Future reports will include more recent data as claims and billing cycles close.

During interviews, four caregivers reported prior use of Wraparound and conveyed mixed but mostly positive experiences. Three highlighted the expediency and responsiveness of program initiation and assistance that delayed more intensive treatment. Two shared that the program was beneficial but was not sufficient to meet youths' needs. Additionally, two caregivers also had difficulty distinguishing between Wraparound and other programs; one participant believed Wraparound was terminated. One caregiver described:

> *The person that I've got now—I think she's with Wraparound. She's fantastic. She took him clothes shopping with his clothing voucher. She's offered to pick him up from tutoring when I wasn't able to go. She stays in contact. She helped me get a tutor for him. . . I mean, she just [goes] really over and beyond the call of duty. She's fantastic, and I've got her number, I can call her anytime, whereas the other place I couldn't call the worker anytime. . . had to call that hotline number, the one that didn't work half the time."*

Another caregiver stated:

> *Wraparound Services were probably the best services we ever got. . . .That's where we had the family therapy, the individual therapy, and then they also went into the school. So it was really beneficial for all of us, and that's when I think that his therapist was actually able to understand more of him because he couldn't hide as much. So that was huge. I think the biggest thing for all of them is just the communication has to be with the parent.*

There were 12 youth who resided in a RMHTF in October 2021 who could be linked to Epi Info data, which captures (among other things) use of Children's Mental Health Wraparound and number of calls or events with Children's Mobile Crisis and Stabilization each month. Among these 12 youths, only one completed a Youth Survey. The 2023 report will continue to explore opportunities to link data sets to obtain as much information as possible on service usage and outcomes among the population of youth residing in residential mental health treatment centers in a given year.

4.2 Positive Behavior Support

4.2.1 How has child functioning among Positive Behavior Support participants changed?

Expected Outcome:

- Improved child functioning Ⓢ Ⓘ Ⓛ

Baseline Findings:

In survey responses, both caregivers and youth reported awareness and usage of Positive Behavior Support. Twenty one percent of surveyed caregivers representing 24 youth reported awareness of Positive Behavior Support, and 42% of those youth received Positive Behavior Support in the last 12 months (Appendix D, Demographics & Awareness, Table 4). Thirty-three percent of caregivers whose youth received Positive Behavior Support in the last 12 months felt that it helped delay residential mental health treatment (Appendix D, Demographics & Awareness, Table 4). Forty-four percent of surveyed youth were aware of Positive Behavior Support, 27% of whom had received it in the last 12 months, and 24% of whom had received it in previous years (Appendix E, Demographics & Service Awareness, Table 3).

Most of the youth in residential treatment who received Positive Behavior Support in the last 12 months were reported to be moderate to high functioning, according to their caregivers and self-reports. Functioning was not significantly different among those who did and did not receive Positive Behavior Support in the last 12 months.

4.2.2 How has academic engagement among Positive Behavior Support participants changed?

Expected Outcome:

- Decreased challenges with school, including school suspensions, expulsions, and absences for each child or youth after Positive Behavior Support intervention Ⓢ Ⓘ Ⓛ

Baseline Findings:

According to the Caregiver Survey (n=104), there were seven youth participants who received Positive Behavior Support and attended public or private school in the past 12 months. Two (29%) of them were suspended or expelled from school in the past 12 months. Two (29%) reported more days in school than before starting behavioral or mental health services and one (14%) reported fewer days in school. Youth survey (n=115) identified nine youths who received Positive Behavior Support and attended public or private school in the past 12 months. Three (33%) of them were suspended or expelled from school in the past 12 months. Three (33%) reported more days in school than before starting behavioral or mental health services and 4 (44%) reported about the same.

4.2.3 How has family engagement with mental health services changed after Positive Behavior Support intervention?

Expected Outcomes:

- Increased youth and caregiver active engagement in mental health treatment services and supports Ⓘ
- Increased youth and caregiver satisfaction with mental health treatment services and supports Ⓢ Ⓘ Ⓛ

Baseline Findings:

Overall, caregivers and youth reported moderate to high scores for engagement and respect, accessibility and satisfaction, and treatment engagement in their surveys respectively. However, caregivers of youth who received Positive Behavior Support in the last 12 months scored significantly lower on the Engagement and Respect Scale and on the Treatment Engagement Scale than caregivers of youth who did not receive Positive Behavior Support. Scores did not differ among youth who did and did not receive Positive Behavior and Support in the last 12 months for any of these scales.

Caregivers and youth were asked about the accessibility of and satisfaction with services. Most caregivers and youth reported moderate to high scores on the Accessibility and Satisfaction Scale. Accessibility and satisfaction did not differ among caregivers whose youth did and did not receive Positive Behavior Support in the last 12 months. Self-reported accessibility and satisfaction also did not differ among youth who did and did not receive Positive Behavior Support in the last 12 months.

Caregivers and youth were asked about the support and respect they received from mental health providers. Most caregivers and youth fell into the moderate to high ranges of the Engagement and Respect Scale. However, caregivers of youth who received Positive Behavior Support in the last 12 months scored significantly lower on the Engagement and Respect Scale than caregivers of youth who did not. Youth self-reported engagement and respect did not differ between those who did and did not receive Positive Behavior Support in the last 12 months.

Caregivers were also asked about their participation with their youth's treatment. Most caregivers (72%) had moderate to high scores on the Treatment Participation Scale. Differences were observed among caregivers whose youth did and did not receive Positive Behavior Support in the last 12 months. Caregivers of youth who received Positive Behavior Support in the last 12 months scored significantly lower on the Engagement and Respect Scale than caregivers of youth who did not receive Positive Behavioral Support.

4.3 Assertive Community Treatment

4.3.1 How has the acceptance of community-based mental health treatment (for Assertive Community Treatment) as an alternative to residential mental health treatment facility placement changed?

Expected Outcomes:

- All children appropriately assessed and placed in residential mental health treatment facilitiesⓁ
- Increased acceptance of community-based mental health treatment as an alternative to residential mental health treatment facility placement Ⓢ Ⓘ Ⓛ

Baseline Findings:

Awareness of Assertive Community Treatment among caregivers and youth was low. Sixteen percent of caregivers representing 19 youth had heard of Assertive Community Treatment, one of whom had received it in the last 12 months, and that caregiver did not feel that it delayed RMHT for that youth (Appendix D, Demographics & Awareness, Table 4). Twenty- four percent of youth had heard of Assertive Community Treatment, and 7% reported using it in the last 12 months (Appendix E, Demographics & Service Awareness, Table 3). There was no reference to Assertive Community Treatment in interviews with youth or caregivers. Acceptance of Assertive Community Treatment and assessments among youth and young adults receiving Assertive Community Treatment will be addressed in 2023. **Due to the target population of youth in residential treatment, few would have been old enough to be eligible and/or would have used Assertive Community Treatment during the baseline year; however, a large percentage of the sample (77%) are or will be eligible within a few years and as such awareness was**

analyzed across all age groups. A greater percentage of Assertive Community Treatment participants are expected to be captured in the at-risk sample.

4.3.2 How has child functioning among Assertive Community Treatment participants changed?

Expected Outcome:

- Increased educational involvement Ⓘ Ⓛ
- Decreased juvenile justice involvement Ⓘ Ⓛ
- Increased engagement in the community, including the workforce, by 18-21-year-olds enrolled in Assertive Community Treatment services Ⓛ
- Increased medication compliance and self-management of psychiatric illness Ⓘ
- Decreased rate of non-compliance to treatment Ⓘ Ⓛ
- Improved child functioning Ⓛ
- Increase in independent living ability Ⓘ Ⓛ
- Increased level of clinical functioning (CANS, CAFAS) Ⓢ Ⓘ Ⓛ

Baseline Findings:

Functioning among Assertive Community Treatment participants will be addressed in 2023, when a greater proportion of young adults who would be eligible for Assertive Community Treatment will be included in the Evaluation.

Across the entire sample (not Assertive Community Treatment specific), caregiver perception of youth functioning and youth self-reported functioning were measured by caregiver-child functioning scale and youth-child functioning scale respectively. Most of the youth in residential cares were reported by caregivers and self-reported to be moderate to high functioning. More than half of youth self-reported as high functioning. In summary, baseline child functioning was reported as follows:

- Caregivers reported that 17% of youth were low functioning, and 2% of youth self-reported as low functioning
- Caregivers reported that 45% of youth had moderate functioning, and 41% of youth self-reported as moderate functioning
- Caregivers reported that 38% of youth were high functioning, and 57% of youth self-reported as high functioning

The majority participants in case series and caregiver interviews reported youth positive behavior changes with residential treatment, though youth were notably more optimistic in their treatment outcomes and post-treatment outlook. Several youths reported improved anger management and coping skills, relationships and communication with family, and behavior awareness and empathy. Most reported improved grades, school experiences, and appetite. Several reported less contact and more reassessment of problematic friendships outside of treatment, and two reported increased conflict with aggressive peers in residential mental health treatment. While youth conveyed lower levels of perceived need and were largely noncommittal to future services, about half expressed interest and consideration for continued therapy/counseling as well as extracurricular activities post-treatment to maintain progress. Many caregivers reported positive youth changes in school and functioning generally (i.e. awareness, coping skills, communication) but were more critical and skeptical, seemingly focused on service needs/challenges for behaviors that may persist without adequate community resources to maintain progress. Caregiver apprehension was in part due to a perceived lack of treatment engagement and communication. Several caregivers also conveyed the mental and emotional strain of placement on the family unit.

Caregivers and youth agreed that as a result of receiving mental and behavioral health services over the last 12 months, youth are better able to follow directions on how to take their medication (Appendix D, Outcomes of MH Services, Table 1; Appendix E, Health & Behavior Outcomes, Table 1).

Two caregivers discussed issues with youth medication compliance following discharge in interviews. More caregivers reported medication concerns on part of residential facilities, namely a lack of communication/information on medication regime and changes. Youth participants largely noted gains in self-management (anger, aggression, depression) and coping skills, and caregivers reiterated improvement in behaviors and functioning generally in residential treatment.

Caregivers and youth were asked about engagement in the community after having received mental and behavioral health services (Appendix D, Outcomes of MH Services, Table 1; Appendix E, Health & Behavior Outcomes, Table 1). Caregivers neither agreed nor disagreed, but youth agreed that they get along better with friends and other people. Both caregivers and youth reported that youth are doing better in school and/or work after receiving mental and behavioral health services.

Most caregivers and youth reported positive advances in engagement and relationships during residential treatment, namely family, school, and functioning in case series and caregiver interviews. Most participants reported improved school performance and experiences, and several youths reported improved relationships with facility teachers and staff. Several youths reported less communication with and more reassessment of potentially problematic friendships outside of residential, and a few reported increased conflict with peers in RMHTF. While youth conveyed lower levels of perceived need and were largely noncommittal to future services, about half expressed willingness for continued therapy/counseling as well as extracurricular activities to maintain progress post-treatment. Many caregivers reported positive changes generally but were more critical and skeptical of service needs/challenges to maintain progress in the community. The perceived lack of engagement with youth and their treatment conveyed by many caregivers seemingly increased uncertainty.

Encounters with law enforcement serve as proxies for potential entry or continued involvement in the juvenile justice system. Caregivers of youth in residential treatment reported that 39% of youth had an encounter with the police in the last 12 months, 43% of whom had been arrested (Appendix D, Law Enforcement, Table 1). Youth in residential treatment reported that 35% had an encounter with the police in the last 12 months, 30% of whom had been arrested (Appendix E, Health & Behavior Outcomes, Table 2). More than half of the youth with a police encounter (58%) went to court because of it (Appendix E, Health & Behavior Outcomes, Table 2). Many participants referenced prior encounters with police that precipitated placement, either by youths' legal/criminal offense or by caregivers taking action themselves (in case series and caregiver interviews). Many also noted stays in detention centers and probation services. Many reflected upon the legal system as the gateway to accessing critical residential services, and police as first responders when other programs were inaccessible or nonresponsive.

There is a general decrease in youth encounters with the police compared to the previous year as reported by both caregivers and youth. However, a greater percentage of youth reported that they had more encounters with police in comparison to the previous year (25% of youth compared to 5% of caregivers). According to these caregivers, 60% of youth experienced fewer encounters with the police than they had in the previous year, for 33% it did not change and 5% had more police encounters than they had in the previous year (Appendix D, Law Enforcement, Table 1). Approximately half of the youth (53%) experienced fewer encounters with the police than they had in the previous year, for 23% it did not change and 25% had more police encounters than they had in the previous year (Appendix E, Health & Behavior Outcomes, Table 2).

4.3.3 Has the proportion of youth (ages 18-21) referred to Assertive Community Treatment services (at residential mental health treatment facilities or Psychiatric Residential Treatment Facilities discharge) increased?

Expected Outcomes:

- Decreased length of stay in residential mental health treatment facilities and Psychiatric Residential Treatment Facilities Ⓛ
- Increased accessibility of mental health treatment services and supports for 18-21-year-olds Ⓢ Ⓘ

Baseline findings:

Accessibility among those 18-21 years old could not be evaluated with Medicaid data due to few claims submitted for Assertive Community Treatment among those with claims for residential treatment. This evaluation question will be assessed in the 2023 report, as additional data are developed.

4.4 Reducing Reliance on Residential Treatment

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

Expected Outcomes:

- Increased exposure of target audiences to educational materials focused on the unintended negative consequences of institutionalization and benefits of being in a family environment. Ⓢ Ⓘ
- Enhanced knowledge and change of beliefs among target audiences of appropriateness of residential mental health treatment facility usage as an integrated service within a continuum of care Ⓘ Ⓛ
- Improved understanding among target audiences of appropriateness of residential mental health treatment facility usage as an integrated service within a continuum of care Ⓘ Ⓛ
- Increased importance of engaging families in the care of their loved one while they are in residential mental health treatment facility Ⓢ Ⓘ

Baseline Findings:

All caregivers and youth who were aware of community-based services reported using one or more in the last 12 months (Appendix D, Demographics & Awareness, Table 4; Appendix E, Demographics & Awareness, Table 3). Caregivers and youth reported similar usage of Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization, and the Statewide Children's Crisis and Referral Line in the last 12 months, except that fewer youth "didn't know" about their use of the Statewide Children's Crisis and Referral Line and a greater percentage of youth said that they called the hotline in previous years when compared to caregivers. While overall usage of community-based services was low, many youths were using more services in the last 12 months than they were in the previous year. Caregivers neither agreed nor disagreed that their youth was able to use telehealth to access and use mental and behavioral health services (Appendix D, Crisis Support & Access, Table 2).

Caregiver awareness and reported service use among youth in their care was as follows (Appendix D, Demographics & Awareness, Table 4):

- ***Assertive Community Treatment***: 16% of caregivers were aware of Assertive Community Treatment, representing 19 youth, 5% of whom had participated in Assertive Community Treatment it in the last 12 months and 5% (one youth) was on the waitlist; caregivers of 26% of youth reported that they did not know.

- ***Children's Mobile Crisis Response and Stabilization***: 27% of caregivers were aware of Children's Mobile Crisis Response and Stabilization, representing 30 youth, 23% of whom participated in Children's Mobile Crisis Response and Stabilization in the last 12 months, 7% were on the waitlist, 10% had used it in previous years, and caregivers of 10% of youth reported that they did not know.

- ***Children's Mental Health Wraparound***: 53% of caregivers were aware of Children's Mental Health Wraparound, representing 56 youth, 34% of whom had participated in Children's Mental Health Wraparound in the last 12 months, none were waiting for services, 21% had used Children's Mental Health Wraparound in previous years, and caregivers of 14% of youth did not know.

- ***Positive Behavior Support:*** 21% of caregivers were aware of Positive Behavioral Support, representing 24 youth, 42% of whom had participated in Positive Behavioral Support in the last 12 months, none were waiting for services, 8% had used Positive Behavioral Support in previous years, and caregivers of 4% of youth did not know.

- ***Statewide Children's Crisis and Referral Line***: 24% of caregivers were aware of Statewide Children's Crisis and Referral Line, representing 28 youth, 7% of whom called the Statewide Children's Crisis and Referral Line in the last 12 months, 7% had used the Statewide Children's Crisis and Referral Line in the previous year, and caregivers of 18% of youth did not know.
  When asked about their own awareness and service use, youth reported that (Appendix E, Demographics & Service Awareness, Table 3).

Youth awareness and reported service use was as follows:

- ***Assertive Community Treatment***: 24% of youth were aware of Assertive Community Treatment, 7% of whom had participated in Assertive Community Treatment it in the last 12 months and 4% were on the waitlist; 7% of youth did not know.
- ***Children's Mobile Crisis Response and Stabilization***: 32% of youth were aware of Children's Mobile Crisis Response and Stabilization, 8% of whom had participated in Children's Mobile Crisis

Response and Stabilization in the last 12 months, 3% were on the waitlist, 5% had used it in previous years, and 14% did not know.

- ***Children's Mental Health Wraparound***: 25% of youth were aware of Children's Mental Health Wraparound, 14% of whom had participated in Children's Mental Health Wraparound in the last 12 months, 7% were waiting for services, 24% had used Children's Mental Health Wraparound in previous years, and 21% did not know.

- ***Positive Behavior Support***: 44% of youth were aware of Positive Behavior Support, 27% of whom had participated in Positive Behavior Support in the last 12 months, 2% were waiting for services, 24% had used Positive Behavior Support in previous years, and 6% did not know.

- ***Statewide Children's Crisis and Referral Line***: 35% of youth were aware of Statewide Children's Crisis and Referral Line, 3% of whom called the Statewide Children's Crisis and Referral Line in the last 12 months, 24% had used the Statewide Children's Crisis and Referral Line in the previous year, and 6% did not know.

No participants referenced Positive Behavioral Support or Assertive Community Treatment during interviews. Four caregivers reported use of Wraparound (one specified Children with Serious Emotional Disorder), two of Mobile Crisis, and ten of Safe at Home. Several caregivers reported positive experiences with Safe at Home and Wraparound, noting responsiveness, consistency, and expedited assistance to delay more intensive treatment. One youth notably desired Safe at Home services to check in on her progress following discharge, though she had refused participation prior to residential placement. One caregiver noted that her Wrapround worker was "fantastic," working "above and beyond the call of duty." Others reported that these programs were beneficial and responsive in offers of assistance but either could not meet youth's needs and/or failed to deliver on services guaranteed. Others reported utilizing a combination of these programs, though had difficulty identifying which provided a particular service. Both accounts conveyed Mobile Crisis as nonresponsive; one caregiver reported that the line was always out of service or no one would answer; another reported that the youth was declined services for not registering following residential discharge. When programs were not responsive, several caregivers reported calling the police. Difficulties encountered included service compatibility, capacity, communication, and responsiveness amid high waitlists and caseloads and inadequate fit for youth's specialized needs. Additional services reported by all participants included prior stays in residential placement and individual and family therapy/counseling of varying intensity and duration.

Caregivers who knew about and whose youth had used community-based services in the last 12 months noticed an impact on future treatment (Appendix D, Demographics & Awareness, Table 4):

- 44% reported that Children's Mobile Crisis Response and Stabilization delayed residential treatment.
- 33% felt that Positive Behavioral Support delayed residential treatment.
- 25% reported that Children's Mental Health Wraparound delayed residential treatment.

Over the last 12 months, approximately half of the caregivers reported improved understanding of services, but the value of home and community-based services remained the same in caregiver survey findings. When caregivers were asked about their understanding of how to access services over the last 12 months, 47% reported that their understanding has improved (Appendix D, Crisis Support and Access, Table 3). Of the 47% of caregivers who reported that their understanding improved over the last 12 months, 55% said it made them more likely to access services in the future. Over half of the caregivers (59%) believed that the value of home and community based mental and behavioral health services stayed the same over the last 12 months (Appendix D, Crisis Support and Access, Table 3). In addition, 21% of them reported that the value and had gotten better and 16% believed the value of community-based services had "gotten worse."

Many caregivers and youth reported relying on the police or hospitals to gain access to mental and behavioral health services (Appendix D, Crisis Support and Access, Table 1; Appendix E, Experiences with Mental Health, Table 5). However, caregivers and youth agree that if mental and behavioral health services are needed in the future, they can access those services outside of a hospital setting. Caregivers agreed that should youth need mental and behavioral health support in the future, they know who to contact (Appendix D, Crisis Support & Access, Table 4) and have the knowledge necessary to start and use Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization, Children's Mental Health Wraparound, Positive Behavioral Support, and Statewide Children's Crisis Referral Line (Appendix D, Future Service Needs, Table 1). Most case series participants expressed the need, desire, and pursuit of future services following residential treatment, and those with services available and in place plan to utilize them following discharge. Caregivers shared a desire and need for more specialized service options in WV, namely therapy/counseling, as well as post-treatment and reintegration support to facilitate a sustainable transition back home, maintain progress, and deter future placement. Youth expressed less perceived need for future services, seemingly more confident of maintaining positive behavior changes in transition. However, half of youth conveyed willingness for therapy/counseling and extracurricular activities to maintain progress. Notably, one youth desired Safe at Home support post-treatment, though had refused participation prior.

4.4.2 How has family engagement throughout the period of placement in residential mental health treatment facility changed?

Expected Outcome:

- Increased family engagement with youth in residential mental health treatment facilities Ⓢ Ⓘ Ⓛ

Baseline Findings:

According to survey data, youth in RMHTFs reported that they were included in planning for changes in their care, but both caregivers and youth neither agreed nor disagreed that they were involved in discharge planning (Appendix E, Experiences with Mental Health, Table 4). Caregivers neither agreed nor disagreed that they approved of the treatment goals for residential mental health treatment, they were included in creating the care plan, they were informed when their child's level or type of care changed, and they were involved in discharge planning. (Appendix D, Experiences with Mental Health Services, Table 5). Caregivers also reported barriers to initiating and continuing services, which included a lack of communication, information sharing, and caregiver involvement in treatment decision making. Caregivers also reported difficulties visiting youth when they are placed out-of-state.

When asked about their engagement in treatment in general and whether they felt that providers respected their cultural and spiritual or religious beliefs, most caregivers and youth reported moderate to high levels of engagement in treatment. Across all caregivers and youth:

- 13% of caregivers and 4% of youth reported engagement and respect as low
- 51% of caregivers and 26% of youth reported engagement and respect as moderate
- 36% of caregivers and 70% of youth reported engagement and respect as high

When asked about their participation in youth's treatment and decision-making in general, most caregivers reported moderate to high levels of treatment participation. Across all caregivers:

- 28% of caregivers reported low scores on the Treatment Participation Scale
- 42% of caregivers reported moderate scores on the Treatment Participation Scale
- 30% of caregivers reported high scores on the Treatment Participation Scale

Most caregivers shared a combination of positive and negative engagement experiences during youth and caregiver interviews. Some reported feeling highly involved throughout the decision-making and treatment planning and implementation processes, while others felt completely left out. These perceptions varied across and within programs and services. During interviews, caregivers described an overall lack of decision-making power and participation in their youth's treatment. While many were provided with status updates from RMHTF, DHHR, or youth themselves, caregivers largely felt at the mercy of the facility. Some caregivers reported that the burden of requesting treatment information for their youth fell wholly on them. In particular, one caregiver reported receiving none of the requested information about their youth's treatment, even after a judge issued a court order for the information to be released. Caregivers reported limited in-person visits to RMHTFs, primarily due to proximity of the residential placement location (both in and out of state). Other barriers related to transportation, difficulties requesting time off from work, travel costs, caregivers' own personal health issues, and COVID were described by multiple caregivers. The main form of communication reported between youth and caregivers was telephone calls, which occurred anywhere from daily to weekly, and typically between five and 15 minutes in length. Sometimes youth and caregivers were able to communicate using virtual options depending on staff availability. Some caregivers reported involvement in weekly, monthly, and/or quarterly treatment team meetings (phone, in-person, virtual), while others shared that they were not included. Some caregivers expressed feeling frustrated and/or less engaged with youth and their treatment because communication was largely determined by youth and staff availability.

Caregivers reported mixed results in treatment engagement, with no caregiver reporting all positive or negative experiences. Youth, however, reported positive engagement in treatment planning, goal setting, and staff. Youth and caregiver perceptions differed, as youth tended to under-report perceived caregiver engagement, potentially pointing to youths' lack of awareness of logistical and process factors. Several caregivers were dissatisfied with abrupt/unanticipated discharges and the lack of planning and support received. Many also reported the mental and emotional strain of separation in the family unit. Higher caregiver satisfaction seemingly corresponded with higher engagement and communication throughout the treatment journey.

4.5 Conclusion

Findings from this mixed methods evaluation reveal that progress has been made in terms of reducing the number of youths in residential treatment. Data show fewer unique youths are in facilities and they are placed for shorter periods of time compared to May 2019. Additional data, such as CAFAS scores, are needed to determine whether some of the youth might be better served in their homes and communities. Post-pandemic trends will also be important to understanding changes to the system.

Caregivers and youth had relatively positive attitudes toward residential treatment. Both caregivers and youth observed improvements in functional wellbeing during residential treatment. Both also reported high functioning among youth in residential; that said, caregivers, overall, felt that residential treatment was the appropriate level of care for their youth at the time of data collection. Moreover, caregivers and youth have tried community-based options by the time they receive residential treatment. Often, they either cannot access community-based services, the wait is too long, or the services are insufficient to meet their needs. Residential treatment is viewed as both good and bad, but most youth currently in RMHTFs report positive experiences and some improvements in functioning. Caregivers across the board want more engagement in treatment and are hopeful, yet apprehensive, that their youths can thrive in their homes and communities once they are discharged due to concern about accessibility and availability of ongoing community-based services.

According to survey data, awareness and usage of community-based services was low. However, caregivers felt like they had sufficient knowledge to start and use the community-based services included in this evaluation once their youth was discharged from residential treatment. Caregivers noted that awareness improves the likelihood of accessing youth services. While some caregivers reported mixed experiences with availability and appropriateness of services for their youth, many felt that Children's Mobile Crisis Response and Stabilization, Positive Behavior Support, and Children's Mental Health Wraparound helped delay residential treatment.

Both caregivers and youth found in-state and home- and community-based services to be far away and lacking in capacity and the level of intensive services that would help delay or reduce the need for residential treatment. Caregivers were more likely than youth to recognize the need for transitional and long-term services after residential treatment. Caregivers were also more likely than youth to report feeling removed from decision-making processes and expressed the need for more and higher quality communication with service providers.

5 Appendix A: Medium, Low, and No Ranking Evaluation Questions: Baseline Findings

This section of the report presents the baseline findings for evaluation questions that are ranked as a medium and low priority by the WV DHHR Steering Committee or Component Workgroups, as well as evaluation questions that did not receive a ranking from these entities. Evaluation questions are organized by question, expected outcome(s) identified during the evaluation plan development, synthesis of quantitative and qualitative baseline findings. Each evaluation question is noted with the intended assessment level (System-, Community/Provider-, and Youth/Caregiver-levels) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term; Table 5-1). Evaluation questions for the overall initiative are presented first, then followed by evaluation questions specific to each workgroup.

Table 5-1: Evaluation Question Symbols and Definitions for Assessments Levels and Outcomes

Symbol	Definition
§	System-Level Outcome
‡	Community/Provider-Level Outcome
†	Youth and Caregiver-Level Outcome
Ⓢ	Short-term Outcome (Year 1)
Ⓘ	Intermediate Outcome (Years 2 – 3)
Ⓛ	Long-term Outcome (Years 4 – 5)

5.1 Medium and Low-Priority Initiative Specific Questions: Baseline Findings

This section of the report presents the baseline findings for evaluation questions that are related to the overall initiative and ranked medium and low priority by the WV DHHR Steering Committee and Component Workgroups.

5.1.1 How engaged are WV families in the mental health treatment services for their children?

Expected Outcome:

- Increased child/family active engagement in mental health treatment services and supports Ⓘ Ⓛ
- Increased Youth and caregiver active engagement in mental health treatment services and supports Ⓘ Ⓛ

Baseline Findings:

Caregivers and youth reported mixed experiences regarding involvement in mental health treatment services. Youth agreed that they were involved in treatment planning or goal setting; the services they got were right for them; and their family got the help that they wanted (Appendix E, Experiences with Mental Health, Table 2). However, caregivers neither agreed nor disagreed with these statements (Appendix D, Experiences with Mental Health Services, Table 1). Caregivers generally know how to start and use community-based services if they are needed in the future (Appendix D, Future Service Needs, Table 1), whereas youth neither agreed nor disagreed (Appendix E, Future Needs, Table 1).

When asked about their engagement in treatment in general and whether they felt that providers respected their cultural and spiritual or religious beliefs, most caregivers and youth reported moderate to high level of engagement and respect in treatment. Across all caregivers and youth:

- 13% of caregivers and 4% of youth reported engagement and respect as low
- 51% of caregivers and 26% of youth reported engagement and respect as moderate
- 36% of caregivers and 70% of youth reported engagement and respect as high

When asked about their participation in youth's treatment and decision making in general, most caregivers reported moderate to high levels of treatment participation. Across all caregivers:

- 28% of caregivers reported low scores on the Treatment Participation Scale
- 42% of caregivers reported moderate scores on the Treatment Participation Scale
- 30% of caregivers reported high scores on the Treatment Participation Scale

Most caregivers shared a combination of positive and negative engagement experiences during youth and caregiver interviews. Some reported feeling highly involved throughout the decision-making and treatment planning and implementation processes, while others felt completely left out. These perceptions varied across and within programs and services. During interviews, caregivers described an overall lack of decision-making power and participation in their youth's treatment. While many were provided with status updates from RMHTF, DHHR, or youth themselves, caregivers largely felt at the mercy of the facility. Some caregivers reported that the burden of requesting treatment information for their youth fell wholly on them. Caregivers reported limited in-person visits to RMHTFs, primarily due to proximity of the residential placement location (both in and out of state). Other barriers related to transportation, difficulties requesting time off from work, travel costs, caregivers' own personal health issues, and COVID were described by multiple caregivers. The main form of communication reported between youth and caregivers was telephone calls, which occurred anywhere from daily to weekly, and typically between five and 15 minutes in length. Sometimes youth and caregivers were able to communicate using virtual options depending on staff availability. Some caregivers reported involvement in weekly, monthly, and/or quarterly treatment team meetings (phone, in-person, virtual), while others shared that they were not included. Some caregivers expressed feeling frustrated and/or less engaged with youth and their treatment because communication was largely determined by youth and staff availability.

5.1.2 How has the family satisfaction with children's mental health treatments and supports changed?

Expected Outcome:

- Increased child/family satisfaction with mental health treatment services and supports Ⓘ Ⓛ
- Increased Youth and caregiver satisfaction with mental health treatment services and supports Ⓘ Ⓛ

Baseline Findings:

When asked about accessibility of and satisfaction with services, most caregivers and youth reported moderate to high levels of service accessibility and satisfaction. More caregivers' scores fell into the moderate range and more youths' scores fell into the high range of this scale. Findings indicate that:

- 23% of caregivers and 9% of youth reported accessibility and satisfaction as low
- 44% of caregivers and 41% of youth reported accessibility and satisfaction as moderate
- 32% of caregivers and 50% of youth reported accessibility and satisfaction as high

Caregivers were asked about support, for example if they had someone to talk to about their youth's wellbeing during times of crisis. Most caregivers reported high levels of social support:

- 4% reported low levels of social support
- 23% reported moderate levels of support
- 73% reported high levels of support

Although caregivers reported moderate to high levels of accessibility and satisfaction in the Caregiver Survey, caregivers participating in interviews revealed mixed satisfaction with services received in WV. Of the nine caregivers participating in the case series study, three reported not being satisfied with services received in WV. They perceived that the availability and coverage for specialized services were insufficient, especially for younger youth (specifically those between 6 and 10 years old). For example, one caregiver described seeking intensive services for her youth for over a decade to address sexually inappropriate behavior. The youth had experienced multiple forms of abuse as a child, and the caregiver began seeking services when he was around age seven. She explained:

> *"The therapies he was getting, nobody addressed the sexual component, and now he's 18 and he's on the edge of becoming a predator. . . . When you see a child, you know—whatever age—is sexually acting out, it needs to be addressed as soon as possible and not wait until they're on that tipping point of becoming an offender. . . it's sad that WV doesn't have that for younger children. . . . [Facility] has a program called [program name], but you have to be 13 to get into that, and that's for sexual offenders so there's nothing for younger kids."*

However, most also discussed specific WV programs, treatment facilities, or providers they were satisfied with (e.g., Wraparound, DHHR case workers). During interviews, caregivers generally focused on the systemic challenges confronted when finding and securing services throughout the treatment trajectory (prior, during, post-treatment). Caregivers reported varied experiences with service and staff engagement, communication, responsiveness, and support throughout processes and across RMHTF, DHHR, and programs.

Across caregiver and case series participants, higher satisfaction seemingly corresponded with greater perceived levels of engagement and support received from a facility, program, or service they encountered, as well as the delivery of more individualized and specialized care specific to their youth's needs. Throughout help-seeking, caregivers reported greater satisfaction with higher engagement of programs and providers, describing those who remained in close contact, were informative and responsive to their needs, and delivered (notably Wraparound). Caregivers spoke to DHHR workers and other community-based providers and advocates who helped them navigate the system and push doors open to get the services they needed. Similarly, throughout treatment, caregivers relayed higher satisfaction with facilities and providers who consistently engaged them in treatment processes, including modality and medication changes, youth and team meetings, decision-making, and discharge planning. Specific to services received, caregivers were most satisfied if their youth had obtained therapy, counseling, and treatment modalities that were specific to their mental and behavioral needs. Successfully accessing and sustaining those specialized services, and feeling involved or at least informed throughout, further impacted caregiver perceptions of satisfaction with the facilities, programs, and services they encountered during their trajectory. While most caregivers reported positive satisfaction with some services, most also reported negative experiences. Caregivers generally agreed that they were not satisfied amid the deficit of specialized services available in WV, underscored with the levels of engagement and support received throughout. Improvements in these areas were cited as necessary and desired by most caregivers._Though the youth interviewed largely reported reluctance for treatment at onset, they reported higher levels of service satisfaction and optimism than caregivers. They particularly liked the therapy, counseling, school, extracurricular activities, consistency and structure of residential placement. Some youth and caregivers expressed facility-specific concerns of staff and physical conditions, including neglectful supervision, fire code violations, and poor facility conditions, which may underscore limitations in program/staff capacity.

5.1.3 How many children have entered the juvenile justice system when they would have been better served in the mental health system?

Expected Outcome:

- Decreased children entering the juvenile justice system to address mental health needs Ⓛ

Baseline Findings:

No current available data can specifically identify the number of children entering the juvenile justice system that would have been better served in the mental health system. Additional information, including assessment data, is needed to more fully address this question.

While the current data do not allow us to assess juvenile justice versus mental health interactions, caregiver and youth surveys did collect information about interactions with the police. Caregivers of youth in residential treatment reported that 39% of youth had an encounter with the police in the last 12 months; 43% of those youth had been arrested (Appendix D, Law Enforcement, Table 1). Among youth in residential treatment, 35% had an encounter with the police in the last 12 months and 30% of those youth had been arrested (Appendix E, Health & Behavior Outcomes, Table 2). In terms of entering the juvenile justice system, more than half of the youth with a police encounter (58%) reported that they ended up going court because of the encounter. (Appendix E, Health & Behavior Outcomes, Table 2).

When asked to reflect on the last 12 months, most caregivers and youth reported a decrease in youth encounters with the police compared to the previous year. Caregivers reported that 60% of youth experienced fewer encounters with the police than they had in the previous year, for 33% it did not change and 5% had more police encounters than they had in the previous year (Appendix D, Law Enforcement, Table 1). Approximately half of the youth (53%) self-reported fewer encounters with the police in the last 12 months than they had in the previous year, for 23% it did not change and 25% had more police encounters than they had in the previous year (Appendix E, Health & Behavior Outcomes, Table 2). Because caregivers and youth were asked to reflect on the last 12 months, this includes the time youth recently spent in a RMHTF. Residential treatment typically includes 24-hour monitoring, so it may be expected that youth had fewer encounters with police when compared to previous years.

6 Appendix A Continued: Medium and Low-Priority Workgroup Specific Evaluation Questions: Baseline Findings

This section of the report presents the baseline findings for evaluation questions that are related to the specific component workgroups and that were ranked as a medium priority, low priority, or no priority was designated. Evaluation questions are organized by question, expected outcomes identified during the evaluation plan development, synthesis of quantitative and qualitative baseline findings. Each evaluation question is noted with the intended assessment level (System-, Community/Provider-, and Youth and Caregiver-levels) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term; Table 5-1.

6.1 Wraparound

6.1.1 How engaged are WV families in Wraparound Treatment?

Expected Outcome:

- Increased child/family active engagement in mental health treatment services and supports Ⓢ Ⓘ Ⓛ
- Increased Youth and caregiver active engagement in mental health treatment services and supports Ⓢ Ⓘ Ⓛ

Baseline Findings:

A majority of caregivers (72%) across the entire sample reported moderate to high levels of participation in their youth's treatment. Treatment participation ratings among caregivers of youth who received Children's Mental Health Wraparound in the last 12 months did not differ from caregivers whose youth did not receive Children's Mental Health Wraparound in the last 12 months. Overall, caregivers and youth reported moderate to high levels of engagement with services and respect from providers. Caregivers were more likely to report moderate scores and youth were more likely to have high scores on the Engagement and Respect Scale. Similar to participation, caregiver ratings and youth self-reports of engagement and respect did not differ when comparing youth who did or did not receive Children's Mental Health Wraparound in the last 12 months. Youth agreed that they helped choose treatment goals, participated in treatment, and got the help they wanted; caregivers neither agreed nor disagreed. Regarding Children's Mental Health Wraparound specifically, caregivers agreed that they approved of treatment plans and were included in the development of care plans.

Caregiver and case series interviews revealed a varied response to Wraparound service engagement. Of 19 caregiver participants, four reported use of Wraparound (one Children with Serious Emotional Disturbances). Three caregivers spoke highly of the Wraparound services they received, noting the expediency and responsiveness of providers and the perception that services helped to delay more intensive therapy and residential treatment. They report high satisfaction with the service, as some workers were available around the clock to address emergency needs, going "above and beyond" their duties. One caregiver appreciated that the service was responsive but felt it was inadequate to effectively engage the youth. Another caregiver was not satisfied with Wraparound, as it couldn't meet the extensive needs of their youth, who was now incarcerated. One caregiver stated that Wraparound services "were probably the best services we ever got."

6.1.2 How has the length of stay for inpatient hospitalizations changed among wraparound participants?

Expected Outcome:

- Decreased child length of stay in residential mental health treatment facilities and psychiatric residential treatment facilities Ⓢ

Baseline Findings:

Wraparound-specific length of stay data are not currently available. Data linkages that will provide length of stay information will be developed for use in future reporting.

6.1.3 How has the use of wraparound services changed?

Expected Outcome:

- Increased accessibility of child/family mental health treatment services and supports Ⓢ
- Increased accessibility of Youth and caregiver mental health treatment services and supports Ⓢ

Baseline Findings:

Both caregivers and youth reported low usage of Children's Mental Health Wraparound in their survey responses but differed in their experiences and perceptions. Caregivers report an increase in use in the last 12 months. Among caregivers who were aware of Children's Mental Health Wraparound, 34% of youth received it in the last 12 months, an increase from 21% in the previous year (Appendix D, Demographics & Awareness, Table 4). Caregivers agree that they know enough about how to start and use Children's Mental Health Wraparound if it is needed in the future (Appendix D, Future Service Needs, Table 1).

On the other hand, there was a decrease of use of Children's Mental Health Wraparound reported by youth, with 14% of youth who knew about Children's Mental Health Wraparound reported receiving it in the last 12 months whereas 24% reported using it in previous years (Appendix E, Demographics & Service Awareness, Table 3). Youth also neither agree nor disagree that they know enough about how to start and use Children's Mental Health Wraparound if it is needed in the future (Appendix E, Future Service Needs, Table 1).

A total of 12 youth were identified from linked youth survey and Epi Info data from October 2021 to April 2022. Among these 12 youth, only one completed the youth survey. Epi Info provides data on receipt of Children's Mental Health Wraparound and Children's Mobile Crisis Response and Stabilization services on a monthly basis. The proportion of Children's Mental Health Wraparound only service received remained low, ranging from 8% to 17% from October 2021 to April 2022, while the proportion of Children's Mental Health Wraparound only service denied fluctuated between 8% and 42%. There was one youth who received both Children's Mental Health Wraparound and Children's Mobile Crisis Response and Stabilization services in a single month.

6.2 Children's Mobile Crisis Response

6.2.1 What proportion of families contact the crisis line more than once?

Expected Outcome:

- Decrease recidivism/repeat users relying on crisis services Ⓘ Ⓛ

Baseline Findings:

Caregivers and youth reported similar low usage of Statewide Children's Crisis and Referral Line. Over the last 12 months, 9% of caregivers and 25% of youth called Statewide Children's Crisis and Referral Line.

Two caregivers from interviews discussed their experiences with Mobile Crisis. Both accounts conveyed Mobile Crisis as nonresponsive. One caregiver was under the impression their youth was eligible and registered for Mobile Crisis support after being discharged from a residential facility. However, the telephone number provided to the caregiver reportedly did not work and the youth could not get services. After finding the correct number, Mobile Crisis personnel explained to her that the youth was not registered for services, and they could not send someone to help. The caregiver reported that the youth is now in jail. Another caregiver was unsatisfied with the service because nobody would answer, or the line was out of service when they called.

While few contacted the Statewide Children's Crisis and Referral Line, many caregivers and youth reported relying on the police, other social services and supports, and emergency departments to access crisis stabilization services over the last 12 months. To access crisis stabilization services over the last 12 months caregivers of 40% of youth in residential called the police for help with a mental or behavioral health emergency, 38% called social services or another support system, and 20% visited the emergency room to get their youth mental health services. Only 10% of youth reported calling the police in the last 12 months, but a similar percentage (37%) reported calling social services or another support system or visiting an emergency room to get help (28%; Appendix E, Experiences with Mental Health, Table 5).

In October 2021 BBH started collecting client-level data, such as the number of calls made to Children's Mobile Crisis Response and Stabilization, in the Epi Info database management system. Likely due to the timing of data collection, only one youth with a survey could be linked to Epi Info data. The Evaluation will continue to make linkages across data sets for future iterations of this report.

6.2.2 How accessible are mobile crisis services to families?

Expected Outcome:

- Increased accessibility of child/family mental health treatment services and supports Ⓢ Ⓘ Ⓛ
- Increased accessibility of Youth and caregiver mental health treatment services and supports Ⓢ Ⓘ Ⓛ

Baseline Findings:

Evaluation findings in the March 2022 report indicated that Children's Mobile Crisis and Stabilization is accessible though statewide coverage. However, during interviews some caregivers expressed difficulty reaching someone when they called mobile response services. Several caregivers and youth also indicated on the survey that they had to wait for services (Appendix D, Demographics & Awareness, Table 4;

Appendix E, Demographics & Awareness, Table 3). Increased awareness and use of the Statewide Children's Crisis and Referral Line will help ensure that Children's Mobile Crisis Response and Stabilization teams are notified and deployed so that youth and their families are able to access the services they need when they need them.

6.2.3 How has the number of petitions for juvenile justice in response to a crisis situation changed?

Expected Outcomes:

- Decreased number of children entering the Juvenile Justice system to address mental health needs Ⓘ Ⓛ
- Decreased number of Juvenile Justice petitions Ⓘ Ⓛ

Baseline Findings:

Currently available data does not allow evaluators to directly assess the changes in number of petitions for juvenile justice in response to a crisis situation. For baseline reporting, data on encounters with law enforcement have been used as proxies for potential entry or continued involvement in the juvenile justice system. Caregivers of youth in residential treatment reported that 39% of youth had an encounter with the police in the last 12 months, 43% of whom had been arrested (Appendix D, Law Enforcement, Table 1). Youth in residential treatment reported that 35% had an encounter with the police in the last 12 months. Of those:

- 30% of youth having an encounter had been arrested (Appendix E, Health & Behavior Outcomes, Table 2);
- More than half (58%) of youth having an encounter went to court (Appendix E, Health & Behavior Outcomes, Table 2).

There is a general decrease in youth encounters with the police compared to the previous year as reported by both caregivers and youth. However, a greater percentage of youth reported that they had more encounters with police in comparison to the previous year (25% of youth compared to 5% of caregivers). According to these caregivers, 60% of youth experienced fewer encounters with the police than they had in the previous year, for 33% it did not change and 5% had more police encounters than they had in the previous year (Appendix D, Law Enforcement, Table 1). Approximately half of the youth (53%) experienced fewer encounters with the police than they had in the previous year, for 23% it did not change and 25% had more police encounters than they had in the previous year (Appendix E, Health & Behavior Outcomes, Table 2).

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

Expected Outcomes:

- Decrease in recidivism/repeat users relying on crisis services Ⓘ Ⓛ

Baseline Findings:

The surveys asked caregivers and youth if they were aware of Children's Mobile Crisis Response and Stabilization. Caregivers and youth who were aware of Children's Mobile Crisis Response and Stabilization were then asked about their use of it. More than a quarter (27%) of caregivers were aware of Children's Mobile Crisis and Stabilization, representing 30 youth, 23% of whom received Children's Mobile Crisis Response and Stabilization services in the last 12 months, and 10% had used it in previous years; caregivers of 10% of youth reported that they did not know (Appendix E, Demographics & Awareness, Table 4). Approximately a third (32%) of youth were aware of Children's Mobile Crisis Response and Stabilization, 8% of whom reported receiving Children's Mobile Crisis Response and Stabilization services in the last 12 months, and 5% had used it in previous years; 14% did not know (Appendix E, Demographics & Awareness, Table 3). Change in usage will be reported in 2023.

A total of 12 youths were identified from linked youth survey and Epi Info data from October 2021 to April 2022. Among these 12 youth, only one completed the youth survey. Epi Info provides data on receipt of Children's Mental Health Wraparound and Children's Mobile Crisis Response and Stabilization services on a monthly basis. Of the 12 youth, two received Children's Mobile Crisis Response and Stabilization services. One of the youths got Children's Mobile Crisis Response and Stabilization service only in one month. The other youth received both Children's Mental Health Wraparound and Children's Mobile Crisis Response and Stabilization services in a single month.

From Medicaid claim data, the number of monthly Children's Mobile Crisis Response and Stabilization claims kept increasing from a low of 60 in June 2019, to a high of 117 in October 2019. The number fluctuated between 86 to 116 in the following year and decreased to around 70 at the end of 2020. The average number of claims per youth per month did not vary much across the months, ranging from 1.7 to 2.7.

6.3 Positive Behavior Support

6.3.1 How has the use of Positive Behavioral Support services changed?

Expected Outcome:

- Increased usage of family-based placements with supportive mental health services

Baseline Findings:

Surveys asked caregivers and youth specifically about Positive Behavioral Support, which is now part of Behavioral Support Services. Both caregivers and youth who knew about Positive Behavioral Support reported using Positive Behavioral Support more frequently than any other community-based service included in this Evaluation. Over one-fifth (21%) of caregivers representing 24 youth were aware of Positive Behavioral Support, and 42% of these used Positive Behavioral Support in the last 12 months. Caregivers indicated that Positive Behavioral Support was the most frequently used community-based service in the last 12 months and 33% of caregivers believed that Positive Behavioral Support delayed placement in a RMHTF (Appendix D, Demographics & Awareness, Table 4). Youth reported a high awareness of Positive Behavioral Support (44%). About a third (27%) of youth participated in Positive Behavioral Support in the last 12 months and 24% participated in previous years. Additionally, 2% were waiting for Positive Behavioral Support services and 6% reported not knowing if they had used Positive Behavioral Support. Between 2019 and 2020, claims for Positive Behavioral Support only show up in Medicaid data in fall of 2019. More recent data will be included in future reports as claims and billing cycles continue to close. Additional data in Epi Info are also being developed to better assess Positive Behavior Support program usage.

6.3.2 How has the quality of life changed for children and families following Positive Behavior Support intervention?

Expected Outcome:

- Reduced occurrence of challenging behaviors and improved quality of life for children, youth, transition-age young adults, and their families following Positive Behavior Support intervention Ⓘ ⓁⓈ

Baseline Findings:

Most of the youth in residential who received Positive Behavior Support in the last 12 months were reported to be moderate to high functioning, according to caregivers and youth. Functioning was not significantly different among those who did and did not receive Positive Behavior Support in the last 12 months. For caregivers, 25% of those in medium-level function scale received PBS and 40% of those in high-level function scale received Positive Behavior Support service. For youths, the percentages are 52% and 44% for those in medium- and high-level function scale, respectively.

6.3.3 How have family/caregiver knowledge and skills changed to meet youth behaviors and needs?

Expected Outcome:

- Increased number of parents with improved knowledge and increased skills and ability to manage youth behaviors and needs Ⓘ Ⓛ

Baseline Findings:

Caregivers neither agreed nor disagreed that they knew who to contact if they had questions or concerns about their youth's services (Appendix D, Experiences w Mental Health Services, Table 1). When caregivers were asked about their understanding of how to access services over the last 12 months, 47% reported that their understanding has improved (Appendix D, Crisis Support and Access, Table 3). Of the 47% of caregivers who reported that their understanding improved over the last 12 months, 55% said it made them more likely to access services in the future, 28% said equally likely and 4% said less likely; 17% said that they do not expect to need additional services in the future (Appendix D, Crisis Support and Access, Table 3). Moreover, caregivers agreed that should youth need mental and behavioral health support in the future, they know who to contact (Appendix D, Crisis Support & Access, Table 4) and have the knowledge necessary to start and use Assertive Community Treatment, Children's Mobile Crisis Response and Stabilization, Children's Mental Health Wraparound, Positive Behavioral Support, and Statewide Children's Crisis and Referral Line (Appendix D, Future Service Needs, Table 1).

While most caregiver participants in youth and caregiver interviews expressed the need and desire for future services, they generally conveyed low confidence that critical services would be available in their communities and accessible to meet youths' complex and ongoing needs. Caregivers shared a desire and need for more specialized service options in WV, notably in-home therapy/counseling and shorter-term, median-tier options that would allow youth to receive more intensive care in the community. Many caregivers also noted the need for greater post-treatment and reintegration engagement and support to facilitate a sustainable transition back home and to school, maintain progress, and deter future placement. Youth expressed less perceived need for future services and were more confident of maintaining positive behavioral health strategies upon return home. For example, during an interview, one youth participant described refusing to participate in Safe at Home services prior to residential treatment but has since noted they would like to receive community-based services after discharge from residential treatment.

Caregivers expressed in the survey and during interviews the desire to be more involved in their youth's treatment. For example, 70% of caregivers fell into the medium to low range of the Treatment Participation Scale. Participation in discussions about their youth's treatment is a prime opportunity for caregivers to learn additional knowledge and skills and is likely to enhance their satisfaction as well.

6.3.4 How has the quality and timeliness of CANS assessments for Positive Behavioral Support participants changed?

Expected Outcome:

- Increased timely completion of CANS assessment on individuals receiving Positive Behavioral Support Intensive Services Ⓢ Ⓘ

Baseline Findings:

Data sources and processes are being developed and will be included in next year's report.

6.4 Assertive Community Treatment

6.4.1 How has involvement with the criminal justice system among Assertive Community Treatment participants changed?

Expected Outcome:

- Decreased children entering the Juvenile Justice system to address mental health needs Ⓛ

Baseline Findings:

Few of the residential population in this Evaluation participated in Assertive Community Treatment, likely due to age ranges and eligibility for Assertive Community Treatment. This question will be more fully addressed in 2023. Due to few youths participating in Assertive Community Treatment, the remaining findings for this evaluation question apply to the caregiver and youth samples more broadly.

6.4.2 How have referrals and orders to the criminal justice system changed for Assertive Community Treatment eligible participants?

Expected Outcome:

- Decreased children entering the Juvenile Justice system to address mental health needs

Baseline Findings:

Due to the age ranges evaluated in the residential population, few youths were of age to be eligible for Assertive Community Treatment. Data are being developed to address this question more fully in 2023. Due to few youths participating in Assertive Community Treatment, the remaining findings for this evaluation question apply to the caregiver and youth samples more broadly. Caregivers of youth in residential treatment reported that 39% of youth had an encounter with the police in the last 12 months, 43% of whom had been arrested (Appendix D, Law Enforcement, Table 1). Youth in residential treatment reported that 35% had an encounter with the police in the last 12 months, 30% of whom had been arrested (Appendix E, Health & Behavior Outcomes, Table 2). More than half of the youth with a police encounter (58%) went to court because of the encounter. (Appendix E, Health & Behavior Outcomes, Table 2).

There is a general decrease in youth encounters with the police compared to the previous year as reported by both caregivers and youth. However, a greater percentage of youth reported that they had more encounters with police in comparison to the previous year (25% of youth compared to 5% of caregivers). According to these caregivers, 60% of youth experienced fewer encounters with the police than they had in the previous year, for 33% encounters with police did not change and 5% had more police encounters than they had in the previous year (Appendix D, Law Enforcement, Table 1). Approximately half of the youth (53%) experienced fewer encounters with the police than they had in the previous year, for 23% encounters with police did not change and 25% had more police encounters than they had in the previous year (Appendix E, Health & Behavior Outcomes, Table 2).

6.4.3 How has the length of stay for inpatient hospitalizations due to a primary health condition changed among Assertive Community Treatment participants?

Expected Outcomes:

- Decreased inpatient hospitalizations among 18–21-year-olds enrolled in Assertive Community Treatment services Ⓛ
- Improved child functioning Ⓛ
- Independent living Ⓘ Ⓛ
- Shorter length of stay for inpatient hospitalizations among 18-21-year-olds Ⓘ
- Increased medication compliance and self-management of psychiatric illness Ⓘ
- Rate of noncompliance to treatment Ⓘ Ⓛ
- Increased engagement in the community, including the workforce, by 18-21-year-olds enrolled in Assertive Community Treatment services Ⓛ
- Decreased Juvenile Justice involvement Ⓘ Ⓛ
- Decreased Hospitalizations and RMHFT stays Ⓘ Ⓛ

Baseline Findings:

Inpatient hospitalizations and lengths of stay were not available in Medicaid data due to few claims for Assertive Community Treatment services. Due to few youths participating in Assertive Community Treatment, the remaining findings for this evaluation question apply to the caregiver and youth samples more broadly.

Caregiver perception of youth functioning and youth self-reported functioning were measured by caregiver-child functioning scale and youth-child functioning scale respectively. Most of the youth in residential cares were reported by caregivers and self-reported to be moderate to high functioning. More than half of youth self-reported as high functioning. In summary, baseline child functioning was reported as follows:

- Caregivers reported that 17% of youth were low functioning, and 2% of youth self-reported as low functioning
- Caregivers reported that 45% of youth had moderate functioning, and 41% of youth self-reported as moderate functioning
- Caregivers reported that 38% of youth were high functioning, and 57% of youth self-reported as high functioning

The majority participants in case series and caregiver interviews reported youth positive behavior changes with residential treatment, though youth were notably more optimistic in their treatment outcomes and post-treatment outlook. Several youths reported improved anger management and coping skills, relationships and communication with family, and behavior awareness and empathy. Most reported improved grades, school experiences, and appetite. Several reported less contact and more reassessment of problematic friendships outside of treatment, and two reported increased conflict with aggressive peers in residential mental health treatment. While youth conveyed lower levels of perceived need and were largely noncommittal to future services, about half expressed interest and consideration for continued therapy/counseling as well as extracurricular activities post-treatment to maintain progress. Many caregivers reported positive youth changes in school and functioning generally (i.e. awareness, coping skills, communication) but were more critical and skeptical, seemingly focused on service needs/challenges for behaviors that may persist without adequate community resources to maintain progress. Caregiver apprehension was in part due to a perceived lack of treatment engagement and communication. Several caregivers also conveyed the mental and emotional strain of placement on the family unit.

In addition, the CAFAS scores will also be obtained from DHHR to include in future reports. CAFAS scores are assessments conducted by experienced providers and will be able to provide points of comparison to self-reports. CAFAS scores are also being used as one criterion for eligibility for residential mental health treatment versus youths who are at-risk for residential placement.

Caregivers and youth agreed that as a result of receiving mental and behavioral health services over the last 12 months, youth are better able to follow directions on how to take their medication (Appendix D, Outcomes of MH Services, Table 1; Appendix E, Health & Behavior Outcomes, Table 1).

Two caregivers discussed issues with youth medication compliance following discharge in interviews. More caregivers reported medication concerns on part of residential facilities, namely a lack of communication/information on medication regime and changes. Youth participants largely noted gains in self-management (anger, aggression, depression) and coping skills, and caregivers reiterated improvement in behaviors and functioning generally in residential treatment.

Caregivers and youth were asked about engagement in the community after having received mental and behavioral health services (Appendix D, Outcomes of MH Services, Table 1; Appendix E, Health & Behavior Outcomes, Table 1). Caregivers neither agreed nor disagreed, but youth agreed that they get along better with friends and other people. Both caregivers and youth reported that youth are doing better in school and/or work after receiving mental and behavioral health services.

Most caregivers and youth reported positive advances in engagement and relationships during residential treatment, namely family, school, and functioning in case series and caregiver interviews. Most participants reported improved school performance and experiences, and several youths reported improved relationships with facility teachers and staff. Several youths reported less communication with and more reassessment of potentially problematic friendships outside of residential, and a few reported increased conflict with peers in RMHTF. While youth conveyed lower levels of perceived need and were largely noncommittal to future services, about half expressed willingness for continued therapy/counseling as well as extracurricular activities to maintain progress post-treatment. Many caregivers reported positive changes generally but were more critical and skeptical of service needs/challenges to maintain progress in the community. The perceived lack of engagement with youth and their treatment conveyed by many caregivers seemingly increased uncertainty.

Caregivers of youth in residential treatment reported that 39% of youth had an encounter with the police in the last 12 months, 43% of whom had been arrested (Appendix D, Law Enforcement, Table 1). Youth in residential treatment reported that 35% had an encounter with the police in the last 12 months, 30% of whom had been arrested (Appendix E, Health & Behavior Outcomes, Table 2). More than half of the youth with a police encounter (58%) went to court because of it (Appendix E, Health & Behavior Outcomes, Table 2).

There is a general decrease in youth encounters with the police compared to the previous year as reported by both caregivers and youth. However, a greater percentage of youth reported that they had more encounters with police in comparison to the previous year (25% of youth compared to 5% of caregivers). According to these caregivers, 60% of youth experienced fewer encounters with the police than they had in the previous year, for 33% it did not change and 5% had more police encounters than they had in the previous year (Appendix D, Law Enforcement, Table 1). Approximately half of the youth (53%) experienced fewer encounters with the police than they had in the previous year, for 23% it did not change and 25% had more police encounters than they had in the previous year (Appendix E, Health & Behavior Outcomes, Table 2).

Caregivers reported that 20% of youth visited the emergency room to get their youth mental health services over the last 12 months (Appendix D, Crisis Support and Access, Table 1). Almost half of youth (47%) self-reported that they had visited the emergency room to get their youth mental health services, 28% had done so in the last 12 months (Appendix E, Experiences with Mental Health, Table 5).

Caregivers and youth agreed that if mental or behavioral health needs in the future that they will be able to get access those to services outside of a hospital setting (Appendix D, Future Service Needs, Table 1; Appendix E, Future Service Needs, Table 1).

6.4.4 How has the use of Assertive Community Treatment services changed?

Expected Outcome:

- Increased usage of family-based placements with supportive mental health services Ⓛ

Baseline Findings:

Due to the age ranges evaluated in the residential population, few youth were of age to be eligible for Assertive Community Treatment. Data are being developed to address this question more fully in 2023. Across the full dataset, both caregivers and youth reported low usage of Assertive Community Treatment.

Sixteen percent of caregivers were aware of Assertive Community Treatment, representing 19 youth, one of whom had received Assertive Community Treatment in the last 12 months (Appendix D, Demographics & Awareness, Table 4). Twenty- four percent of youth were aware of Assertive Community Treatment, and 7% reported using it in the last 12 months (Appendix E, Demographics & Service Awareness, Table 3).

6.6 Reducing Reliance of Residential Treatment

6.6.1 How has family engagement in aftercare planning as part of discharge planning changed?

Expected Outcomes:

- Increased provider engagement of caregivers in aftercare planning and services for their loved one Ⓢ Ⓘ Ⓛ
- Increased caregiver engagement in the aftercare planning and services for loved ones leaving residential care Ⓢ

Baseline Findings:

For their engagement with RMHTFs specifically, youth were included in planning for changes in their care, but both caregivers and youth neither agreed nor disagreed that they were involved in discharge planning. Caregivers neither agreed nor disagreed that they approved of the treatment goals for RMHT and that they were included in creating the care plan. Additionally, caregivers neither agreed nor disagreed that they were informed when their child's level or type of care changed, and that they were involved in discharge planning. (Appendix D, Experiences with Mental Health Services, Table 5). Caregivers also reported barriers to initiating and continuing services, which included a lack of communication, information sharing, and caregiver involvement in treatment decision making. Caregivers also reported difficulties visiting youth when they are placed out-of-state. Youth reported that they were included in planning for changes in their care while in residential, but neither agreed nor disagreed that they were involved in discharge planning (Appendix E, Experiences with Mental Health, Table 4).

Caregivers across interviews were largely dissatisfied with discharge planning and support received. Caregiver participants who knew their youth was leaving residential placement soon, or had very recently left residential treatment, attempted to arrange post-treatment support such as weekly individual therapy, in-home case worker visits (reported as Safe at Home), and in-school services to assist with reintegration. However, several caregivers also described abrupt and unanticipated discharges from RMHTF that impeded discharge and aftercare planning. It should be noted that abrupt changes across systems were a result of COVID-19 pandemic protocols and caregiver experiences suggest a need for additional information to understand post-pandemic impacts. A few caregivers and youth reported uncertainty if they would receive services after leaving residential treatment because of living in a rural area without many options for mental and behavioral health treatment. Sudden discharge from residential would mean a lack of services in place for when the youth returns home. It would then take time for the youth to get scheduled to receive services.

7 Appendix B: Quantitative Data Collection Methods

7.1 Populations of Interest and Study Design

7.1.1 Overview

The Children's Mental Health Evaluation baseline data collection included community and systems-level (reported in March 2022) and caregiver and youth, focused on primary data collection among youth up to 21 years old who received care at RMHTFs in WV and other states. The caregiver and youth data collection included a survey that was designed to better understand the perspectives and experiences of the youth in the children's mental health system in WV. Two survey instruments were developed to collect data from caregivers and youth under the age of 21 about their experiences and satisfaction with behavioral and mental health services in WV.

7.1.2 Caregiver Sample

The Caregiver Survey was developed to collect data from caregivers of youth under the age of 18 about the caregivers' experiences and satisfaction with behavioral and mental health services in WV that were received by the youth in their care. Caregivers who had responsibility for youth between the ages of 12 and 17 were also asked to provide consent to contact the youth in their care, so that youth could be asked to complete a similar survey asking them questions about their experiences with services they had received.

The sample records for youth receiving care in RMHTF and their associated caregivers (N=802) are described in detail in the following section. In total, 527 records were eligible to receive a survey invitation and 108 completed the survey by phone or web between October 28, 2021 and February 17, 2022. A 30.9% response rate of caregivers was achieved. Surveys were programmed and administered with WVU's HIPAA-compliant REDCap software. REDCap is a secure web application for building and managing online surveys and databases.

The caregiver sample was derived from an original sample provided to WVU OHA by DHHR that included names of 802 youth[1] under 21 years of age. This included a list of 69 facilities in West Virginia and 12 other states (see figure 7-1, below) where youth were housed at the time the sample records were assembled.

It was necessary to determine the number of youth with viable caregiver contact information (including either mailing addresses, phone numbers, or both), to determine how best to contact caregivers and invite them to complete the survey. Caregivers of youth aged 18 and over were not included in the list to be surveyed, since these youth were identified as adults (n=46) who could provide their own consent and feedback on the provided mental health services. Cases for youth under 12, which would only involve interviews with the caregivers since the youth were too young to be surveyed, were also identified.

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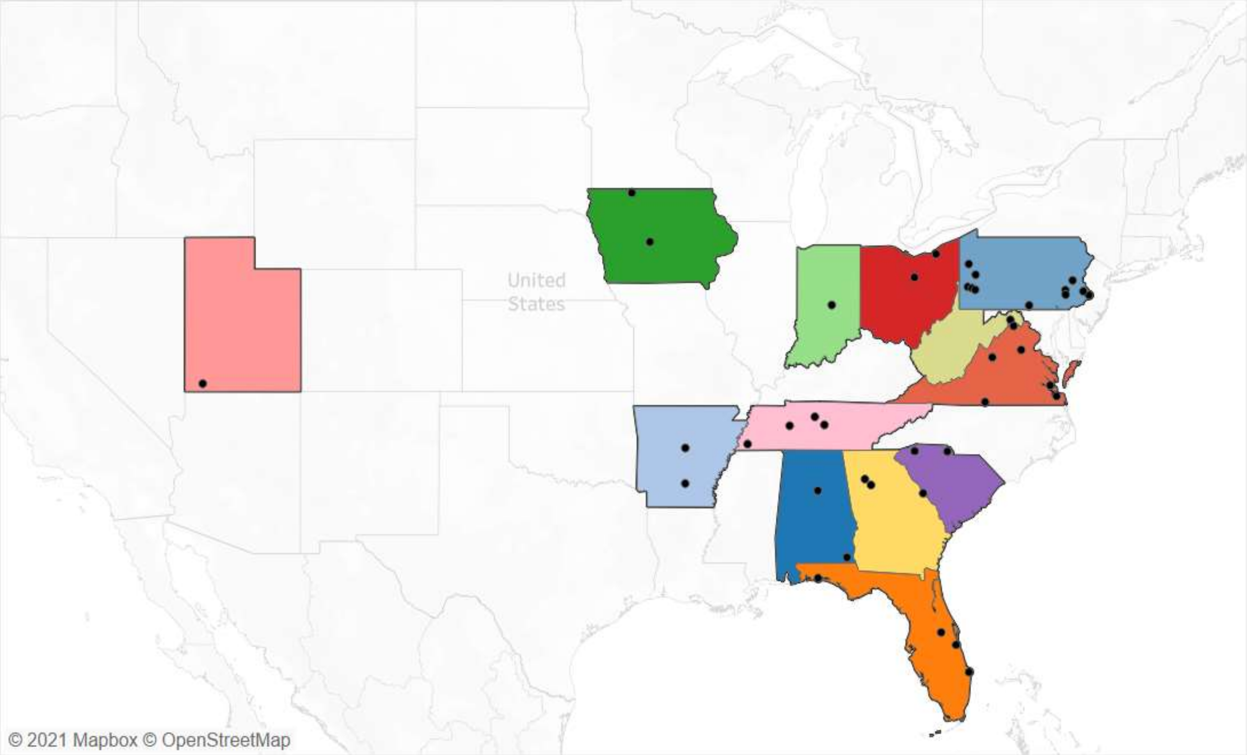
[1] There were 803 cases in the sample files sent by West Virginia University Office of Health Affairs, however one youth was a duplicate.

Figure 7-1: Map of Facilities Located Outside of WV



There were also youth for whom there was no caregiver information provided in the sample. As these youth could be classified as Wards of the State, they did not require a caregiver survey because WV DHHR gave “blanket consent” for them to be surveyed (n=151). Therefore these records were not included in the caregiver sample.

After review, there were 605 youth who were ages 12 to 18. Of these, 500 (62.3%) records included at least one caregiver with a mailing address and 380 (47.4%) had at least one caregiver with a phone number. There was also a subset of 17 caregivers who were associated with more than one youth which required a unique data collection approach since the evaluation required obtaining individual surveys from caregivers for each youth. Data collection for caregivers with more than one youth was handled using a “paper sample” approach. Among the caregivers of youth who were ages 12 to 18, there were 79 records that had no viable contact information that were, therefore, excluded from the study. During the course of data collection, these records were sent for locating to see if updated contact information was available so they could be included. Locating efforts yielded one mailing address from this group making the final sample size 527 records with viable contact information. Because the contact types are not mutually exclusive, different records received different combinations of outreach. No e-mail addresses were included in the sample for any of the caregivers so thie method of outreach was not used. Table 7-1 shows the type of outreach by sample type.

Table 7-1: Contact Method Utilized for Each Sample Type at the Start of Data Collection

	NO CAREGIVER CONTACT/OUTREACH NEEDED		PHONE ONLY		MAIL ONLY		PHONE AND MAIL		NO CONTACT INFO. PROVIDED (EXCLUDED FROM OUTREACH)		TOTAL SAMPLE	
Sample Type	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Youth ages 18-21	46	23.4%	-	-	-	-	-	-	-	-	46	5.7%
Wards	151	76.6%	-	-	-	-	-	-	-	-	151	18.8%
Youth Under 18	-	-	26	100.0%	146	100.0%	354	100.0%	79	100.0%	605	75.4%
Total	**197**	**24.6%**	**26**	**3.2%**	**146**	**18.2%**	**354**	**44.1%**	**79**	**9.9%**	**802**	**100.0%**

7.1.3 Youth Survey Sample

The sample records for youth receiving care in RMHTF (N=802, described in detail in the following section) were provided by WV DHHR to the WVU OHA project team. From these records, eligibility to be included in the Youth Survey was limited to records over age 12 for which consent was obtained from the caregiver (n=69), cases that were Wards of the State[2] (n=151), and cases that were 18 years old or older (n=46). In total, 266 records were included in the evaluation and 115 completed the survey between November 16, 2021 and April 18, 2022. A 47.9% response rate of youth in the sample was achieved. Surveys were programmed and administered with WVU's HIPAA-compliant REDCap software. REDCap is a secure web application for building and managing online surveys and databases.

The youth sample included names of 802 youth[3] under 21 years of age, from 69 facilities in WV and 12 other states (see figure 2.1, below) where these youth were housed at the time the sample records were assembled. Youth were categorized into age groups of under 12 years of age (n=46), 12-17 (n=710) years-old, and 18 and older (n=46). Cases for youth under 12, were excluded from this part of the evaluation since the youth were considered too young to provide informed answers to the survey questions.

In order for youth between the ages of 12 to 17 to be eligible to be included in the survey, consent of the caregiver needed to be obtained during the administration of the Caregiver Survey. Viable contact information (including either mailing addresses, phone numbers, or both) was necessary so that caregiver's could be surveyed and consent obtained to interview youth. Because outreach for youth with caregivers without contact information (n=76) was not possible, they were excluded from the Caregiver Survey and subsequently from the Youth Survey. There were also youth age 12-17 for whom there was no caregiver information provided in the sample. As these youth could be classified as Wards of the State, they did not require consent through a caregiver survey because WV DHHR gave "blanket consent" for them to be surveyed (n=151[4]).

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[2] State Ward – a child who had all parents' rights terminated by legal action, relinquishment, or death.

[3] There were 803 cases in the sample files sent by West Virginia University Office of Health Affairs, however one youth was a duplicate.

[4] Among the 151 youth classified as wards of the state, there were 8 cases age 18 or older who could provide their own consent.

Youth ages 18 and over were included in the list to be surveyed. Since these youth were identified as adults who could provide their own consent and feedback on the provided mental health services, a corresponding caregiver survey and consent was not required.

Of the youth associated with caregivers, consent was collected for 69 youth. Table 7-2 provides a summary of how the sample was derived.

Table 7-2: Youth Classification and Inclusion Status

Age Group/Classification	Included		Excluded		Total	
Under 12	**0**	**0.0%**	**46**	**8.6%**	**46**	**5.7%**
Youth Age 12-17	**220**	**82.7%**	**490**	**91.4%**	**710**	**88.5%**
Ward of the State*	151	56.8%	0	0.0%	151	18.8%
Consent Obtained	69	25.9%	0	0.0%	69	8.6%
Consent Not Obtained	0	0.0%	414	77.2%	414	51.6%
No Contact Information	0	0.0%	76	14.2%	76	9.5%
Youth Age 18+ ("Adult")	**46**	**17.3%**	**0**	**0.0%**	**46**	**5.7%**
Total	**266**	**33.2%**	**536**	**66.8%**	**802**	**100.0%**

*Among the 151 youth classified as wards of the state, there were 8 cases age 18 or older who could provide their own consent.

7.2 Survey Content and Structure

7.2.1 Survey Development

The development of the Youth Survey and the Caregiver Survey were iterative processes that relied on the expertise of WVU faculty subject matter experts and subject matter experts in youth and juvenile justice systems. The survey instruments contained a variety of question-and-answer formats and addressed different aspects of experiences related to a specific set of behavioral and mental health services offered in WV. Therefore, it was important to test the questionnaire items with individuals who had experience receiving mental health services.

7.2.2 Cognitive Interviews, Caregiver Questionnaire

The Caregiver Survey contained a variety of question-and-answer formats and addressed different aspects of the respondents' experiences related to a specific set of behavioral and mental health services offered in WV. Therefore, it was important to test the questionnaire items on parents, guardians, and primary caregivers of youth ages 21 or younger who were similar to those who would take part in the actual study. This testing ensured the questionnaire items were understood uniformly by all respondents and the references to different aspects of behavioral or mental health services were clear. The universe containing WV parents, guardians, and primary caregivers who met the criteria for inclusion in the study was limited and did not allow for cognitive interviewing recruitment of the actual sample members. However, priority was given to respondents who had some experience with mental or behavioral health services and worked to recruit a variety of caregiver types. Between July 28, 2021, and August 6, 2021, two cognitive interviewers conducted interviews with nine parents, guardians, and primary caregivers of youth aged 21 or younger who resided in WV. Cognitive testing focused primarily on general comprehension of the survey questions.

Key findings from the cognitive interviews were synthesized, along with recommendations into a report. The WVU OHA project team refined the recruitment and consent sections to accurately reflect the Evaluation activities and updated the language to make it appropriate for the RMHTF population.

7.2.3 Cognitive Interviews, Youth Questionnaire

Because all youth receiving mental health services in WV were eligible to be included in the evaluation, youth from surrounding states were recruited, who had experience receiving mental health services, for the cognitive interview. The purpose and procedures of the cognitive interviews offered a $75 Visa gift card after the interview was completed and asked a series of background questions to ensure potential respondents qualified to participate. Cognitive interviews were completed with 11 youth of various ages and backgrounds. A mix of mental health diagnoses were also represented. Table 7-3 shows the demographic characteristics of the participants in the cognitive interview.

All of the cognitive interviews were interviewer-administered using a questionnaire read to respondents over video conference. During the cognitive interviews, the interviewer read questions aloud to the respondent. The cognitive interview guide included scripted and generic probes as well as “think-alouds.” Respondents were introduced to the study and to cognitive interviewing, which included a practice exercise to introduce participants to the concept of thinking aloud while answering a question. After that exercise, they were instructed to tell the interviewer what they were thinking as they responded to the questions. They were also occasionally asked specific, scripted probes for some of the questions (such as, “What does a particular phrase mean to you?”). Other times the interviewer asked generic probes (such as, “What were you thinking?”) if the respondent seemed to have difficulty answering a question.

Table 7-3: Demographic Characteristics of Cognitive Interview Participants

Age	Gender	Race/Ethnicity	State	Diagnosis
21	F	White	NC	Anxiety and Depression
20	M	Asian American	GA	Depression and Binge Purge Anorexia
21	F	White	NC	Anxiety
21	F	White	VA	Anxiety, Depression, and OCD*
18	M	Hispanic	FL	Depression
17	M	Hispanic	NC	Depression and Autism (high functioning)
17	M	Bi-racial	OH	Oppositional Defiant Disorder
16	F	African American	NC	ADHD#
12	F	African American/Native American	TN	Anxiety and Depression
14	F	White	GA	ADHD
13	F	Hispanic/African American	TN	ADHD and Depression

*Obsessive Compulsive Disorder
#Attention Deficit Hyperactivity Disorder

The key findings from the cognitive interviews were synthesized, along with recommendations into a report. Overall, participants generally found the questions understandable, though the youngest participants (12-14) were the ones most likely to struggle with understanding the context of the questions. The WVU OHA project team refined the recruitment and consent sections to accurately reflect the Evaluation activities for the caregiver and youth level and updated the language to make it appropriate for the RMHTF population.

7.2.4 Caregiver Survey, Content and Structure

The Caregiver Survey began with an introduction containing information about the evaluation and explained that the caregiver would be asked to provide permission to contact the youth in their care, so the youth could do a similar survey asking them questions about their experiences with behavioral and mental health services they had received. Respondents were then presented with a screening question to confirm they were the parent, guardian, or legal caregiver of the youth in question. Caregivers who responded “no” were screened-out as ineligible and no further questions were asked.

Those who confirmed they were the right person were then asked to list the names of any programs they could think of that provided behavioral or mental health services in WV. Following this unaided awareness question, respondents were then presented with a list of 11 behavioral or mental health services that are offered in WV to determine which ones they had heard of previously. Following the service awareness related questions were several questions related to the RMHTF placement of the youth including confirmation of the facility, length of placement, and number of previous stays in a RMHTF. Depending on the age of the youth in question, respondents were asked to provide consent for the youth to be interviewed about their experiences with behavioral and mental health services. If the youth in question was under 12 or at least 18 years old, the consent section was skipped. If caregivers provided consent and a youth had been discharged or transferred from the facility of record, respondents were asked to provide updated contact information for outreach to the youth.

Whether they gave permission for their youth to be interviewed or not, respondents were asked to continue with the survey and provide feedback on their experience with the behavioral or mental health services their youth had received in WV. Respondents were only asked about the types of services received in the past 12 months if they said they had heard of the service. If they answered that their youth had received a particular service in the past 12 months, respondents were asked whether they agreed with the goals set for their youth and whether they were included when creating a plan of care as part of that program.

Other questions asked of caregivers included experience in the past 12 months with police, social services, teachers, doctors, or other trusted adults, and experience and satisfaction with mental and/or behavioral health services received by their youth, including interactions with staff members. They were also asked about outcomes related to youth and their family as a result of services received in the past 12 months, youth encounters with police in the past 12 months, youth school involvement in the past 12 months, whether there were barriers to starting and/or continuing behavioral or mental health services, and their level of agreement with statements about knowing how to start and use services if they are needed in the future. Demographic questions, such as gender, sexual orientation, race/ethnicity, employment, income, and WV service area (county) were collected of all respondents.

7.2.5 Content and Structure, Youth Survey

The Youth Survey began with an introduction containing information about the evaluation and collects assent/consent[5] to being surveyed. After the youth agreed to participate, the facilitator administered a cognitive assessment by reading a statement then asking the youth to tell the facilitator what that phrase meant to them. Based on the participant's response, the facilitator determined if the youth was cognitively capable of participating in the survey. Any youth who refused to participate or was deemed not cognitively capable were ineligible to continue.

Those who continued were asked to list the names of any programs or services they could think of that provided behavioral or mental health services. Following this unaided awareness question, respondents were then presented with a list of 11 behavioral or mental health services that are offered in WV to determine which ones they heard of previously. Following the service awareness related questions were several questions related to the RMHTF placement of the youth, length of placement, and number of previous stays in a RMHTF.

Respondents were asked to provide feedback on their experience with the behavioral or mental health services they received. Respondents were only asked about the types of services received in the past 12 months if they said they had heard of the service.

Other questions asked of youth included experience in the past 12 months with police, social services, teachers, doctors, or other trusted adults, and experience and satisfaction with mental and/or behavioral health services, including interactions with staff members. They were also asked about outcomes as a result of services received in the past 12 months, encounters with police in the past 12 months, school involvement in the past 12 months, whether there were barriers to starting and/or continuing behavioral or mental health services, and their level of agreement with statements about knowing how to start and use services if they are needed in the future. Depending on the topic, some questions were only asked of participants aged 18 years or older. Demographic questions, such as gender, sexual orientation, race/ethnicity, were collected of all respondents.

7.3 Survey Administration

7.3.1 Youth Survey, Facility Outreach

Data collection for the Youth Survey was conducted by teleconference[6] by WVU OHA research specialists ("facilitators"). Before the one-on-one surveys with the youth, WVU OHA coordinated two informational

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[5] Assent was collected for youth aged 12-17 and any wards of the state, while adult youth (18+) were old enough to provide their own consent.

[6] n=6 surveys were conducted in-person at the facility.

sessions among mental health care facilities. Of those RMHTF administrators invited to attend one of the two information sessions, 31 attended. Contact information was confirmed for 41 of the facilities. There were 28 facilities that did not attend the session, in part, because contact information was inaccurate and points of contact could not be identified prior to the session administration.

Table 7-4: Facility Attendance for Pre-Survey Information Sessions

Information Session Attendance		
Facilities Invited	**41**	**59.4%**
Facilities Attended	31	44.9%
Attendance %	75.6%	
Facilities with no contact information	**28**	**40.6%**
Total Facilities	**69**	**100.0%**

During these sessions, facilities were provided with an overview of the evaluation, how the RMHTFs would be involved, the process for conducting surveys with youth at the facilities, and a brief description of the survey topics. The session administrator also solicited feedback from the facilities for any potential obstacles to the process. Several attendees noted that because the survey would be conducted via teleconference, confidentiality agreements for WVU OHA staff visiting facilities would not be necessary, thus removing a potential barrier.

Facility attendees were also asked to provide the most appropriate person(s) and their contact information for the facilitators to contact to schedule the survey. If a facility was missing contact information, WVU OHA facilitators visited the facilities' websites to identify potential contacts and would follow up with phone calls to the facility. When available, researchers would also send an email to potential contacts when their email address was obtainable on the facility website. After this email was sent and WVU OHA was not still not able to obtain the best contact information, including the primary point of contact for a facility WVU OHA began reaching out to these facilities by phone, typically reaching out to someone in administration such as a Chief Exeutive Officer or Chief Operating Officer. In cases where WVU OHA could not find specific names of people to contact, staff reached out to the facility by phone to inquire who would be the best person to speak with. Typically, the first individual would refer to someone else such as a clinical director, case manager, or therapist to schedule the surveys and facilitate the data collection process. WVU OHA staff sent all facilities in attendance an email, thanking them for attending the session.

7.3.2 Survey Launch, Youth Survey

Given the constraints of the project's timeline as well as the relatively small sample, there was no formal pretest or "soft launch" of the survey. Rather, the survey was implemented with the entire sample of caregivers of youth under 18 years of age with viable contact information. After the first night of dialing, data were reviewed to ensure the accurate functioning of the script and items' responses. As a result of this review, one change was made to reflect the addition of an option for "I don't know" to Question C39 (Looking ahead to the next 12 months, that is until [CURRENT MONTH, NEXT YEAR] please say how strongly you agree or disagree with the following statements when thinking about [INSERT YOUTH NAME]?)

The English version of the survey was launched on October 28, 2021. The Spanish version of the survey was launched on December 14, 2021. At that point, there was only one caregiver identified as needing a bilingual interviewer to call them in Spanish. While the survey was prepared so it could be conducted in Spanish, all of the caregiver surveys were completed in the English language.

For caregivers with multiple youth, it was necessary to include different text to confirm all of the youth in their care, and explain that separate surveys needed to be completed focusing on each specific youth. In some cases, two caregivers were associated with multiple youth, which further complicated outreach. Due to the complexities involved in setting up the data collection process for caregivers associated with more than one youth, calling to this subset of caregivers began on February 1, 2022. This outreach was accomplished by a dedicated set of interviewers specifically trained to work these cases and keep track of these respondents using a paper sample record. Even though calls to these caregivers were started late in the field period, those caregivers who had a viable mailing address in the sample received the mailed respondent communications on the same schedule as the rest of the sample. As a result, one caregiver was able to complete a web survey for two of her youth prior to February 1, 2022. Three caregivers were not initially identified as having more than one youth. These caregivers received the normal protocol of communication described in the following section, however, they were transitioned to phone outreach once identified as members of the multi-youth associated caregivers group.

7.3.3 Survey Launch, Caregiver Survey

Given the constraints of the project's timeline as well as the relatively small sample, there was no formal pretest or "soft launch" of the survey. Rather, the survey was implemented with the entire sample of caregivers of youth under 18 years of age with viable contact information. After the first night of dialing, data were reviewed to ensure the accurate functioning of the script and items' responses. As a result of this review, one change was made to reflect to the addition of an option for "I don't know" to Question C39 (Looking ahead to the next 12 months, that is until [CURRENT MONTH, NEXT YEAR] please say how strongly you agree or disagree with the following statements when thinking about [INSERT YOUTH NAME]?)

7.3.4 Responent Communication

Respondent outreach communications for traditional mail were drafted by WVU OHA and reviewed by the project sponsor.

Caregiver Survey Contact Protocol

The Caregiver Survey was in the field for 16 weeks. Invitation letters were sent to any caregivers with a mailing address and called caregivers with a phone number. Caregivers who had at least one phone number in the sample received a letter stating they would be contacted by phone to take a telephone survey. The letter also included information relevant to the caller ID information that might be displayed to prompt them to answer the phone. Caregivers who did not have a phone number in the sample received a letter that did not have caller ID information.

Caregivers who had a mailing address and a phone number were first contacted to complete the survey by phone. This was accomplished using computer assisted telephone interview (CATI) software. Phone outreach was prioritized so that interviewers could establish rapport with caregivers, answer any questions or concerns they had about the request for permission to interview their youth, and help increase their willingness to provide permission to interview the youth in their care. CATI software distributed calls across different days and times of the week. Up to eight attempts were made to reach each respondent. To increase the probability of reaching participants, voicemails were left indicating the option to participate either by phone or online, along with the information needed to access each method. Requests for callbacks were honored and some caregivers received more than eight phone calls as a result. If there were two caregivers for a youth who each had phone numbers, the second caregiver was attempted if the first caregiver was unreachable after eight call attempts.

For caregivers who had a phone number and a mailing address, the invitation letter did not include information for accessing the web version of the survey, since the initial focus was on reaching them by phone. Caregivers who had a mailing address, but no phone were sent a version of the invitation letter that directed them to complete the survey via the web. Two reminder letters were sent during the data collection period, one in mid-December and one in mid-January. The reminder letters that were sent to caregivers with phone numbers added information for accessing the web survey. Additionally, phone calls were made to unresolved cases who had a telephone number in the sample file.

When a caregiver had completed the full survey, they were offered a $25 electronic Visa gift card as a token of appreciation for their time. When caregivers chose this option, they were told they would receive an e-mail within 14 days that included instructions on how to collect and redeem their electronic Visa gift card. If a caregiver did not have an e-mail address or did not have Internet access, they were given the option of receiving the gift card via postal mail. One caregiver refused the incentive, and another caregiver contacted the study team to provide an updated address to resend an incentive.

Table 7-5 shows the dates of respondent outreach by caregiver sample type.

Table 7-5: Dates of Respondent Outreach in Caregiver Survey

	Advance notification letter	Phone outreach	Reminder Letter #1	Reminder Letter #2
Phone number in Sample	11/1/2021	10/28/2021	12/16/2021	1/19/2022
No phone number in Sample	11/5/2021	n/a	12/16/2021	1/19/2022

7.3.5 Scheduling Youth Surveys

A list of youth classified as Wards of the State and adults, along with their unique survey access codes which facilitators would use to access the youth's case record in REDCap, was created. Information for sample records classified as youth ages 12 to 17 followed as the release of that record was dependent on the collection of consent from the Caregiver Survey. These records were released weekly (beginning

November 23, 2021), on a rolling basis as consent was obtained. For each record where consent was collected, a consent form was created which included the youth name and facility, along with the name of the caregiver who provided consent and the date consent was obtained. Files were password protected and sent to the WVU OHA team via secure file transfer protocol.

When it was time to start scheduling for data collection, an email was sent from the WVU OHA program director to all residential facilities for whom contact information was available. The purpose of the email was threefold: 1) to thank those who attended the information session, 2) to provide those who did not attend with a copy of the blanket consent form from WV DHHR as well as the PowerPoint presentation that gave an overview of the project, and 3) to provide notification that project staff would be calling to start scheduling times to conduct surveys with youth at their facility.

Naturally, due to differences in administration, not every facility received the same contact protocol, however WVU OHA facilitators attempted to maintain a uniform process which started with a phone call to the point-of-contact. If no contact was made on the initial attemptand if the message confirmed the contact's identity and position on the voicemail, the facilitator would leave a detailed message, sometimes including the name of the youth participant to be surveyed. A follow-up email was sent (referencing the phone call) which included available times to conduct the survey. Facilitators typically called back within the week (3-5 days between contact attempts) if there was no response. During follow-up calls, facilitators staggered the times of day when attempting outreach and used their judgement when to leave messages to avoid overwhelming the facilities.

Survey facilitation sessions were typically scheduled between WVU OHA operations business hours of 9 AM – 5 PM. Some facilities operated on the public school schedule and some youth were involved in extracurricular activities. These factors necessitated the need to schedule some surveys outside of normal business hours.

In some instances, facilitators were informed that a youth was no longer in the program. In these cases, WVU OHA inquired about reasons the youth left and where they went and recorded this information in a shared database. Due to differing policies at each facility, this information was not always provided. If youth were transferred to another facility, attempts were made to contact the youth and complete the survey at the new facility.

7.3.6 Conducting the Survey, Youth Survey

Among the 115 completed surveys, 109 (94.8%) were conducted via teleconference ("Zoom") and six (5.2%) were conducted in-person at the facility. Facilities varied as to whether they required a staff member to be present during the survey session. If staff members were in the room, the youth was asked if they were comfortable talking with staff present, which they were most of the time. If youth were not comfortable with staff hearing the discussion, they were able to read the survey questions to themselves and communicate their answer with facilitators. In at least one instance, a youth asked to use hand signals to communicate their answer (e.g., one finger for the first option, two for the second, etc.).

The six in-person surveys were all conducted at the same facility due to concerns about not having enough staff available to sit with youth during the survey process. Having the WVU OHA facilitator present alleviated this issue and, due to its close proximity to the WVU office, was easy to accommodate. The in-person facilitator was led to a private conference room where they set up their equipment (laptop) while the facility contact retrieved the youth. During the survey, only the youth and facilitator were present. Upon completion of the survey, WVU OHA facilitator walked the youth to the office of the contact who then returned the youth to the appropriate area of campus.

In cases where the youth did not show up at the scheduled survey time, the faciltiator immediately attempted to contact the facility to remind them of the scheduled meeting and rescheduled if necessary. If the facility could not be reached, a message was left and another attempt was made within the next two business days outlining the facilitator's availability.

Survey length averaged between 30 to 40 minutes and varied depending on the demeanor of the youth and how talkative they were. Youth were offered a $10 Visa gift card for completing the survey to thank them for their participation in the evaluation. As there was some concern about handing money directly to the youth while in RMHTF care, incentives were distributed to the facilities to distribute among the youth upon discharge.

7.4 Survey Outcomes and Response Rates

7.4.1 Survey Outcomes, Youth Survey

Overall, 115 of the 266 sampled youth fully (42.9%) or partially (0.4%) completed the survey. There were six surveys identified as partial incompletes that did not provide data sufficient for analysis since they completed less than 70% of the survey.

There were 132 youth (49.6%) for whom eligibility could not be determined because they refused to participate, were discharged or no longer at the facility, or otherwise did not start the survey.

WVU OHA survey facilitators identified 13 youth (4.9%) who had a cognitive impairment which prohibited them from participating in the survey. Four of these youth (1.5% of the total population) were flagged as such during the cognitive assessment built into the survey instrument, and nine (3.4%) were identified either during the survey introduction or by RMHTF staff before the survey process started.

Table 7-6: Survey Outcome by Consent Protocol

	Caregiver Consent: Youth Age 12-17		**Self Consent: Youth 18+ (Adults)**		**Blanket Consent: Wards**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Completed Survey (I)	**33**	**47.8%**	**13**	**28.3%**	**68**	**45.0%**	**114**	**42.9%**
Partial Complete (70% or more) (I)	**0**	**0.0%**	**0**	**0.0%**	**1**	**0.7%**	**1**	**0.4%**
Partial Incomplete (Qualified but <70%) (P)	**1**	**1.4%**	**2**	**4.3%**	**3**	**2.0%**	**6**	**2.3%**
Unknown Eligibility (UE)	**34**	**49.3%**	**29**	**63.0%**	**69**	**45.7%**	**132**	**49.6%**
Refusal Before Survey Started	0	0.0%	0	0.0%	2	1.3%	2	0.8%

Refusal to Assent/Consent	1	1.4%	1	2.2%	4	2.6%	6	2.3%
Discharged/Transferred/ No Longer in Facility	21	30.4%	20	43.5%	28	18.5%	69	25.9%
Pending, Survey Not Started	12	17.4%	8	17.4%	35	23.2%	55	20.7%
Total Included in RR	**68**	**98.6%**	**44**	**95.7%**	**141**	**93.4%**	**253**	**95.1%**
Screen-Out (Ineligible)	**1**	**1.4%**	**2**	**4.3%**	**10**	**6.6%**	**13**	**4.9%**
Cognitive Issue Identified - Before Assessment Administered	0	0.0%	2	4.3%	7	4.6%	9	3.4%
Cognitive Issue Identified - During Assessment	1	1.4%	0	0.0%	3	2.0%	4	1.5%
Total Sample	**69**	**100.0%**	**46**	**100.0%**	**151**	**100.0%**	**266**	**100.0%**

7.4.2 Response Rate, Youth Survey

As shown in Table 7-7, 108 caregivers of the 527 sampled youth fully (19.9%) or partially (0.6%) completed the Caregiver Survey. There were 26 surveys identified as partial incompletes that did not provide data sufficient for analysis since they completed less than 70% of the survey.

There were 321 cases (60.9%) with unknown eligibility. These cases included caregivers who refused on the phone or were not reached but there was no indication that all available contact information was bad.

An overall response rate (AAPOR RR3[7]) for the Caregiver Survey as shown below:

$$RR3 = I / (I + P \ \ (UE*e_1*e_2)$$

Where:

I = the total number of caregivers who answered 70% or more of their question items

P = the total number of caregivers who completed the screening questions and were eligible for the survey but did not complete at least 70% of their question items

UE = the total number of caregivers for whom eligibility is unknown because they did not start the survey, or they started the survey but did not complete the screening questions

e_1 = the estimated proportion of caregivers assumed to be eligible because they had valid contact information

e_2 = the estimated proportion of caregivers assumed to be eligible because they satisfied the screening criteria

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[7] Disposition codes and reporting are consistent with the American Association for Public Opinion Research standards.

These response rate calculations were based on a sample of n=455 caregivers of youth that excluded the following caregivers determined to be ineligible:

- 46 caregivers of youth with bad contact information in all possible modes of contact. For example, a caregiver with both a mailing address and a telephone number on the sample frame where a notification from USPS was received that the address was undeliverable and found the telephone number to be non-working or disconnected.
- 26 caregivers who started the survey and were determined to be ineligible during the screening questions.

The response rate calculations incorporated two eligibility terms. The first (e_1) addressed uncertainty about whether caregivers had valid contact information and the second (e_2) addressed uncertainty about whether unscreened caregivers were eligible for the survey (for example, whether they were the parent or legal guardian of a youth who had received behavioral or mental health services in WV in the past 12 months).

The overall response rate (AAPOR RR3) for the Caregiver Survey was 30.9%. As shown in Figure 7-2, response rates were highest (53.2%) for 15 caregivers with only a mailing address in the sample frame.

Table 7-7: Final Outcomes by Final Contact Type

	Phone Only		Mail Only		Phone and Mail		Overall	
	n	%	n	%	n	%	n	%
Complete (I)	**3**	**15.0%**	**5**	**33.3%**	**97**	**19.7%**	**105**	**19.9%**
Phone	3	15.0%	0	0.0%	68	13.8%	71	13.5%
Web	0	0.0%	5	33.3%	29	5.9%	34	6.5%
Partial Complete (70% or more) (I)	**0**	**0.0%**	**0**	**0.0%**	**3**	**0.6%**	**3**	**0.6%**
Phone	0	0.0%	0	0.0%	3	0.6%	3	0.6%
Web	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Partial Incomplete (Qualified but <70%) (P)	**0**	**0.0%**	**0**	**0.0%**	**26**	**5.3%**	**26**	**4.9%**
Phone	0	0.0%	0	0.0%	21	4.3%	21	4.0%
Web	0	0.0%	0	0.0%	5	1.0%	5	0.9%
Unknown eligibility (UE)	**11**	**55.0%**	**6**	**40.0%**	**304**	**61.8%**	**321**	**60.9%**
Phone Refusal	1	5.0%	0	0.0%	30	6.1%	31	5.9%
Non-Working Phone, Mail Pending	0	0.0%	0	0.0%	60	12.2%	60	11.4%
Mail Non-Delivery, Phone Pending	0	0.0%	0	0.0%	82	16.7%	82	15.6%
Pending No Response	10	50.0%	6	40.0%	132	26.8%	148	28.1%

Total Included in RR	**14**	**70.0%**	**11**	**73.3%**	**430**	**87.4%**	**455**	**86.3%**
Bad Contact Info.	**5**	**25.0%**	**4**	**26.7%**	**37**	**7.5%**	**46**	**8.7%**
Non-Working Phone, No Mailing Address	5	25.0%	0	0.0%	0	0.0%	5	0.9%
Mail Non-Delivery, No Phone Number	0	0.0%	4	26.7%	0	0.0%	4	0.8%
Mail Non-Delivery and Non-Working Phone	0	0.0%	0	0.0%	37	7.5%	37	7.0%
Screen-Out	**1**	**5.0%**	**0**	**0.0%**	**25**	**5.1%**	**26**	**4.9%**
Phone	1	5.0%	0	0.0%	19	3.9%	20	3.8%
Web	0	0.0%	0	0.0%	6	1.2%	6	1.1%
Total Excluded from RR (Ineligible)	**6**	**30.0%**	**4**	**26.7%**	**62**	**12.6%**	**72**	**13.7%**
Total Sample	**20**	**100.0%**	**15**	**100.0%**	**492**	**100.0%**	**527**	**100.0%**

Figure 7-2: Response Rates for Caregiver Survey, Overall and by Contact Type

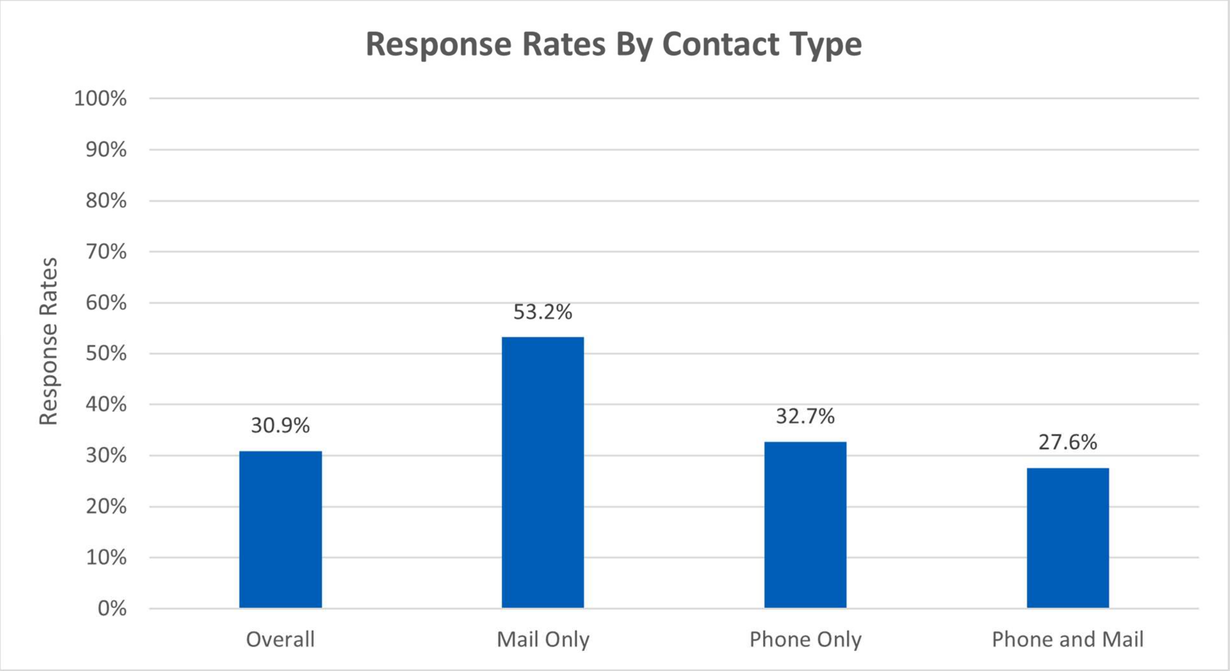

Table 7-8 presents how the completed surveys were collected by contact information type. Completion by phone was the dominant type with 74 (68.5%) of the interviews completed this way. Thirty-four (31.5%) completed the web version of the survey. This is based on the final contact type after updated information was added.

Table 7-8: Method of Completion by Final Contact Type

	Web Complete		Phone Complete		Total	
CONTACT TYPE	**n**	**%**	**n**	**%**	**n**	**%**
Phone Only	-	-	3	100.0%	3	2.8%
Mail Only	5	100.0%	-	-	5	4.6%
Phone and Mail	29	29.0%	71	71.0%	100	92.6%
Total	**34**	**31.5%**	**74**	**68.5%**	**108**	**100.0%**

7.4.3 Collection of Consent

Another important aspect of this effort was the collection of consent for interviewing youth aged 12-17 who were housed in a RMHTF. As shown in Table 5.6, of the 109 caregivers who were asked to provide consent for their youth to be interviewed, 69 (63.3%) provided consent while the remaining 40 (36.7%) declined to give consent. Youth consent was asked of some caregivers who did not complete the full survey, while caregivers of youth under 12 were not asked to provide consent because the youth were not going to be interviewed in the facilities.

Consent collection was markedly more successful when the caregiver was interacting with an interviewer on the phone. Caregivers were more likely to give phone consent (66.2%) than when they were interacting with the survey online (56.3%). This reinforces the reasoning for prioritizing phone outreach where possible, which was why cases with phone information were not provided online access information initially and were only sent that information after phone efforts were unsuccessful.

Table 7-9: Consent Status by Completion Status and Survey Mode

	Completed Survey				Minimally Completed[#]				Total					
Consent Status	**Web**		**Phone**		**Web**		**Phone**		**Web**		**Phone**		**Overall**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Gave Consent	17	58.6%	49	68.1%	1	33.3%	2	40.0%	18	56.3%	51	66.2%	69	63.3%
Declined Consent	12	41.4%	23	31.9%	2	66.7%	3	60.0%	14	43.8%	26	33.8%	40	36.7%
Total	**29**	**100%**	**72**	**100%**	**3**	**100%**	**5**	**100%**	**32**	**100%**	**77**	**100%**	**109**	**100%**

*The number of surveys in the Completed Surveys category in this table total 101 and not 108 because caregivers of youth under 12 years old were not asked to provide consent (n=7).

The Overall Total in this table includes 8 minimally completed (partials) who answered the consent question but did not complete 70% more of the questionnaire.

7.4.4 Response Rate, Caregiver Survey

Using the AAPOR standard definitions[8], an overall response rate (AAPOR RR3) for the Youth Survey of 47.9% was computed. Response Rate 3 is a calculation that accounts for the proportion of cases of unknown eligibility that are actually eligible using the following formula:

RR3 = I / (I + P + (UE*e1)

Where:

I = the total number of youth who answered 70% or more of their question items

P = the total number of youth who completed the cognitive screening question and were eligible for the survey but did not complete at least 70% of their question items

UE = the total number of youth for whom eligibility is unknown because they did not start the survey, or they started the survey but did not complete the cognitive screening question

e1 = the estimated proportion of youth assumed to be eligible because they satisfied the cognitive screening criteria

These response rate calculations were based on a sample of n=253 youth that excluded 13 youth who were determined to be ineligible before or during the cognitive screening process. The response rate calculations incorporated one eligibility term. The eligibility term (e1) addressed uncertainty about whether unscreened youth were eligible for the survey (for example, whether they would have passed the cognitive screening criteria).

As shown in Figure 7-3, response rates were lowest (32.0%) for youth age 18 or older.

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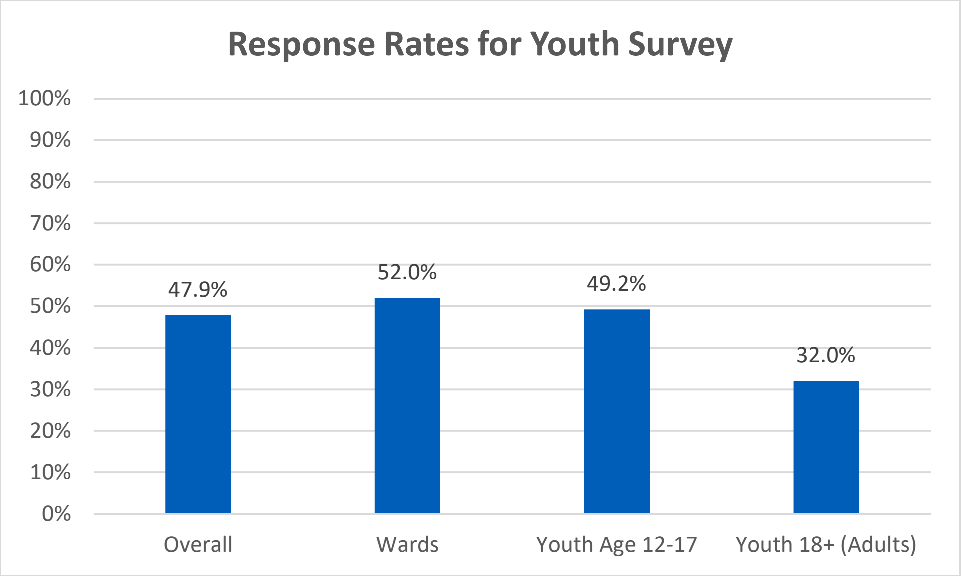
[8] https://www.aapor.org/Standards-Ethics/Standard-Definitions-(1).aspx

Figure 7-3: Response Rates for Youth Survey, Overall and by Consent Protocol



7.4.5 Youth Assent/Consent

Among the 69 youths aged 12 to 17 for which caregiver consent was obtained, 36 (52.2%) began the survey. Only one of these participants declined to participate when the facilitator described the survey to them. Among those who agreed to continue, one youth was considered ineligible due to a cognitive barrier, and one ended the survey before completing more than 70% of the questions. The remaining 33 youth completed the survey.

Sixteen of the 46 youth over 18 years of age (adults) were asked to give their own consent, of whom 15 (93.8%) agreed to participate. Assent rates were similarly high for wards of the state where 76 (95.0%) of the 80 cases who started the survey agreed to continue.

Table 7-10: Assent/Consent Rates by Consent Protocol

	Caregiver Consent: Youth Age 12-17		No Consent: Youth 18+ (Adults)		Blanket Consent: Wards		Total	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Agree to Participate	**35**	**97.2%**	**15**	**93.8%**	**76**	**95.0%**	**126**	**95.5%**
Completed Survey	33	91.7%	13	81.3%	69	86.3%	115	87.1%
Partial Incomplete	1	2.8%	2	12.5%	3	3.8%	6	4.5%
Ineligible Cognitive Barrier	1	2.8%	0	0.0%	4	5.0%	5	3.8%

Declined Participation	**1**	**2.8%**	**1**	**6.3%**	**4**	**5.0%**	**6**	**4.5%**
Total Youth Asked to Provide Assent/Consent	**36**	**100.0%**	**16**	**100.0%**	**80**	**100.0%**	**132**	**100.0%**

8 Appendix C: Quantitative Data Analytic Methods

8.1 Analytic Methods

This section describes the analytic approaches used for the Caregiver Survey and Youth Survey. Data from this Evaluation were primarily reported as frequencies (i.e., counts), valid percentages that account for missing data and "I don't know" responses when applicable, and measures of central tendencies such as means, medians, and ranges. When write-in data were available, responses were compiled, reviewed, summarized, and incorporated into the findings. Analyses were primarily conducted using Statistical Analysis System[9] and Statistical Package for Social Science[10] data analytic software. Sections below describe how final samples were derived, and how certain stratification variables were constructed.

8.2 Caregiver Survey

8.2.1 Survey Sample

The Caregiver Survey was sent to the caregivers of youth ages 0 to 21 years old who received care in RMHTFs in WV and other states as of October 1, 2021. The survey population is the caregivers of 802 youths receiving care in RMHTFs. This section describes the application of exclusion criteria that lead to the final sample included in analyses (i.e., the analytic sample).

There were several exclusion critera that were applied to the population. Several caregivers (n = 4) originally reported their youth as aged 12-17, but at the time of the survey reported youth age as 18; these were removed from further analysis. The youth aged 18-21 were identified as adults (n=46) who could provide their own consent and feedback about their mental health services. Cases for youth under 12 would only involve interviews with the caregivers since the youth were too young to be surveyed. Wards of State (n=151) were also excluded in the caregiver sample since there was no caregiver information available. Caregivers of 605 youth were eligible for the survey after applying these exclusion critera. Validation of contact information lead to a sample size of 527 eligible survey invitations. Table 8-1 shows the type of outreach by sample type.

Table 8-1 Contact Method Utilized for Caregiver of Each Sample Type at the Start of Data Collection

Sample Type	No caregiver contact/outreach needed	Phone only	Mail only	Phone and mail	No contact information provided (excluded from outreach)	Total sample
Adults (youth aged 18-21)	46	- (-)	- (-)	- (-)	- (-)	46 (5.7%)

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

[10] SPSS [Computer software]. IBM Corp. Released 2020. IBM SPSS Statistics for Windows, Version 27.0. Armonk, NY: IBM Corp.

	(23.4%)					
Wards	151 (76.6%)	- (-)	- (-)	- (-)	- (-)	151 (18.8%)
Youth Under 18	- (-)	26 (100.0%)	146 (100.0%)	354 (100.0%)	79 (100.0%)	605 (75.4%)
Total	197 (24.6%)	26 (3.2%)	146 (18.2%)	354 (44.1%)	79 (9.9%)	802 (100.0%)

8.2.2 Survey Outcomes and Response Rates

Surveys were considered "complete" if 70% or more of the items contained responses. Following this definition, of the 527 persons who were invited to take the survey, 105 were fully completed and three contained responses to more than 70% of items and were included for analyses. . There were 26 surveys identified as partial incompletes that did not provide data sufficient for analysis since respondents completed less than 70% of the survey. There were 321 cases (60.9%) with unknown eligibility due to refusal on the phone or pending no response (e.g., not reached out, bad mail address). There were another 46 respondents (8.7%) whose contact information was not accurate. After survey was started, 26 additional caregivers were determined to be ineligible during the screening questions confirming the correct contact information.The detailed exclusion criteria with counts and percentages in each step are shown in Table 8-2.

An overall response rate, AAPOR standard definitions (RR3) for the Caregiver Survey was computed as shown below:

$$RR3 = I / (I + P \ (UE*e1*e2)$$

Where:

- I = the total number of caregivers who answered 70% or more of their question items
- P = the total number of caregivers who completed the screening questions and were eligible for the survey but did not complete at least 70% of their question items
- UE = the total number of caregivers for whom eligibility is unknown because they did not start the survey, or they started the survey but did not complete the screening questions
- e1 = the estimated proportion of caregivers assumed to be eligible because they had valid contact information
- e2 = the estimated proportion of caregivers assumed to be eligible because they satisfied the screening criteria

Table 8-2: Final Caregiver Survey Analytical Data

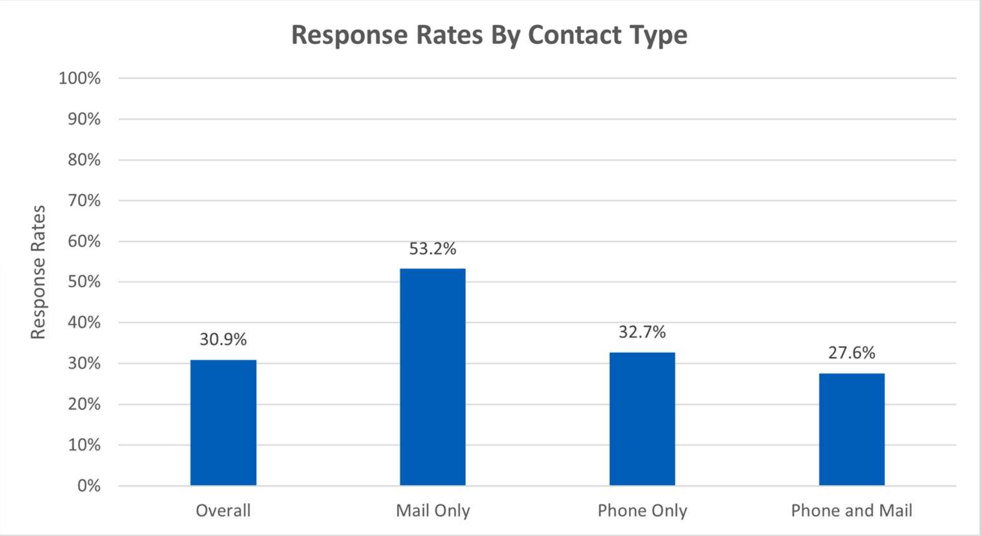
Exclusion Criteria	**N (%)**
Complete (I)	108 (20.5%)
Full Complete (I)	105 (19.9%)

Partial Complete (70% or more) (I)	3 (0.6%)
Partial Incomplete (Qualified but <70%) (P)	26 (4.9%)
Unknown eligibility (UE)	321 (60.9%)
Phone Refusal	31 (5.9%)
Non-Working Phone, Mail Pending	60 (11.4%)
Mail Non-Delivery, Phone Pending	82 (15.6%)
Pending No Response	148 (28.1%)
Total Included in AAPOR RR3	455 (86.3%)
Bad Contact Information	46 (8.7%)
Non-Working Phone, No Mailing Address	5 (0.9%)
Mail Non-Delivery, No Phone Number	4 (0.8%)
Mail Non-Delivery and Non-Working Phone	37 (7.0%)
Screen-Out	26 (4.9%)
Total Excluded from RR (Ineligible)	72 (13.7%)
Total Sample	527 (100.0%)

The response rate calculations incorporated two eligibility terms. The first (e1) addressed uncertainty about whether caregivers had valid contact information and the second (e2) addressed uncertainty about whether unscreened caregivers were eligible for the survey (for example, whether they were the parent or legal guardian of a youth who had received behavioral or mental health services in WV in the past 12 months).

Among the 802 youths in the population, caregivers of 108 completed surveys by phone or web between October 28, 2021 and February 17, 2022, achieving a 30.9% Caregiver Survey response rate based on the AAPOR RR3 standard response rate definition. As shown in Figure 8-1, response rates were highest (53.2%) for caregivers with only a mailing address in the sample frame, and lowest (27.6%) for caregivers with both phone and mailing address.

Figure 8-1: Response Rates for Caregiver Survey, Overall and by Contact Type



8.2.3 Reclassification of specified "other" survey item responses

There were several survey items that allowed respondents to select an "other" response.

Table 8-3: Describes the Reclassification of Write-Ins for "Other Services Have Received or Is Waiting to Receive" (Survey Item Label C1_text).

Original responses	Re-classification
He has anxiety anger behavior issues	Behavioral Health
Individual therapy and family therapy	Behavioral Health
Park Valley behavioral health center for help with her medication and counseling or therapy.	Behavioral Health
Therapy	Behavioral Health
Theripi from drug court	Behavioral Health
Currently inpatient at Milcreek Behavioral Health Center in Fordyce Arkansas...	Behavioral Health
CSED Waver Program	Children with Services Emotion Disorders (CSED)
Therapy at Child Protect in Princeton WV.	Community care
theripy at the prestera center	Community care
Worthington center Inc.	Community care
Out-Patient Mental Health Services upon return home next month	Community care
Your accadamy	Counseling
A social worker [provider name] is providing case management of the child's case. Locating appropriate facilities to work with the child with her mental health and dealing with her legal issues. She is really doing a great job.	Counseling
Active Counseling. He is no longer under psych care.	Counseling
big brothers program	Counseling

counseling	Counseling
COUNSELING AND THERAPY SERVICES IN THE FACILTY. AND ALSO GROUP THERAPY IN THE FACILITY.	Counseling
counselor outside states	Counseling
quiet minds therapeutic counseling mentoring	Counseling
Round table program for sexual issues brought on by Biological Family	Counseling
S.t.a.r.s.	Counseling
SHE'S RECIEVING COUNSELING SERVICES.	Counseling
Mental heath evaluation by DHHR	Mental health evaluation by DHHR
The child is just getting started in a mental health program	Residential Mental Health Services
Facility care	Residential Mental Health Services
Grant Gardens and Burlington	Residential Mental Health Services
She has been admitted into Highland hospital twice.	Residential Mental Health Services
safe at home	Safe at Home
safe at home,	Safe at Home
IEP Program with school.	Speech/occupational Therapy

8.2.4 Scale development and validation

Several scales were created based on items in the Caregiver Survey. A majority of these items were adapted from the YSSF. Exploratory factor analysis was performed to explore the underlying structures and validate each scale. Items in each scale were also analyzed for internal consistency using Cronbach's alpha coefficient to determine the stability of each scale. Based on the Caregiver Survey, five scales were developed: Child Functioning, Access and Satisfaction, Social Support Systems, Family Treatment Participation, and Engagement and Respect.

The Child Functioning scale includes seven items (c16_1a, c16_1b, c16_1c, c16_1d, c16_1e, c16_1f, c16_1g). These Likert-type scale items included 5 response options that ranged from “Strongly Disagree” to “Strongly Agree” and measured caregiver’s perceptions of youth functioning in daily life. To perform exploratory factor analysis, all seven items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don’t know/does not apply was recoded as N/A). Principal Component Factor analysis (PCA) with varimax rotation was conducted to determine the components in the scale. The Kaiser-Meyer-Olkin (KMO) measure was .872, indicating adequate sample size for factor analysis. Bartlett’s Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was good as measured by Cronbach’s alpha coefficient ($\alpha = .904$).

Table 8-4: Caregiver -Child Functioning Scale Factor Analysis Result

Survey Item Label	Survey Item	Factor Loading
C16_1a *	Your child is better at handling daily life.	.882
C16_1f	Your child is better able to handle it when things go wrong.	.862
C16_1g	Your child is better able to do the things they want to do.	.836
C16_1c *	Your child gets along better with friends and other people.	.828
C16_1e *	Your child is better able to follow directions on how to take their medication.	.803
C16_1b *	Your child gets along better with family members.	.712
C16_1d *	Your child is doing better in school and/or work.	.665
Note: * Indicating items adapted from the Youth Services Survey for Family (YSSF).		

To create the Child Functioning Scale, the recoded items were combined (minimum score = 0, maximum score = 28). Caregiver scores were assigned into three categories as follows: low (0-9), moderate (10-19) and high (20-28).

The Access and Satisfaction Scale includes seven items (c4_a, c4_b, c4_c, c4_d, c4_e, c4_f, c4_g).These Likert-type scale items included five response options that ranged from "Strongly Disagree" to "Strongly Agree" and measured caregiver's perceptions of initiating and accessing mental health services for their child. To perform exploratory factor analysis, all seven items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don't know was recoded as N/A). PCA with varimax rotation was conducted to determine the components in the scale. The KMO measure was .841, indicating adequate sample size for factor analysis. Bartlett's Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was good as measured by Cronbach's alpha coefficient ($\alpha = .849$).

Table 8-5: Caregiver-Access and Satisfaction Scale Factor Analysis Result

Survey Item Label	**Survey Items**	**Factor Loading**
C4_e *	The needed behavioral or mental health services are available at times that work for you.	.836
C4_c	Your child was able to get behavioral or mental health services without having to wait too long.	.827
C4_g *	You are satisfied with your experiences getting behavioral or mental health help for your child.	.762
C4_a	You know which types of behavioral or mental health services might be available to help	.717

C4_d *	The locations of behavioral or mental health services are easy to get to for you.	.711
C4_b	You know how to contact a behavioral or mental health professional who can help	.656
C4_f	Your child is able to meet with the behavioral or mental health professional they need using telehealth.	.537
Note: * Indicating items adapted from the Youth Services Survey for Family (YSSF).		

To create the Access and Satisfaction Scale, the recoded items were combined (minimum score = 0, maximum score = 28). Caregiver scores were assigned into three categories as follows: low (0-9), moderate (10-19) and high (20-28).

The Caregiver Social Support Scale includes four items (c16_2b, c16_2c, c16_2d, c16_2e). These Likert-type scale items included five response options that ranged from “Strongly Disagree” to “Strongly Agree” and measure caregiver’s perceptions of their support system. To perform exploratory factor analysis, all four items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don’t know/does not apply to N/A). PCA with varimax rotation was conducted to determine the components in the scale. KMO measure was .766, indicating adequate sample size for factor analysis. Bartlett’s Test of Sphericity was significant, *p* < .001, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was high as measured by Cronbach’s alpha coefficient (α = .834).

Table 8-6: Caregiver-Social Support Systems Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor Loading
C16_2b *	You know people who will listen and understand you when you need to talk.	.853
C16_2c *	You know people you are comfortable talking with about your child's problems.	.850
C16_2d *	In a crisis, you would have the support you need from family or friends.	.795
C16_2e *	You have people with whom you can do enjoyable things.	.774
Note: * Indicating items adapted from the Youth Services Survey for Family (YSSF).		

To create the Social Support Systems Scale, the recoded items were combined (minimum score = 0, maximum score = 16). Caregiver scores were assigned into three categories as follows: low (0-5), moderate (6-11) and high (12-16).

The Family Treatment Participation Scale includes nine items (c7_1a, c7_1b, c7_1c, c7_1d, c7_1e, c7_1f, c7_1g, c7_1h, c7_1i). These Likert-type scale items included 5 response options that ranged from

"Strongly Disagree" to "Strongly Agree" and measure caregiver's perceptions of their participation in their child's treatment. To perform exploratory factor analysis, all nine items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don't know to N/A). PCA with varimax rotation was conducted to determine the components in the scale. The KMO measure was .871, indicating adequate sample size for factor analysis. Bartlett's Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was high as measured by Cronbach's alpha coefficient ($\alpha = .909$).

Table 8-7: Caregiver-Family Treatment Participation Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor Loading
C7_1h *	The behavioral or mental health services your child and/or family received were right for you.	.880
C7_1a *	Overall, you are satisfied with the behavioral or mental health services your child received.	.835
C7_1i *	Your family got the help you wanted for your child.	.828
C7_1c *	You helped to choose your child's treatment goals.	.802
C7_1f	You did not have to wait too long to get answers to your questions about your child's progress.	.737
C7_1b *	You helped to choose your child's behavioral or mental health services.	.730
C7_1d	You helped with your child's treatment.	.725
C7_1e *	You felt your child had a behavioral or mental health professional to talk to when they were troubled.	.689
C7_1 g	You knew who to contact when you had questions or concerns about your child's behavioral or mental health services.	.610
Note: * Indicating items adapted from the Youth Services Survey for Family (YSSF).		

To create the Family Treatment Participation Scale, the recoded items were combined (minimum score = 0, maximum score = 36). Caregiver scores were assigned into three categories as follows: low (0-12), moderate (13-24) and high (25-36).

The Engagement and Respect Scale includes six items (c7_2a, c7_2b, c7_2c, c7_2d, c7_2e, c7_2f). These Likert-type scale items included five response options that ranged from "Strongly Disagree" to "Strongly Agree" and measure caregiver's perceptions of culturally sensitive practices. To perform exploratory factor analysis, all four items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don't know to N/A). PCA with varimax rotation was conducted to determine the components in the scale. The KMO measure was .784, indicating adequate sample size for factor analysis. Bartlett's Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was good as measured by Cronbach's alpha coefficient ($\alpha = .881$).

Table 8-8: Caregiver-Engagement and Respect in Treatment Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor Loading
C7_2f *	Staff were thoughtful of your cultural/ethnic background (race, language, etc.).	.839
C7_2b *	The people helping your child stuck with you no matter what.	.831
C7_2c *	Staff treated you with respect.	.816
C7_2a	The care team always checked with a family member when creating or updating your child's plan of care.	.798
C7_2e *	Staff respected your family's religious/spiritual beliefs.	.790
C7_2d *	Staff spoke with you in a way that you understood.	.740
Note: * Indicating items adapted from the Youth Services Survey for Family (YSSF).		

To create the Engagement and Respect Scale, the recoded items were combined (minimum score = 0, maximum score = 24). Caregiver scores were assigned into three categories as follows: low (0-8), moderate (9-16) and high (17-24).

8.3 Youth Survey

8.3.1 Survey Sample

The Youth Survey was developed to collect data from youth up to 21 years old who received care at RMHTFs in WV and other states. The survey population included 802 youths receiving care in RMHTF. The list was provided to WVU OHA by WV DHHR. This section describes the exclusion criteria that was used to derive the final analytic sample.

Several exclusion criteria were applied to the youth population to determine eligibility to participate in the survey. Youth under the age of 12 (n = 220) were excluded because these youths were considered too young to provide answers to the survey questions. Youth ages 18-21 took the survey without required consent from caregiver. Consent by a caregiver was needed for the remaining youth ages 12 to 17 to be eligible to take the survey. Youths who were Wards of State at the time of data collection were given "blanket consent" from WV DHHR to participate in the survey (n = 151). A total of 76 youths (14.2%) with designated caregivers were excluded due to lack of contact information, and another 414 youths (77.2%) were excluded because caregiver consent was not obtained. Table 8-9 describes the number and percentage of youths who were invited to participate in the survey with the following criteria described above:

1. Youth over age 12 and whose consent was obtained from the caregiver, consent from caregiver needed (n=69, 25.9%).

2. Youth staying in the wards of the state, WV DHHR gave “blanket consent” (n = 151, 56.8%).
3. Youth 18 years old or older, consent from caregiver not needed (n = 46, 17.3%).

Table 8-9: Youth Survey Screening and Exclusion

Age Group/Classification	Included		Excluded		Total	
Under 12	0	0.0%	46	8.6%	46	5.7%
Youth Age 12-17	220	82.7%	490	91.4%	710	88.5%
Ward of the State*	151	56.8%	0	0.0%	151	18.8%
Consent Obtained	69	25.9%	0	0.0%	69	8.6%
Consent Not Obtained	0	0.0%	414	77.2%	414	51.6%
No Contact Information	0	0.0%	76	14.2%	76	9.5%
Youth Age 18+ ("Adult")	46	17.3%	0	0.0%	46	5.7%
Total Sample	266	33.2%	536	66.8%	802	100.0%
*Among the 151 youth classified as Wards of the State, there were 8 cases age 18 or older who could provide their own consent.						

8.3.2 Survey outcomes and response rates

There were 132 youth (49.6%) for whom eligibility could not be determined because they refused to participate, were discharged or no longer at the facility, or otherwise did not start the survey. Additionally, WVU OHA survey facilitators identified 13 youth (4.9%) who had a cognitive impairment which prohibited them from participating in the survey. Four of these youth (1.5% of the total population) were flagged as such during the cognitive assessment built into the survey instrument, and nine (3.4%) were identified either during the survey introduction or by RMHTF staff before the survey process started. Surveys were considered “complete” if a youth answered 70% or more of their question items. Among the 115 completed responses, 114 (99.1%) were identified as fully completed and one (0.9%) was identified as partially completed (i.e., the youth completed 70% or more of the survey). If a youth started the survey and fewer than 70% of survey items were answered, the response was coded as a partial incomplete, or minimally completed, survey. There were six surveys identified as partial incompletes. Numbers and percentages are outlined in Table 8-10.

Table 8-10: Final Youth Survey Analytical Data

Response	N (%)
Total survey recipients	266
Partial incomplete	6 (2.3%)
Eligibility could not be determined	132 (49.6%)
Had a cognitive impairment	13 (4.9%)
Full complete	114 (42.9%)
Partial complete	1 (0.4%)
Total completed	115 (43.2%)

According to the AAPOR RR3, based on a sample of n=253 youth that excluded 13 youth who were determined to be ineligible before or during the cognitive screening process, the response rate is determined as 47.9%. The response rate calculations incorporated one eligibility term. The eligibility term (e1) addressed uncertainty about whether unscreened youth were eligible for the survey (for example, whether they would have passed the cognitive screening criteria).

RR3 = I / (I + P + (UE*e1))

Where:

- I = the total number of youths who answered 70% or more of their question items
- P = the total number of youths who completed the cognitive screening question and were eligible for the survey but did not complete at least 70% of their question items
- UE = the total number of youths for whom eligibility is unknown because they did not start the survey, or they started the survey but did not complete the cognitive screening question
- e1 = the estimated proportion of youth assumed to be eligible because they satisfied the cognitive screening criteria.

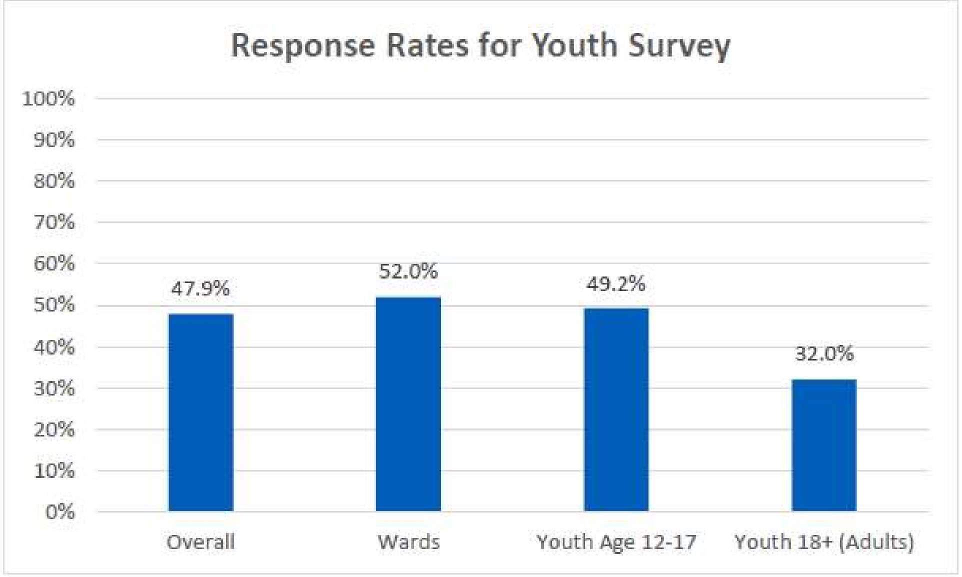
A detailed survey outcome by consent protocol is demonstrated in Table 8-11.

Table 8-11: Youth Survey Outcome by Consent Protocol

Response	Caregiver Consent: Youth Age 12-17	Self-Consent Youth 18+ (Adults)	Blanket Consent: Wards	Total
Fully Completed Survey (I)	33 (47.8%)	13 (28.3%)	68 (45%)	114 (42.9%)
Partial Complete (70% or more) (I)	0 (0%)	0 (0%)	1 (0.7%)	1 (0.4%)
Partial Incomplete (Qualified but <70%) (P)	1 (1.4%)	2 (4.3%)	3 (2%)	6 (2.3%)
Unknown Eligibility (UE)	34 (49.3%)	29 (63%)	69 (45.7%)	132 (49.6%)
Refusal Before Survey Started	0 (0%)	0 (0%)	2 (1.3%)	2 (0.8%)
Refusal to Assent/Consent	1 (1.4%)	1 (2.2%)	4 (2.6%)	6 (2.3%)
Discharged/Transferred/No Longer in Facility	21 (30.4%)	20 (43.5%)	28 (18.5%)	69 (25.9%)
Pending, Survey Not Started	12 (17.4%)	8 (17.4%)	35 (23.2%)	55 (20.7%)
Total Included in RR	68 (98.6%)	44 (95.7%)	141 (93.4%)	253 (95.1%)
Screen-Out (Ineligible)	1 (1.4%)	2 (4.3%)	10 (6.6%)	13 (4.9%)
Cognitive Issue Identified - Before Assessment Administered	0 (0%)	2 (4.3%)	7 (4.6%)	9 (3.4%)
Cognitive Issue Identified - During Assessment	1 (1.4%)	0 (0%)	3 (2%)	4 (1.5%)
Total Sample	69 (100%)	46 (100%)	151 (100%)	266 (100%)

Specifically, as shown in the Figure 8-2 below, response rates were lowest (32.0%) for youth age 18 or older, and highest (52.0%) for youth in the Wards of State.

Figure 8-2: Response Rates for Youth Survey, Overall and by Consent Protocol



There were 253 youths who are eligible to receive the survey, and 115 completed the survey between November 16, 2021 and April 18, 2022 achieving a response rate of 47.9%.

8.3.3 Reclassification of specified "other"

There were several survey items that allowed participants to mark "other" and write in responses. The write-in responses were reclassified by extracting information (e.g., name of facility, type of specific service) on existing types of mental and behavioral health services information from the original responses. The following tables 8-12 through 8-13 include the raw data and reclassifications of the write-in responses.

Table 8-12: Other Mental Health or Behavioral Health Services Youth Hard of or Being Offered (C0_1).

Response	Re-classification
Abraxas 1 in Pennsylvania, helped with mental health services and drug use; Highland had mental health services;	Residential
Abraxas fire-starting program; therapy; Highland;	Residential
Abraxas treatment facility for coping skills	Residential
Behavioral Placement, Restorative Justice.	Residential
Board of Childcare and Pressley Ridge	Residential
Board of childcare, Abraxas, (Name of Provider), (Name of Provider), Chestnut Ridge Hospital.	Residential
Burlington and therapy services back home.	Counseling

CPS, highland	Residential
Coping Skills	Counseling
Counseling for anger	Counseling
Counseling only	Counseling
Counseling,	Counseling
DHHR, clothing vouchers, counseling services, weekly therapy	Counseling
(Name of Provider). Therapy back home talking about school stuff.	Residential
Doesn't know the names but has had therapy	Counseling
Doesn't recall	Don't know
Fox Run	Residential
Fox Run placement, both highland hospitals. WVU Medicine for therapy and met with psychologist.	Residential
Fox Run, Helinski Shelter, Grafton, Golden Girls,	Residential
GJR, Sam House, Juvenile Center of Wheeling, Burlington, Arkansas placement. Therapy at house.	Residential
Greenbriar, Beckley.	Residential
Group homes, shelter, mental hospitals. Robert C. Byrd	Residential
Gulf Coast treatment center.	Residential
Harbor point, academy programs, placements and detention.	Residential
Highland Hospital; River park; Alabama Clinical Schools; Elkins Mountain School	Residential
Highland hospital (long term and short term), board of childcare, Samaritan house. Detention. Foster care.	Residential
Highland, Crittenton	Residential
I don't know honestly.	Don't know
I don't really know	Don't know
I went to River Park	Residential
Kids peace, foundations for living, Hovan Hall, Highland, Burlington United Methodist; what I did in them, some of them I self-harmed and some of them I ran from	Residential
Medicated treatment	Medication
New Horizons, River Park, Highland, Youth Services	Residential
New River Ranch, therapy, doctor for ADHD and anxiety, individual therapy, equine therapy	Residential

One for mental health, one for sexual behavior.	
Placement	Residential
Rehab services. Academy programs group home placement with therapy, family therapy. Medication for depression.	Medication
Residential mental health treatment and detention centers. Drug Court	Residential
Residential services.	Residential
Residential.	Residential
Riverpark, Highland, Chestnut Ridge, Gulf Coast. Therapy.	Residential
Safe at home, different therapy services in office setting.	Wraparound
Safe at home, placements, CSED.	Residential
Sandy Pines, River Park, Chestnut Ridge, Highland.	Residential
Saw a doctor and therapist in WV for ADHD. Various placements	Counseling
Talked to therapist in school about finding ways to stay out of trouble.	Counseling
Therapy and group therapy	Counseling
Therapy at BCC. Multiple placements.	Residential
Therapy at turning point	Counseling
Therapy, Riverpark, Highland.	Counseling
West Virginia DHHR	State intervention
Westbrook for therapy was offered. School therapy.	Counseling
Worker connects to foster homes and placements, therapy services	Counseling
YRC, JDC, therapy	Counseling
YSC	Residential
being at placement;	Residential
chestnut ridge, mountain youth academy, Daniels Group Home, Highland, Safe at Home,	Residential
counseling	Counseling
counseling,	Counseling
counseling, job training, highland hospital, RiverPark hospital	Counseling
counseling, medication, psych eval	Counseling
counseling, moving into other homes, mental hospital, family therapy with mother, sexual behavior services.	Counseling
counseling, psychiatrist to check on meds	Counseling

counseling/therapy	Counseling
detention; Elkins Mountain School; Highland;	Residential
evaluations for diagnoses, therapy,	Therapy
foster care,	Foster care
foster home, therapy	Foster care
group and individual therapy	Counseling
group and medication	Medication
group; placements;	Residential
groups; medication; talking with therapist	Medication
highland Clarksburg	Residential
highland hospital, Barboursville school, river park hospital board of childcare	Residential
lots of residential placements with both group and individual therapy.	Residential
mental hospital, Newport News, placement, foster care,	Foster care
people coming to your house and seeing and talking to you	Counseling
psychiatrist, therapy,	Counseling
residential services - Elkins Mtn Oakridge, Yale Academy, Safe-at-home	Residential
residential,	Residential
residentials, chestnut ridge, Beaumont pines, highlands, mental facilities	Residential
river park hospital, therapist, ADHD meds and sleep problems	Residential
RiverPark hospital; highland hospital; Springbrook;	Residential
safe at home	Wraparound
screaming and hurting myself	
Seneca - counseling	Residential
Teays valley, therapy,	Residential
therapy	Counseling
therapy and medicine	Counseling
therapy and psychiatrists	Counseling
therapy in a lot of different areas since being in state's custody	Counseling
therapy,	Counseling
therapy, group therapy,	Counseling
therapy, group therapy, school, foster care, getting involved in sports.	Counseling

therapy, impulse-control education	Counseling
therapy, medicine	Counseling
therapy, mental hospitals, detentions,	Counseling
therapy, progressive muscle relaxation, meditation	Counseling
therapy, residential treatment,	Counseling
therapy, treatment for health issues, planning for the future with others	Counseling
therapy, yrs., referred to a therapy type place but did not go	Counseling
timber ridge in Virginia	Residential
treatment facility or services; youth services; child protective services;	Residential

Table 8-13: Includes the Write-Ins and Reclassification for "Other Mental or Behavioral Health Services Youth Received in the Past 12 Months" (Survey Items Label C2_text).

Original responses	Re-classification
Board of childcare	Board of childcare
Detention Center	Detention center
Elkins Mtn School	Residential
Harbor Point behavioral health - says they were abusive with restraints. That he had to go to the hospital after one because he couldn't breathe.	Residential
Highlands Hospital	Residential
Probation - call in regularly, be good, go to school and get good grades	Probation
Residential facility in Tennessee. Hermitage Hall.	Residential
Safe at Home, CSED	Wraparound
Shelter - Gustke	Shelter
Trying to find a group home for me in West Virginia	Group home
Waiting for placement in another facility in WV.	Residential
goodwill job training and life skills classes	Employment support
highland hospital	Residential
Jurisdiction	Jurisdiction
outpatient therapy	Outpatient
psych eval, psychiatrist/meds, therapy/counseling	Psychiatrist
psychiatric care including meds although he is not currently on meds.	Psychiatrist
psychiatrist	Psychiatrist
psychiatrists and therapy	Psychiatrist
re-education placements, crisis shelters	Psychiatrist
received medication/psychiatrist	Psychiatrist
taking medicine, therapy	Medication
the mental hospital, helped with coping skills and mental issues. helped get rehabilitated back into your family.	Residential

therapy while in detention (Name of Provider)	Therapy
therapy, supportive counseling,	Therapy
was in Highland before this placement	Residential
yrs.	NA
years in jurisdiction	NA

8.3.4 Scale Development and Validation

Several scales were created based on items in the Youth Survey. The majority of these items were adapted from the Youth Services Survey (YSS). To explore the underlying structures and validate each scale, exploratory factor analysis was performed. Items in each scale were also analyzed for internal consistency (Cronbach's alpha coefficient) to determine the stability of each scale. Based on the Youth Survey, three scales were developed: Child Functioning, Access and Satisfaction, and Treatment Engagement and Respect.

The Child Functioning scale includes six items (c8_a, c8_b, c8_c, c8_d, c8_e, c8_f). These Likert-type scale items included 5 response options that ranged from “Strongly Disagree” to “Strongly Agree” and measured youth’s perception of their functioning in daily life. To perform exploratory factor analysis, all six items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don’t know/does not apply was recoded as N/A). PCA with varimax rotation was conducted to determine the components in the scale. KMO measure was .699, indicating adequate sample size for factor analysis. Bartlett’s Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was acceptable as measured by Cronbach’s alpha coefficient ($\alpha = .717$).

Table 8-14: Youth -Child Functioning Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor 1 Loading	Factor 2 Loading
C8_a *	I am better at handling daily life.	7.56	
C8_c *	I get along better with friends and other people.	7.51	
C8_d *	I am doing better in school and/or at work.	6.54	
C8_e *	I am better able to handle it when things go wrong.	5.94	
C8_f *	I am satisfied with my family life right now.		.859
C8_b *	I get along better with family members.		.848
Note: * Indicating items adapted from the Youth Services Survey (YSS).			

To create the Child Functioning Scale, the recoded items were combined (minimum score = 0, maximum score = 24). Caregiver scores were assigned into three categories as follows: low (0-8), moderate (9-16) and high (17-24).

The Access and Satisfaction Scale includes five items (c3_a, c3_b, c3_c, c3_d, c3_e). These Likert-type scale items included 5 response options that ranged from “Strongly Disagree” to “Strongly Agree” and measured youth's perceptions of initiating and accessing mental health services. To perform exploratory factor analysis, all five items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don’t know was recoded as N/A). A PCA with varimax rotation was conducted to determine the components in the scale. The KMO measure was .850, indicating adequate sample size for factor analysis. Bartlett’s Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was good as measured by Cronbach’s alpha coefficient ($\alpha = .840$).

Table 8-15: Youth-Access and Satisfaction Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor Loading
C3_c	The behavioral or mental health services I needed were available at times that worked for me.	.838
C3_a	I was able to get the behavioral or mental health services without having to wait too long.	.826
C3_b *	The locations of behavioral or mental health services were easy to get to for me.	.774
C3_e *	I was satisfied with my experiences getting behavioral or mental health help.	.738
C3_d	I was able to meet with the behavioral or mental health professional I needed using telehealth.	.725
Note: * Indicating items adapted from the Youth Services Survey (YSS).		

To create the Access and Satisfaction Scale, the recoded items were combined (minimum score = 0, maximum score = 20). Caregiver scores were assigned into three categories as follows: low (0-6), moderate (7-13) and high (14-20).

The Engagement and Respect scale includes seven items (c5_a, c5_b, c5_c, c5_d, c5_e, c5_g). These Likert-type scale items included 5 response options that ranged from “Strongly Disagree” to “Strongly Agree” and measured youth's perceptions of culturally sensitive practices. To perform exploratory factor analysis, all seven items were recoded (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree to 0, 1, 2, 3 & 4 respectively; I don’t know was recoded as N/A). PCA with varimax rotation was conducted to determine the components in the scale. The KMO measure was .855, indicating adequate sample size for factor analysis. Bartlett’s Test of Sphericity was significant, $p < .001$, indicating factor analysis is appropriate. Small coefficients (absolute value below .45) were suppressed. The internal consistency of the scale was good as measured by Cronbach’s alpha coefficient ($\alpha = .875$).

Table 8-16: Youth - Engagement and Respect in Treatment Scale Factor Analysis Result

Survey Item Label	Survey Items	Factor Loading
C5_e *	Staff respected my family's religious/spiritual beliefs.	.833
C5_f *	Staff respected my religious/spiritual beliefs.	.828
C5_b	I felt that I had someone to talk to when I was troubled.	.823
C5_c *	Staff treated me with respect.	.749
C5_a	The people helping me stood by me during hard times.	.734
C5_g	Staff were thoughtful of my race, cultural, and ethnic background.	.724
C5_d *	Staff spoke with me in a way that I understood.	.622
Note: * Indicating items adapted from the Youth Services Survey (YSS).		

To create the Engagement and Respect Scale, the recoded items were combined (minimum score = 0, maximum score = 28). Caregiver scores were assigned into three categories as follows: low (0-9), moderate (10-19) and high (20-28).

8.4 Limitations

There were several limitations to the methods and analytics that are worth noting, which are listed below. We also enumerated below the mitigating measures to minimize the impact of the limitations to the study. Although the overall completion rates for the Caregiver Survey (30.9%) and Youth Survey (47.9%) were acceptable according to standard conventions[11], youth ages 12 to 17 and older and youth who were not wards of the state were underrepresented compared to their share of the youth population residing in mental health treatment facilities in WV. The obstacles related to this issue were mainly contacting and obtaining consent from caregivers of youth who were not wards of the State. Additionally, respondents who identified as female and those over the age of 18 were less likely to respond to survey compared to other youths. Given the limited demographic information available for non-responding youth, especially Wards of the State, there could be other factors potentially related to survey nonresponse that were not able to be measured in this analysis. Overall, these results indicate a potential risk of nonresponse biases, in particular when analyzing survey outcomes related to characteristics of the youth. The analysis has accounted for the potential risk of nonresponse biases by analyzing outcomes by caregiver status (i.e., those who were/not wards of State). The response rate could also potentially impact the validity of the scales created in analysis. Factor analysis could be re-run in the future with a larger and more representative sample to further validate the scales.

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[11] Baruch Y, Holtom BC. Survey response rate levels and trends in organizational research. *Human Relations*. 2008; 61(8), 1139-1160.

The second limitation of the report is that regional trends could not be analyzed for youth. The small numbers of survey respondents in some of the BBH regions prevent us from analyzing regional variations in the survey outcomes. Instead of analysis by region, we analyzed outcomes by caregiver status.

There are also several known limitations to survey data collection. One potential limitation is selection bias, which occurs when the respondents who are invited to participate systematically differ from the population of interest, thereby leading to systematic errors in outcomes and related interpretations of the data. To mitigate selection bias, the Caregiver Survey and Youth Survey sample was derived from a full list of youth (the survey population) residing in mental health facilities in WV provided by WV DHHR as of October 1, 2021.

Recall bias is another known limitation of survey data, such that participants might not accurately remember certain details or experiences, which could result in inadvertent omissions of information or other differences in the accuracy of their survey responses. One way that recall bias might be introduced is through the wording of survey items and response options. To help reduce recall bias associated with the survey language, subject matter experts from the state, WVU, and several consulting firms assisted with survey development and refinement. The robust, mixed methods approach utilized by this evaluation also helped mitigate recall bias. Qualitative approaches such as interviews and focus groups allowed for in-depth discussions to ensure respondents could elaborate on their experiences with the children’s mental health system. For example, interviews were conducted with Youth Survey respondents to follow up and gain greater insights into their perspectives, thereby reducing the likelihood of recall bias by allowing comparisons of youth responses across data collection methods. By using multiple methods and triangulating the data, this evaluation was able to highlight and synthesize with confidence the areas in which stakeholders’ perceptions converged as well as areas where they did not.

9 Appendix D: Caregiver Survey Table Index

The following index lists data tables that can be found in accompanying file, WVU_Evaluation_CaregiverSurvey_DataTables.

9.1 Demographic and Awareness Tab

Table 1: Caregiver's Youth Residential History in RMHTF, statewide and by region

Table 2: Caregiver Demographic Characteristics, statewide and by region

Table 3: Caregiver's awareness of mental and behavioral health services

Table 4: Caregiver Evaluation Service Awareness, Participation and Waitlists, statewide and by region

Table 5: Frequency and Description of Other Mental Health Services Received

Table 6: Other services has received or is waiting to receive

9.2 Crisis Support and Access

Table 1: Caregiver needs for crisis stabilization

Table 2: Caregiver agreement regarding received behavioral or mental health services

Table 3: Caregiver understanding of how to access behavioral or mental health services

Table 4: Caregiver perceived future youth mental health service needs

9.3 Experiences with Mental Health Services

Table 1: Caregiver experiences with mental and behavioral health services

Table 2: Caregiver experiences with staff when receiving mental and behavioral health services

Table 3: Caregiver experiences with Assertive Community Treatment services

Table 4: Caregiver experiences with Positive Behavior Support services

Table 5: Caregiver experiences with RMHTF services

Table 6: Caregiver experiences with Children's Mental Health Wraparound services

9.4 Starting Service Barriers

Table 1: Caregiver challenges with receiving child services before child started receiving care

Table 2: Wait times for child to start mental or behavioral health program after program was chosen

Table 3: Caregivers biggest challenge to starting mental and behavioral health services

Table 4: Caregivers “other” challenges to starting mental and behavioral health services

9.5 Continuing Service Barriers

Table 1: Caregiver challenges with continuing child services after child started receiving care

Table 2: Wait times for child to start mental or behavioral health program after program was chosen, statewide and by region

Table 3: Caregivers biggest challenge to continuing mental and behavioral health services

Table 4: Caregivers “other” challenges to continuing mental and behavioral health services

Table 5: Caregiver needed supports that were not available

9.6 Outcomes of Mental Health Services

Table 1: Caregiver perceived child outcomes of receiving mental and behavioral health services

Table 2: Caregiver perceived family outcomes from child receiving mental and behavioral health services

9.7 Future Service Needs

Table 1: Caregiver perceived future youth mental health service needs

9.8 Law Enforcement

Table 1: Caregiver reports of child law enforcement experiences for the past 12 months

Table 2: Caregiver reports of child school experiences for the past 12 months, statewide and by region

10 Appendix E: Youth Survey Table Index

The following index lists data tables that can be found in accompanying file, WVU_Evaluation_YouthSurvey_DataTables.

10.1 Demographics and Services Awareness Tab

Table 1: Youth Demographics, statewide and by status of ward

Table 2: Youth awareness of mental and behavioral health services

Table 3: Youth Evaluation Service Awareness, Participation and Waitlists

Table 4: Frequency and Description of Other Mental Health Services Received

10.2 Experiences with Mental Health Tab

Table 1: Youth experiences with mental and behavioral health services

Table 2: Youth experiences with mental and behavioral health treatment engagement

Table 3: Youth experiences with support and respect

Table 4: Youth experiences with care and discharge planning

Table 5: Youth experiences with seeking help to receive mental or behavioral health care

10.3 Health & Behavior Outcomes Tab

Table 1: Youth perceptions of health outcomes

Table 2: Youth reports of law enforcement interactions for the past 12 months

Table 3: Youth reports of school experiences for the past 12 months

10.4 Starting Service Barriers Tab

Table 1: Youth perspectives on challenges with receiving services before starting care

Table 2: Wait times for child to start mental or behavioral health program after program was chosen

Table 3: Youth's perceived biggest challenge to starting mental and behavioral health services

10.5 Continuing Service Barriers Tab

Table 1: Youth perspectives on challenges with continuing services after starting care

Table 2: Youth's perceived biggest challenge to continuing mental and behavioral health services

Table 3: Youth needed supports that were not available

10.6 Future Service Needs Tab

Table 1: Youth perceived future mental health service needs

11 Appendix F: Qualitative Data Collection Methods

11.1 Overview of Qualitative Data Collection Methods

WVU OHA used semi-structured interviews to collect qualitative data at the Youth/Caregiver level. One-on-one interviews allow for an in-depth exploration of an individual's unique experiences.

Table 11-1: Overview of Qualitative Data Collection

Data Source	Data Collection Method	Participant Type	Baseline Data Collection	Number of Interviews
Caregiver Interviews	Interviews	Caregivers with youth currently/recently in RMHTFs	Spring 2022	12
Case Series Interviews	Interviews (Paired)	Paired caregivers and youth currently/recently in RMHTFs	Spring 2022	19 (total) 9 paired caregivers and youth 1 youth interview

Data were collected from 1) caregivers who completed the Caregiver Survey and 2) youth and their caregivers participating in in the case series study. The longitudinal case series design will eventually provide insights about changes in youths' and caregivers' experiences over time; however, cross-sectional data from youth and caregiver pairs are included in this report to provide in-depth baseline data about their experiences with residential treatment. Separate interview guides were developed for each data source based on the corresponding evaluation questions identified in the WV DOJ DHHR Children's In-Home and Community-Based Services Improvement Project Evaluation Plan (April 8, 2021). Semi-structured interview guides were drafted by the Principal Investigators and included four to six core questions with probes to be explored by interviewers. Feedback on the interview guides was solicited from WVU Subject Matter Experts and incorporated into the interview guide by WVU OHA. Corresponding note-taking forms that mirrored the interview guides were developed for each data source. All personnel involved in data collection and analysis received training in qualitative interviewing. Data collection began in February 2022 and ended in May 2022. This phase of data collection only sampled youth currently in RMHTFs. The WVU OHA team used purposive sampling throughout to identify participants that are particularly knowledgeable about the phenomenon of interest. Recruitment strategies included direct outreach to participants and survey recruitment. Caregivers were recruited to participate in follow-up interview by indicating their interest to be contacted at the end of the Caregiver Survey. Caregivers who completed the Caregiver Survey and were interested in participating in an interview and were not part of a dyad in the case series study were asked to participate in a standalone caregiver interview.

All interviews were conducted using HIPAA-compliant Zoom accounts. Each session included one facilitator, one note-taker, and on some occasions, one staff member to provide Zoom technology support. For interviews with youth, occasionally an RMHTF staff member was present. Informed consent was obtained by presenting each participant with information about the Evaluation project, 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 Zoom with participants' consent to be recorded. To show appreciation for their participation, participants received a thank you note and were offered a $25 Visa gift card.

11.2 Caregiver Interviews

Caregiver interviews were conducted to obtain a rich understanding of caregivers' awareness of mental health resources and DHHR programs within and across WV regions and to obtain insights into their perceptions of barriers and facilitators to receiving care, quality of services received, and satisfaction with mental health services. Interview questions focused on 1) awareness of and access to mental health services, 2) caregiver involvement in treatment, 3) youth and family changes since initiation of services, 4) satisfaction and concerns. Each interview question was further tailored and specified for two distinct groups in each of the six BBH regions: 1) caregivers with youth in RMHTFs, and 2) caregivers with youth at-risk of placement in RMHTFs. This report only includes data collected from caregivers with youth in RMHTFs. Interviews with caregivers with youth at-risk of placement in RMHTFs are being planned for fall 2022. Interviews conducted in Year 3 will include questions to assess change in experiences with child mental health services over time. In the Caregiver Survey, individuals who expressed interest in participating were contacted initially by phone and subsequently by email. In total, 12 caregivers with youth in RMHTFs participated in the Caregiver Interviews. Participants were purposively selected to achieve representations of six BBH regions. Each of the six BBH regions was represented by at least one participant. Interviews ranged from 30 to 60 minutes.

Table 11-2: Caregiver Interview Demographics

		Percent*
Sex at birth	Male	1 (8%)
	Female	11 (92%)
Sex identification	Male	1 (8%)
	Female	11 (92%)
Race	White	12 (100%)
	Black	1 (8%)
	Other	0 (0%)
	Identified more than one race	1 (8%)
Hispanic, Latino or Spanish origin	Yes	0 (0%)
	No	12 (100%)

Type of Employment	Wages	4 (33%)
	Self-employed	1 (8%)
	Out of work for 1 year or more	1 (8%)
	Out of work for less than 1 year	0 (0%)
	A homemaker	2 (17%)
	A student	1 (8%)
	Retired	2 (17%)
	Unable to work	1 (8%)
	Refused	2 (17%)
Employment history	Education	1 (8%)
	Hospitality or service	0 (0%)
	Healthcare	0 (0%)
	Manufacturing, Mining or Construction	0 (0%)
	Retail	0 (0%)
	Banking, finance, accounting, real estate or insurance	1 (8%)
	Transportation	0 (0%)
	Government, public administration or military	0 (0%)
	Information/technology	0 (0%)
	Other	2 (17%)
	Not currently employed	0 (0%)
	Refused	0 (0%)
*Denominator is the total number of caregivers interviewed (n=12)		

11.3 Case Series Interviews

A longitudinal case series study is being conducted to gain an in-depth understanding of youth and caregivers' experiences with child mental health services over time. This mixed-methods design allows the team to obtain diverse perspectives as well as explore any program-specific changes over time from different data sources, including Medicaid claims data, surveys, and interviews. Each youth-caregiver pair, once identified, was invited to participate in a separate one-on-one interview and then will be asked to participate in a follow-up interview every six months for the duration of the project. Interview questions for participants enrolled in the case series focused on 1) awareness of and access to mental health services, 2) service experiences, 3) involvement in treatment, 4) youth and family changes since services, and 5) satisfaction and concerns with services. Separate interview guides were developed for caregivers and youth. Each question was further tailored for two distinct groups: 1) youth in RMHTFs matched with their caregivers, and 2) youth utilizing community-based mental health services matched with their caregivers who are at-risk for residential placement This report only includes data collected from youth in RMHTFs and their caregivers. Interview with youth utilizing community-based mental health services and their caregivers is in the planning phase and will be conducted in Fall 2022. Caregivers participating in the standalone caregiver interviews will not be eligible for participation in the case series study.

WVU OHA aimed to enroll a diverse sample in terms of youth demographics, length of stay in residential treatment, and facility location for the case series study. Thus, the sampling plan included targeted recruitment of 10 youth from the following categories: youth who are Wards of the State (n=1), minority youth (n=2), youth from each Centers of Medicare and Medicaid Services region (n=6), and youth who were placed out of state for residential treatment (n=1). Contact information from youth who completed the Youth Surveys who fell into one of these categories was randomly sorted and their corresponding caregiver was contacted by WVU OHA staff to obtain informed consent to participate in the case series study. WVU OHA staff first obtained caregiver consent to participate in a series of interviews as part of the case series study and asked for consent for their youth to be contacted to participate as well. After caregiver consent was obtained, the RMHTF housing the youth was contacted via telephone to schedule the youth interview, after obtaining the youth's assent. Only pairs of caregivers and youths with complete survey data and who consented to be a part of longitudinal case series study were invited to participate in interviews. Caregivers and youth were interviewed separately. In total, nine pairs of caregivers and youth were identified and interviewed. In order to gain the perspectives of a youth who was a Ward of the State, a tenth youth participant was interviewed and there is no corresponding caregiver interview data for this participant. Interviews ranged from 15 to 60 minutes.

Table 11-3: Case Series Participant Demographics

		Youth	Caregiver
Sex at birth	Female	4 (44%)	7 (78%)
	Male	5 (56%)	2 (22%)
Sex identification	Female	3 (33%)	7 (78%)
	Male	6 (67%)	2 (22%)
Age	12-14	4 (44%)	-
	15-17	5 (56%)	-
Race	White	4 (44%)	8 (89%)
	Black	0 (0%)	1 (11%)

	Native American	0 (0%)	0 (0%)
	Identified more than one race	5 (56%)	0 (0%)
Hispanic, Latino or Spanish origin	Yes	2 (22%)	0 (0%)
	No	5 (56%)	9 (100%)
	I don’t know	2 (22%)	0 (0%)
Caregiver-youth relationship	Biological parents	2 (22%)	
	Biological grandparents	5 (56%)	
	Adoptive parent	2 (22%)	
	Group home/awaiting foster care	1 (11%)	
Notes: - represents missing.			

12 Appendix G: Qualitative Data Analytic Methods

12.1 Analytic Methods

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. Identifying information (i.e., participants' full name) was removed following established methods for de-identification of protected health information in accordance with HIPPA privacy rules. Transcripts were grouped based on data source for analysis.

The WVU OHA team used conventional content analysis to analyze all interview data. 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.[12]. 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. If any revisions to the codebook were identified after round one, those revisions were made, and the transcripts were re-coded. The WVU OHA team produced an ATLAS.ti data report that contained all quotes that were assigned to each code. Coders worked independently to 1) read all data for each code, 2) synthesize and clean the quotes, and 3) develop high-level summaries paired with illustrative quotes for each code. Coders then inserted the code summaries and relevant quotes into a data matrix that contained evaluation questions and outcome indicators. Qualitative findings from interviews with youth and caregivers (e.g., categories, themes, quotes, and code descriptions) were integrated with quantitative results when appropriate.

Standalone caregiver interviews were analyzed via the content analysis process described above; however, three additional analytic steps were undertaken with the caregiver and youth interviews that are part of the longitudinal case series study. After the first round of conventional content analysis was complete, a case profile was created for each caregiver-youth pair in the case series. These case profiles contain a narrative summary of key themes that emerged from individual interviews with youth and their caregivers, as well as a dyadic (paired) profile summarizing varied perceptions and relationship between the caregiver-youth pair. The case profiles provide a cross-sectional baseline from which to develop a unique narrative over time, tracing patterns and changes in relationships and experiences that will connect to outcomes across participants.[13] A condensed version of the case profiles for each caregiver-youth pair is presented in Appendix H. To facilitate longitudinal data analysis, these baseline data will be used to develop cross-case data matrices that will include data from multiple qualitative (caregiver and

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[12] Hsieh H, Shannon E. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005; 15(9), 1277-1288.

[13] Vogl S, Zartler U, Schmidt E & Rieder I. Developing an analytical framework for multiple perspectives, qualitative long longitudinal interviews (MPQLI). *International Journal of Social Research Methodology*. 2018; 21(2), 177-190.

youth interviews) and quantitative sources (caregiver and youth surveys), Epi info and WV Medicaid data (CANS/CAFAS scores).

Trustworthiness is widely used as the criteria for evaluating qualitative research. The WVU OHA team has worked to ensure that the four constructs of trustworthiness outlined by Lincoln and Guba [14](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 was used to ensure credibility, including 1) data triangulation (i.e., including data from multiple sources using different methods), 2) reflective memoing (i.e., taking details notes during all stages of the data collection and analysis process), 3) frequent debriefing (i.e., in-depth discussions about the emerging findings and analysis process), and 4) review of all interview guides by SMEs to promote confidence in the qualitative evaluation design and findings. *Transferability* is the extent to which the findings can be transferred to similar situations. The WVU OHA team 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 that might like to conduct similar work. This detailed information about the research design, data collection, analytical process also aids in the *Dependability* of findings. Finally, *Confirmability* refers to the degree to which the research findings can be confirmed by others. During data analysis, each transcript was coded by at least two coders independently and in-depth debriefing sessions facilitated intercoder agreement and reliability. In addition, an audit trail was established to document the changes made during evaluation, lessons learned, and limitations.

12.2 Qualitative Method Limitations

There are several limitations related to the qualitative findings in the report. The overall sample size was robust, especially for a qualitative study. Participants for both the standalone caregiver interviews and interviews with youth and caregivers as part of the case series study were recruited from the Caregiver Survey, which included a total of 108 individuals based on survey competition. Survey nonresponse directly impacted the sampling for qualitative data collection. While data were saturated for key findings across evaluation questions, data were not analyzed to explore BBH regional differences due to the limited sample size.

The WVU OHA team also experienced difficulties recruiting interested participants. Some caregivers did not answer the initial and follow-up contact telephone call. Finding time to meet the complex needs of caregivers for scheduling interviews was also challenging. For example, some potential participants experienced issues with unstable or unreliable computer or cellphone equipment and internet access, limiting their ability to be contacted in a timely manner and participate in interviews. Due to time lags between identifying interested participants and scheduling interviews, some youths were interviewed immediately after discharge from residential treatment facilities and were transitioning back to their homes. Similarly, some caregivers were interviewed as the youth were being discharged. Finally, protocols

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[14] Lincoln Y, Guba, E. *Naturalistic Inquiry*. Thousand Oaks, CA: SAGE; 2017.

for obtaining participant consent and assent for the caregiver-youth pairs (i.e., ensuring caregivers gave permission for youth to participate before approaching youth) created challenges for recruitment. There were instances where the caregiver gave WVU OHA consent to contact their child, but the child did not complete the Youth Survey. This eliminated the pair from participating in the case series.

Across this large-scale evaluation, there were multiple interviewers. Their varying knowledge and skill levels related to both facilitation and topics discussed may have impacted the quality and quantity of data collected. Although confidentiality was assured, some participants may have been hesitant to share their experiences with mental health services, especially negative experiences and challenges. Sometimes a residential facility staff member was present during interviews with youth participants. Their presence, as well as general social desirability bias, could potentially impact the quality of data. Further, some of the language used in the interview guides were not commonly used by caregivers and youth engaged in child mental health service. Caregivers and youth often referred to treatment the youth was engaged in as “placement”, or they used the name of the facility. This contrasted with language used in the interview guides that asked about experiences with “residential treatment” and “facilities.” These discrepancies in phrasing may have caused confusion during the interview process. In the future, the interview guides will incorporate language more familiar to caregivers and youth.

Data were analyzed by a large team of coders, which has strengths but also limitations. Specifically, with more analysts, there is the potential to lose some reliability in the qualitative findings. However, intense and frequent debriefing sessions between coders across all analysis teams aid in establishing acceptable reliability. This method is recommended over other methods, such as intercoder agreement, when there are substantial amounts of data to analyze. ATLAS.ti computer software was used to facilitate all aspects of data management, organization, and coding. There are strengths and weaknesses to using qualitative data analysis software; while software facilitates the ability to manage a large volume of data, analysts sometimes focus more on breadth than depth and meaning. To aid in analysis, the WVU OHA team used a data analysis worksheet to record key findings. Data analysis worksheets can provide structure and consistency across large coding teams but can also create restrictions on how the data are integrated. Care needs to be taken to ensure that important pieces of data do not become de-contextualized with software and worksheet use, leading researchers to miss the essence of meanings in data.

13 Appendix H: Qualitative Findings: Case Series Profiles

13.1 Overview

The case series is a longitudinal study that aims to gain an in-depth understanding of individual and family experiences with children's mental health services in WV over time. The Residential Case Series Profiles summarize qualitative data collected at baseline from in-depth interviews with youth and their caregivers involved in the case series (n = 19 total participants). Each of the ten Profiles includes a narrative summary of key themes emerging from interviews with individual youth (n = 10) and their caregiver (n = 9), as well as a synthesis of interview perceptions and dynamics in youth-caregiver pairs (n = 9). Specific information included from interviews includes caregiver and youth reports of: types of services and programs received, engagement in treatment, changes to functioning during residential treatment, and satisfaction with services. These profiles form the cross-sectional baseline from which to trace patterns and change in experiences, perceptions, and outcomes of case series participants over time. A new profile will be created and analyzed within and across prior profiles for each individual and pair every six months for Phase 3 and throughout the duration of the Evaluation period.

13.2 Residential Case Series Profiles

13.2.1 Residential Youth Pair 1

Residential Youth 1

Youth 1 currently resides in a WV group home setting through Burlington United Methodist Family Services. She reports a history of anger and depression and has been in and out of four foster care homes and had four hospitalizations at Highland Charleston. Youth 1 is currently awaiting a new foster care placement and hasn't had any contact with her biological parents or family "in forever" because they "lost rights" to her. Youth 1 reports positive behavior changes and reduced feelings of "sadness and depression." She notes that during her previous placement at Highland Charleston, she received help with routines and engaging in extracurricular activities such as sports and basketball. She seems engaged, accepting, and satisfied with her current treatment and the services and programming offered at Burlington. She shares, "I'm getting help from the staff with my anger and my aggression. . . I'm getting help with, you know, throwing tantrums and stuff—I'm getting help with a lot of stuff here." When asked what she likes about her treatment, she states that she likes getting to talk about her treatment goals and her discharge plan to "get a foster home and stay there. I don't want to come back to a placement or here." She notes that she is going to try to be "kind" to the next foster family. Since entering treatment, Youth 1 reports that friendships have stayed about the same and that school has "been going good," and she has been "doing good with my grades." She would like to continue working with a therapist following discharge from Burlington. Youth 1 could not identify a trusted adult in her life right now, except for a previous DHHR case worker; however, she could not remember the DHHR worker's name.

Residential Caregiver 1

Youth 1 is a Ward of the State, thus there is no corresponding caregiver data.

Residential Youth-Caregiver Pair 1

**See Residential Youth 1 summary*

13.2.2 Residential Youth-Caregiver Pair 2

Residential Youth 2

Youth 2 is currently in out-of-state placement at Hermitage Hall RMHTF. He reports placement in seven foster care homes after both his biological parent and grandparent lost custody. He has also received services at Highland Hospital and Children's Home of Wheeling, along with two prior hospitalizations at River Park. Since entering treatment, Youth 2 reports improved grades and school experiences but shares that the school in his placement is "difficult" because of ongoing social issues. He reports no physical changes. Youth 2 expresses engagement in and desire for current treatment stating, "I'm glad I'm getting to work on my sexual behavior. But I would also like for me to be able to work on my PTSD and my anger issues." He expresses wanting more engagement in court proceedings as well. He reports that Caregiver 2 is involved in treatment "in every way and every day" and is aware of the distance that impedes her visits. When asked about future services desired following treatment, Youth 2 seems indecisive, stating, "PTSD treatment, definitely, and anger issues. . . Well actually no, because I feel like after this it should be enough because I've been through so much." Youth 2 reports overall "medium" satisfaction and variable experiences with prior placements and services received, including one where he did not receive any treatment as he waited for availability at Hermitage Hall. He describes his experience at Highland as "helpful" and "refreshing because I got to be social with everybody. . . so I made friends," and he was able to discuss his PTSD and problems with them. He also reports that Children's Home of Wheeling was "really a good placement."

Residential Caregiver 2

Caregiver 2 is the biological grandmother and adopted mother of Youth 2. She reports gaining custody of him and his two siblings several years ago following their Child Protective Services (CPS) removal from her daughter's home. She shares, "He was in foster care for two years before I got him. . . And I was foster family number seven." Caregiver reports that Youth 2 has a history of violent episodes, legal charges, threats of self-harm, and stays in emergency shelters and has received counseling through DHHR for experiences of abuse. He has had two prior hospitalizations at River Park RMHTF, for reportedly attacking his foster parents and a staff member, respectively. Caregiver reports his current out-of-state treatment is for sexually inappropriate behavior, sharing, "Where he was before I got him, he was sexually abused [and experienced] abandonment, physical abuse, emotional abuse, you know the whole gamut before I got into the picture." Caregiver 2 reports that she is "not at all" satisfied with services received in WV and describes a lack of intensive, in-state treatment services for younger youth with sexual abuse history and behavior. She states:

> *The therapies he was getting, nobody addressed the sexual component, and now he's 18 and he's on the edge of becoming a predator. . . . When you see a child, you know—whatever age—is sexually acting out, it needs to be addressed as soon as possible and not wait until they're on that tipping point of becoming an offender. . . it's sad that WV doesn't have that for younger children. . . . River Park has a program called Roundtable, but you have to be 13 to get into that and that's for sexual offenders so there's nothing for younger kids.*

Caregiver 2 conveys great efforts to engage in treatment while Youth 2 has been in and out of her care but reports that services, support, and communication received through WV DHHR and treatment facilities have been insufficient. Caregiver 2 states, "I had to contact that [DHHR] worker and introduce myself, my phone number, you know all that; and that's happened every time it's been changed, I've not been informed [of the change] until I got the paperwork from whatever facility that he was in." Caregiver 2 reports that she didn't receive a warning of discharge from prior River Park placements. When asked about discharge and reintegration support received from the facility, Caregiver 2 states, "It's hard to say because it's not like they were concerned about getting him integrated, they were more concerned about getting him out, which I can understand." Thus far, communication with Youth 2's current out-of-state placement has been better than with prior treatment facilities. Caregiver 2 participates in weekly family therapy via Zoom because the long drive (6 – 7 hours) impedes in-person visitation. She is very concerned with Youth 2's trajectory when he leaves residential treatment and receives only community-based services. She does not believe he will get the same level of therapy in WV that he is currently receiving in his out-of-state placement unless he is engaged in intensive programs such as the Residential Roundtable program for sexual offenders.

Residential Youth-Caregiver Pair 2

Youth 2 is currently in an out-of-state RMHTF, reportedly for treatment of aggressive and sexually inappropriate behavior. He experienced sexual, physical, and emotional abuse at a young age. He has a history of seven foster care placements, community-based counseling and treatment, legal charges, threats of self-harm and two prior hospitalizations at River Park RMHTF for violent behavior. Both Youth 2 and Caregiver 2 report engaging in virtual weekly family therapy, as distance prevents in-person visitation. Youth 2 is moderately satisfied with treatment and services received and reports improved grades and school experiences despite ongoing social issues. Caregiver 2 seems engaged in all aspects of treatment but notes a significant lack of intensive services for younger youth in WV with a history of sexual abuse and inappropriate sexual behavior. She reports that the services, support, and communication received throughout WV, in DHHR and RMHTFs, have been insufficient, but communication with Youth 2's current out-of-state placement has been better. Caregiver 2 is concerned with Youth 2's trajectory and feels that he needs intensive services now and following discharge to avoid serious, life-altering consequences. Youth 2 is noncommittal to services following discharge but seems engaged with current treatment and would like more focus on his Post Traumatic Stress Disorder (PTSD) and anger issues.

13.2.3 Residential Youth-Caregiver Pair 3

Residential Youth 3

Youth 3 is currently in in-state placement at Yale Academy RMHTF, following assault, burglary, and battery charges as well as probation. She reports positive engagement and satisfaction in services offered at Yale Academy, stating, “I like therapy. I like going to school. I like the teachers. I like the staff.” She reports improved grades and also enjoys the art classes and extracurricular activities. “I have other things to do. Like, here I can go play basketball and get my mind off stuff like outside of here.” Youth 3 discusses her past behaviors leading to placement and states, “Yeah. I still get a little bit irritated at times, but I can control my anger.” Youth 3 is currently in the custody of her biological grandmother (Caregiver 3) who youth says she is now more honest with. She reports that Caregiver 3 is engaged in her treatment, despite distance. Youth 3 reports that her DHHR worker has difficulty reaching her caregiver by phone but is skeptical, as the caregiver always responds when Youth 3 attempts to contact her. Youth 3 reports prior experiences at Cammack Children’s Center and Grant Gardens RMHTF. Youth 3 shares, “I mean [Grant Gardens] cared, but it wasn’t as structured,” and “the therapy was horrible; the case manager was horrible.” She has also received Safe at Home services in the past but refused to participate. Youth 3 anticipates being on probation upon discharge and seems hopeful and alert, conveying a willingness to continue with services to help her deter past problematic friendships and behaviors so that she can stay at home. She desires, “things like Safe at Home. People coming and checking up. I feel like it’ll be good, but I feel like I will go back to my old ways.” She wants to graduate high school early to go to Academy-Careers and Technology school and study nursing.

Residential Caregiver 3

Caregiver 3 is Youth 3’s biological grandmother. Caregiver 3 received custody from Youth 3’s parents, who both have a history of bipolar disorder. Caregiver 3 reports that Youth 3 has diagnoses of bipolar disorder and oppositional defiant disorder (ODD) and has received therapy and Safe at Home services in the past. Caregiver 3 reports that Youth 3 has a history of violent and threatening behaviors, stealing property, and substance use, with legal assault charges leading to her first placement at Grant Gardens. These behaviors continued after those residential stays, resulting in her current placement at Yale Academy. Youth’s placement is three hours away, and visitation has been difficult for Caregiver 3 due to distance and personal health issues. Caregiver is “proud” of youth for her improvements in school and grades since entering Yale Academy but is concerned with ongoing behavior issues. She speaks at length about the difficulty with getting Youth 3 the services she needed prior to residential placement, sharing, “I had asked them to put her in like a . . . behavior class because she was bipolar plus ODD, and they said they didn’t have that in the school . . . . [Her doctor] thought that she wouldn’t change, and it would get worse.” Then one doctor Youth 3 was seeing “didn’t want to take her anymore” and the other “moved.” Caregiver 3 reported that the services they were able to receive were helpful but ineffective for engaging Youth 3. “[Safe at Home] would come in and talk with her, or if I was having problems I could call, and they would come and try to talk with her. But that’s all they could do was talk. They couldn’t make her stay in the house.” Caregiver 3 reports that communication and engagement with DHHR has also been challenging amid frequent turnover. Caregiver 3 describes exhausting resources along her help-seeking journey, sharing, “I went to the courthouse so many times, I called the police so many times. It’s like pulling teeth trying to get help. And this is the system. This system is, not meaning no harm, messed up.” Caregiver 3 was eventually able to connect with a foster care organization she had previously fostered with and secure a court date that resulted in youth’s current placement. She describes the process:

> *It’s like, I was just a body [in court] with no say... And they [were] the ones that got her in. And she ran out of the court, she ran from them in the court. She ran outside and they had a feeling that*

> *she was going to run so they followed her. [Youth eventually returned home.] And then I reported it, and that's when they sent her away.*

Caregiver 3 reports that youth will be discharged soon. When asked about reintegration planning and future services desired, Caregiver 3 reports having no discussions with Yale Academy, stating, "No. I don't know because I haven't talked to anybody." Caregiver 3 is concerned that youth's destructive behaviors will persist post-treatment as they have in the past. "It's just her behavior. That's the thing. Trying to keep her, you know, away from the girls who do drugs and hang out in the streets."

Residential Youth-Caregiver Pair 3

Caregiver 3 discusses her experiences in help-seeking and her difficulty with communication, support and frequent turnover, namely with DHHR but also RMHTFs. Caregiver 3 shares that she was not able to communicate or engage well with Grant Gardens, due to infrequent facility follow-up, distance, and her health. Youth states that her first experience in Grant Gardens RMHTF was "horrible," with little treatment structure despite the staff being caring. Youth 3 reports high satisfaction and improved grades at Yale Academy, and enjoys therapy, staff, school, and extracurricular activities. She believes her behaviors and relationship with Caregiver 3 are improving. Youth is hopeful that positive changes will continue upon return home with support like Safe at Home checking in; but she feels she will go back to "old ways" and has rejected participation in Safe at Home in the past. Caregiver reiterates positive improvement with school but is also concerned that Youth's destructive behavior will persist upon discharge despite treatment. She cites that Yale Academy did not properly prepare her or youth for home visits and hasn't discussed any discharge and reintegration. Caregiver desires post-treatment services but is hesitant that they will materialize and/or be effective.

13.2.4 Residential Youth-Caregiver Pair 4

Resident Youth 4

Youth 4 is currently in out-of-state placement at Harbor Point RMHTF, with a history of aggressive behaviors and police/legal issues both in the community and during placement. This is his third RMHTF placement, and his aggressive behaviors have led to police encounters, juvenile detention, and a transfer from one RMHTF. Youth 4 has also received individual and family therapy and utilized Children's Mobile Crisis Response and Stabilization, Safe at Home, and Wraparound services in the past. Though he reports that the Harbor Point staff "overall is pretty good" and he's satisfied with his treatment, he would prefer to be at his prior placement at Youth Academy. He liked Academy's level system structure and felt "really close" with a lot of staff, but describes Harbor Point as "unprofessional" and "unorganized" at times. Youth 4 describes improved appetite and "better grades because the teachers are, like, a lot more helpful." However, he reports "more conflicts" with aggressive RMHTF peers, stating, "Because it's just a bunch of. . . aggressive kids put in, put together. . . so fights are going to happen." Though he is initially hesitant when asked about future services, Youth 4 seems optimistic about learning coping and self-management tools to reduce aggression and expresses willingness to make changes upon returning home. He states he is "probably going to go to therapy . . . outside of here" and will "think twice" about spending time with friends he recognizes as problematic to ensure he doesn't return to placement.

Residential Caregiver 4

Caregiver 4 is Youth 4's biological grandparent and cares for his two siblings as well. While COVID-19 limited in-person visitation during youth's prior in-state placement, Caregiver 4 reports being engaged in current treatment and family therapy meetings every two weeks by phone. However, she hasn't been able to visit the out-of-state placement due to distance and expense, sharing:

> *I would have to stay a night at a motel and money is a problem. . . I need gas, I need to stay overnight to get some rest, so that I can make the trip back home. I guess financially I'm not able to visit my son right now.*

Caregiver 4 states that she is not satisfied with services received in WV and discusses mixed experiences. She describes their recent Wraparound worker as "fantastic" and took Youth 4 clothes shopping, found him a tutor, picked him up as needed, and stayed in contact. Caregiver states the Wraparound worker went "really over and beyond the call of duty." Caregiver describes prior use of other community-based services that were less beneficial. She states that Youth 4 is "strong willed" and didn't engage in prior individual and group therapy. Safe at Home came to their house and:

> *offered a lot of opportunities and things that they would do to get the children out. . . They'd always say is there anything you need, anything I can do for you, just let me know. . . Well that never came through, so I just feel like they was [sic] a lot of talk and not no action.*

Caregiver 4 reports that Children's Mobile Crisis Response and Stabilization was non-responsive with multiple attempts, stating, "A lot of times the phone number wasn't working. . . or nobody would answer." This resulted in her calling the police for crisis management services. Caregiver 4 has felt frustrated by out of state placement as well as deficient communication and engagement in treatment. Caregiver 4 states, "I just want to stay involved in all of this therapy and anything they are doing," and adds that the facility is "supposed to. . . call me whenever they change his medicines and stuff, but I've not gotten a phone call yet." She has seen improvements in Youth 4 that she largely attributes to medication and maturity. For example, she notes that Youth 4 now counsels his sibling when they talk by phone, saying:

> *His brother used to be in cahoots with him and getting him into trouble and stuff and decline in his grades, and [Youth 4] will get on the phone with him and tell him he needs to listen, he needs to do the right thing, he needs to study, he needs to get his grades up, he needs to stay out of trouble. [Youth 4] matured a lot.*

Residential Youth-Caregiver Pair 4

Youth 4 reportedly has a history of severe aggression, medication, outpatient therapy, community-based services, and two prior placements at RMHTFs; past behaviors have led to police/legal interactions and transfer from one RMHTF. Pair reports moderate satisfaction with current treatment. Since entering the current RMHTF, Caregiver 4 notes that Youth 4 has experienced improvements but attributes them to medication and maturity. Youth 4 reports improved grades and teacher experiences though continued conflict with aggressive RMHTF peers. He seems optimistic to learn self-management tools and reassess problematic friendships once home to avoid future placement. Caregiver 4 expresses mixed feelings on prior community services received, including unanswered requests with Children's Mobile Crisis Response and Stabilization, undelivered services with Safe at Home, and assistance "over and beyond the call of duty" with Wraparound. Caregiver 4 reports active engagement in Youth 4's residential treatment but has been frustrated with limitations of distance, expense, COVID-19, and a perceived lack of communication by staff. Pair did not report desiring any additional services.

13.2.5 Residential Youth-Caregiver Pair 5

Residential Youth 5

Youth 5 is currently in out-of-state placement at Abraxas RMHTF, following a prior residential placement out of state, two juvenile detention placements, probation, and outpatient therapy. He has been at Abraxas for about eight months and reports seeing a case manager weekly and clinician biweekly. Youth 5 conveys that staff are encouraging and responsive to his needs, stating, “Whenever I need to talk to them, I can talk to them.” He expresses positive changes in sleep, behaviors, attitude, and engagement since entry, as well as improved grades and school experiences. Youth 5 relays that he was initially angry, blaming Caregiver 5 for his placement and refusing to talk to his caregivers for the first several months. Youth 5 reports that his treatment has “put stuff in perspective” on the connections between his behaviors and circumstances. He conveys empathy towards family and people that his actions have impacted and describes putting himself into other people’s shoes “so I don’t create victims.” Youth 5 reports an improved relationship with his family and consistent contact with his good friends outside of placement. He is optimistic about positive changes continuing once he returns home to not “get in trouble with the law again.” Youth 5 shares that he will rely on family support post-treatment. He does not want continued therapy, as it made him “mad” and uncomfortable to discuss the past. He denies receiving any community-based treatment or services prior to residential placement.

**Youth 5 did not recognize the term “residential” when it was initially posed and had to ask for clarification.*

Residential Caregiver 5

Caregiver 5 is Youth 5’s adoptive parent. He reports initially seeking therapy and treatment for Youth 5’s anger issues, but youth was “resistant” and difficult to engage. Caregiver 5 reports that Youth 5 experienced legal trouble thereafter and was court-mandated to participate in an outpatient program but continued to show little engagement. Though youth’s entry into RMHTFs affected the family “mentally a lot,” Caregiver 5 reports that Abraxas counseling improved Youth 5’s behavior awareness and relationship with caregivers. However, Caregiver 5 would have liked more family therapy and greater involvement throughout treatment. He reports dissatisfaction with DHHR engagement and waitlists for services. He shares:

> *DHHR is so backed up right now that they don’t have anybody available. So it’s a several month waiting list [for counseling] they said. . . [Youth’s DHHR worker] quit. . .so they assigned him a new one, and I know we got an email from her, but we never met her, we didn’t even meet her in court. There were several people in the courtroom, but I have no idea which one of them was the DHHR worker, she didn’t even talk to us.*

Caregiver 5 reiterates that it would be “nice for DHHR to reach out to us rather than us always trying to figure things out.” The Abraxas reintegration process was “not so good,” and Caregiver 5 would have liked more notice, planning, and support to prepare for Youth 5's discharge, including setting expectations and setting up service opportunities. He described the discharge planning process:

> *We were told that they would let us know well ahead of time, so we could start planning for his release and start having that counseling, and then, we were notified five days ahead of time. . . We were told we were going to have a family session [to discuss triggers, what to watch out for, and expectations]. . . but we didn't have that. . . So we ended up just doing that by ourselves with him last night.*

Caregiver 5 hopes to keep Youth 5 at home to complete the semester virtually and acclimate prior to exposure to familiar "bad influences." However, he is uncertain that this will materialize and hasn't found the school system helpful.

Residential Youth-Caregiver Pair 5

Youth 5 reportedly has a history of anger issues, juvenile detention, probation, and parent and court-mandated community-based therapy but was not interested or engaged in treatment prior to his current placement at Abraxis. Youth 5 reports positive changes in sleep, behaviors, relationships, and engagement with placement, school, and family following the first few months at his current placement. Youth 5 does not wish to continue with therapy following discharge but is optimistic about positive changes and family as his support system. Caregiver 5 reiterates Youth 5's positive changes in relationships and behaviors during his current placement. Caregiver 5 has been involved with treatment but would have liked more family therapy, greater engagement throughout treatment, and more communication and reintegration support. Caregiver 5 reports satisfaction with Abraxas counseling services, which decreased with an abrupt early release and lack of discharge planning; he reports dissatisfaction with DHHR engagement and waitlists for services. Caregiver 5 hoped for more and continued therapy/counseling and related service options, which were impeded by Youth 5's unanticipated early discharge amid limited notice, communication, and reintegration support from the facility, as well as long waitlists to see a community-based therapist.

13.2.6 Residential Youth – Caregiver Pair 6

Youth 6 is currently at in-state Pressley Ridge RMHTF and reports prior placements at River Park, an emergency shelter, and inpatient and outpatient therapy for anger, depression, and conflict. Youth 6 reports positive engagement in treatment and participates in individual, family, and group therapy 2-3 times per week. When asked about satisfaction with his current placement, Youth 6 responds, "They're pretty great honestly. . . Everybody wants to be at home, like that's a fact. . . Once I got here and realized how it is kind of helping me, so I'd rather be here." However, he would like longer phone calls with family, who are seemingly supportive and engaged with him in treatment. He wants placement to help him reach his goals to "fix my anger issues, find coping skills, and help fix my depression issues. . . I've already worked on my behavior issues enough here, like, a lot." He is happy to report feeling "pretty great" with improved grades, eating, weight gain and likes school, extracurriculars, and therapy. He conveys greater appreciation of his caregivers and reports improvements in their relationship and less arguing. Youth 6 has good friendships with some peers in placement but conflict with others who "like to fight" and feels out of contact with friends outside of placement. Youth 6 seems optimistic and hopes treatment will help him to improve his emotional and behavioral issues so that he can return to school and family. He is willing to continue therapy following discharge, ideally with his former therapist at Westbrook.

Residential Caregiver 6

Caregiver 6 is Youth 6's biological mother and appears very engaged in treatment. She is divorced from Youth 6's father, who youth reportedly fought with and now receives minimal support from. Caregiver 6 reports that Youth 6 has had major behavioral and emotionally manipulating behaviors that she has researched and tried to address prior to his RMHTF placement, including therapy, alternative school, and community-based services. However, services such as alternative school were not available and others could not meet Youth 6's extensive, specialized needs. She describes the challenges finding adequate community-based treatment in an interaction with a DHHR-referred therapist: "[Youth] faked hallucinations and so [the therapist] wouldn't prescribe for him anymore. . . She said that he was beyond her capability and referred me to a different therapist which was still not the right kind of therapist." Youth 6 was placed in DHHR custody and an emergency shelter prior to his current RMHTF placement. Caregiver 6 believes youth requires extensive treatment and that his current RMHTF is the first service that is helping to make a real difference, which she attributes to youth receiving twice the therapy that he has received elsewhere. Caregiver 6 describes Youth 6's current placement, stating:

> *He gets a lot more individual attention because it's smaller. . . So they have more staff there and supervisors. [So when an incident occurs] they actually will put him one-on-one with keeping somebody with him and talking with him about coping and things like that.*

Residential Youth-Caregiver Pair 6

Youth-Caregiver Pair 6 both seem engaged and supportive of Youth 6's current RMHTF placement. Caregiver 6 reports that this placement is making a real difference for the first time related to Youth 6's serious behavioral and emotional issues that were not adequately addressed in his previous experiences with therapy and community-based services. Caregiver 6 details Youth 6's extensive issues and their challenges in finding adequate treatment to meet his needs. Youth reports setting goals for improving his anger, depression, and behaviors. He is participating in individual, group, and family therapy and happily reports improved grades, eating, and weight gain as well as liking school, extracurriculars, and therapy since entering placement. Pair 6 also reports improvement in their relationship following a lot of conflict prior to placement.

13.2.7 Residential Youth-Caregiver Pair 7

Residential Youth 7

Youth 7 has recently returned home from River Park RMHTF and is not currently receiving treatment. He has prior placements with Stepping Stones, Prestera, and Valley Mental Health and a history of Attention Deficit Hyperactivity Disorder (ADHD), depression, substance use, anger, and behavioral issues. He is currently waiting for services to be put in place, which he conveys he is open to. He reports having struggled previously with feeling "really angry" and controlled by others in prior placements. However, Youth 7 thinks residential placement was necessary and benefited him, stating that it gave him gratitude, humility, and perspective on his actions and their consequences. Now he feels he has tools to be “more calm,” “independent,” and states that he “wants to work for everything” he gets. Youth 7 reports less energy, exercise, and a decline in grades during placement, though he states his grades have recently improved. He still has “real friends” outside of residential treatment who have stuck with him through placement and his issues. He rates his experience at River Park as “excellent” and relays that he had “manipulated” his entry into the program by feigning a “big drug problem” because he was “getting in a dark place.” He describes his experience at Stepping Stones as “horrible” and shares concerns with staff and poor facility conditions. When asked about service satisfaction, Youth 7 responds, “Honestly, I didn’t like any of it, cause you know, I was being punished. But you know, that probably the whole point of it, you’re not supposed to like it. . . So I guess I wouldn’t change it.” He does not mention any prior therapeutic services and would desire basketball and extracurricular activities in future services. He feels he is doing well back home and openly shares his feelings and information.

Residential Caregiver 7

Caregiver 7 is Youth 7’s biological mother who reports that both Youth 7 and his sister have mental and behavioral health issues. Caregiver 7 reports that Youth 7 has received many previous mental and behavioral health services, including daily counseling/therapy and psychiatry and residential placements at River Park, Stepping Stones, and Prestera. At the time of the interview, Caregiver 7 reports that Youth 7 has just been removed from home to Valley Mental Health. She reports overall satisfaction with services received and reports improvement in Youth 7’s behavior since entering residential treatment. Stepping Stones helped him to control his anger and aggression, while River Park helped him stop using substances. However, she describes challenges finding services that meet his needs, namely restrictive age requirements that limited the specialized mental health services he needed when he was younger. She is uncertain that the services received so far have provided sustaining benefit, as Youth 7 has returned to multiple placements despite receiving residential and community-based treatments. Caregiver 7 also described facility understaffing and the need for more counseling and therapy services (e.g., Stepping Stones was understaffed and overwhelmed with overactive children). She would have also liked to be more involved in the treatment and reintegration process, rather than guessing what would happen. Caregiver 7 reiterates that out-of-state placement was a hardship for the whole family and that children should not be sent out of state for care. She expresses frustration at not knowing which services may help Youth 7 at this point, but she is driven to find a solution. Caregiver 7 would like Youth 7 to have a service provider he could reach out to and who would reach out to him following placement. She would really like to see him graduate high school and be a well-functioning member of society.

Residential Youth-Caregiver Pair 7

Youth 7 has a history of ADHD, depression, substance use, anger, and behavioral issues. Though he had recently returned home from RMHTF as the time of his interview, Youth 7 seemingly had been placed in treatment by the time Caregiver 7 was interviewed several days later. Youth 7 has received multiple services in the past (therapy/counseling, psychiatry, and placements in RMHTFs) and feels he is doing well at home and is willing to continue to work on his issues. Youth-Caregiver Pair 7 report overall satisfaction with RMHTFs in helping youth's anger and aggression (Stepping Stones) and substance use (River Park). Caregiver 7 describes challenges finding services that meet Youth 7's needs, such as age restrictions and out-of-state placement for specialized services. Caregiver 7 is uncertain that the services received have provided long-term benefit. Both Youth 7 and Caregiver 7 were less satisfied with Stepping Stones due to staffing issues. Caregiver 7 would like more communication and involvement in youth's treatment and reintegration, as well as therapy and counseling services. Caregiver 7 expresses frustration at not knowing which services may help Youth 7 at this point but is driven to find a solution. She would like to see Youth graduate high school and become a well-functioning adult. Youth 7 perceived the necessity and benefit of residential placement, making him feel more grateful, humble, calm, and considerate of his actions and consequences, despite temporarily experiencing less energy, exercise, and a decline in grades (which have since improved).

13.2.8 Residential Youth-Caregiver Pair 8

Residential Youth 8

Youth 8 is currently in a RMHTF placement with one previous in-state placement at Florence Crittenton and receives individual counseling through Youth Health Service. She has also received counseling with Newport News and Prestera in the past. Overall, she has not liked residential placements and does not feel her issues warrant any treatment or residential placement. She relays that she is in placement because there was nowhere else for her to go. Notably, Youth 8 conveys that her prior placement at Florence Crittenton was a better experience due to the consistency of regular therapy with supportive providers; now she only sees a counselor every few months. She reports doing well in school. Youth 8 is potentially leaving placement soon and is ready to be out. She thinks she will go to a foster care placement upon discharge and is unaware of any services set up for her return. She seems withdrawn and reports little engagement with Caregiver 8, family, and friends outside of residential.

Residential Caregiver 8

Caregiver 8 is Youth 8's biological grandmother and reports that Youth 8's mother has a history of substance use and "kidnapping" Youth 8. She reports that Youth 8 has anger issues, including assaulting her. Caregiver 8 reports overall positive satisfaction with services received but would have liked greater engagement and involvement in every aspect of Youth 8's placement, including treatment, planning, and decision-making. She reports high engagement with Prestera services, and Newport News counseling was very helpful for getting into the "nitty gritty" of their problems. Caregiver 8's involvement in Youth 8's current placement has increased, but she would have liked greater engagement and inclusion at the onset of treatment and therapy. She really likes that Youth 8 was able to have home visits during residential treatment. Caregiver 8 is optimistic about gaining custody of Youth 8 and is in the process of setting up community-based treatment, including day report, probation, family therapy, and a mentor for Youth 8's return home.

Residential Youth-Caregiver Pair 8

Youth-Caregiver Pair 8 report mixed perceptions of their situation. This is Youth 8's second residential placement, and she currently receives individual therapy through Youth Health Service and has a history of anger and violent behaviors. Caregiver 8 appears to be more engaged in the current treatment process than Youth 8 relays and demonstrates herself. Youth does not perceive any need or interest in treatment or services, though her prior RMHTF placement at Florence Crittenton was a more positive experience due to the consistency and support of the therapists. Caregiver 8 reports overall positive satisfaction in services received both in WV and out of state, but she would have liked greater involvement in every aspect of Youth 8's placement from the onset, including treatment, planning, and decision-making. Caregiver 8 felt more involved in Prestera services and found Newport counseling very helpful. She really likes that Youth was able to have home visits during residential treatment. Caregiver 8 optimistically reports she is in the process of gaining custody and setting up community-based services (day report, probation, family therapy, mentor) upon Youth 8's return home; however, Youth 8 anticipates that she will be placed into foster care upon discharge. It is unknown whether Youth 8 is fully aware of Caregiver 8's plans to seek custody. Youth 8 seems withdrawn and reports little contact with Caregiver 8, family, and friends. However, she is excelling in school.

13.2.9 Residential Youth-Caregiver Pair 9

Residential Youth 9

Youth 9 has recently returned home from out-of-state RMHTF placement and has a history of multiple placements in and out of state, including therapeutic and case management services with Prestera, Newport, Safe at Home, crisis intervention, and DHHR. Youth reports current engagement and willingness for therapy, which he currently travels to. He shares experiencing difficulty and "medium" satisfaction with his previous RMHTF placements. He reports infrequent therapy and fighting among his peers in the past, stating, "The most worst part. . . was that the therapists didn't come here all the time, she only came there once a week [and] all that racket and fighting over there." He seems to have liked the therapy but not other aspects of treatment related to "skills," stating, "It won't work for me." He reports a "horrible" experience in an Arkansas RMHTF in the past. He is unaware of Caregiver 9's involvement in his treatment. He reports trying to improve his relationship with his caregivers and using coping skills, sharing, "I try to be alone, I try to calm down." He also reports improvements in exercise and school, which is much "easier," but has been feeling drowsy, which he perceives is due to medication. Youth 9 was brief in his responses.

Residential Caregiver 9

Caregiver 9 is Youth 9's biological grandparent and adopted parent who gained custody from Youth 9's parents, who reportedly had substance addictions. He seems highly engaged in all aspects of

Youth 9's treatment journey. He reports that Youth 9 has special needs, namely Reactive Attachment Disorder (RAD) and ODD. The family has struggled obtaining adequate services since moving to a border county of WV in 2013. Youth 9 initially saw a psychiatrist and pediatrician for four years with school-based referral, which was their "first point of contact" in WV. Caregiver 9 then connected with WVDHHR for assistance, and Youth 9 received caseworkers and community services such as Safe at Home and Crisis Intervention for the next two years. Feeling out of options as issues escalated, Caregiver 9 regrettably reports having to file legal charges against Youth 9 in order to access residential treatment. Youth 9 has stayed in various short-term residential placements, spanning from four days to three weeks. Caregiver 9 shares many challenges accessing services in WV that meet Youth 9's needs and are covered by Medicaid, "There's no one in the Panhandle of WV that feels qualified to work with [Youth 9] and the family in overcoming this." While they found specialized providers in bordering states, those services were not covered. He explained, "When you go out of state with WV Medicaid, you are limited to the county that is adjacent to the WV border." Those services that were available via DHHR were far away with long waitlists amid high caseloads. He described that even when they received referrals to counseling providers in WV, "new patients were not being accepted; caseloads are full. So even if we made that journey, there's still difficulty in obtaining services." What's more, "The current structure of WV Medicaid doesn't allow for Zoom calls." These barriers were exacerbated when a short-term behavioral health facility they had used multiple times closed. Caregiver 9 describes positive and negative engagement and satisfaction with prior RMHTFs. Challenges experienced included an abrupt discharge with five days' notice and no planning, facility safety concerns, as well as not obtaining treatment information. He shared that a judge ordered one of the RMHTF's to produce monthly reports for Youth 9, but they have yet to receive any information. On the other hand, a different out-of-state RMHTF placement was a positive experience in which Caregiver 9 reports higher engagement throughout treatment. He shared:

> *DHHR established a treatment team, and we were very much a part of that. The school was involved in it. We felt that we had both support and a say in [Youth 9]'s receiving services. [Facility in PA] is an excellent facility. . . . And they did their work thoroughly. They had an excellent intake procedure. We were physically present and involved with it.*

He describes the discharge plan from a prior residential facility in Pennsylvania as "a good one" but "the difficulty was in finding the service providers that WV Medicaid would pay for. [Caregivers] are on Medicare, so other than Children's Health Insurance Program, there's no insurance for [Youth 9]. So that limits." Caregiver 9 describes that although it is "agony" having your child in residential treatment and receiving services, the real issue is that insurance is "not covering the one problem that is making it difficult for the child to stay at home in the beginning." Despite challenges, Caregiver 9 reiterated how "helpful and sympathetic" WVDHHR has been to their family despite their ongoing need for access to specialized services. He states, "We're grateful to the help that DHHR has provided us. We realize that their caseload is humongous, and their purse is very small; and we understand how that complicates it, but we've always felt that the workers were there for us."

Residential Youth-Caregiver Pair 9

Youth 9 reportedly has special needs (RAD and ODD) and a history of multiple residential placements and community services, including therapy, psychiatry, caseworkers, receiving Safe at Home, and Crisis Intervention. Caregiver 9 has been highly determined and involved throughout Youth 9's treatment journey since they moved to a WV border county in 2013. They have met challenges accessing adequate services to meet Youth 9's special needs. Medicaid restrictions limit the specialized services Youth 9 can receive in and out of state; those available locally did not treat Youth 9's diagnoses and had long waitlists amid high caseloads. The specialized services found out of state were not covered by WV Medicaid. However, Caregiver 9 notes how "helpful and sympathetic" WVDHHR has been to their family. Caregiver 9 reports mixed engagement and satisfaction with various RMHTFs, ranging from "excellent" service provision, discharge planning, weekly calls and frequent visits (Pennsylvania facility) to receiving no treatment information from another treatment facility (Arkansas) despite a court order. Youth 9 reports continuing therapy and improving in school and exercise, though he feels drowsy possibly due to his medication. Youth 9 also reports working on his coping skills and relationship with his parents.

13.2.10 Residential Youth-Caregiver Pair 10

Residential Youth 10

Youth 10 is currently in RMHTF placement and had one prior residential placement, but they report not remembering details or any additional information to provide. Youth 10 has therapy sessions three times a week and attends psycho-educational groups. They like "activities and calling mom and dad." Youth 10 reports low engagement of their caregivers, not seeing them often due to distance, but caregivers "encourage" youth through treatment. Youth 10 was able to visit their family for Christmas and misses their dog at home. Youth 10 has access to daily phone calls with Caregiver 10, though reports they don't talk often, as youth is sometimes asleep when phone calls are permitted. Upon being prompted by a therapist in the room at time of interview, Youth 10 reports weekly family engagement meetings to discuss "behavior" and "communication." Youth has a documented issue with communication, which may help explain the brief interview responses.

Residential Caregiver 10

Caregiver 10 is Youth 10's adoptive parent. She describes extensive help-seeking and limited treatment services and support received prior to residential placement, stating, "I really haven't had very many services helping me out." Caregiver 10 met challenges within the school system and DHHR due to policy restrictions. She describes searching "everywhere" for available services, stating:

> *I didn't know where to go, and I mean I was like grasping at strings you know, I was just trying to find help anywhere, and I would call DHHR up and talk to them. I even called around and asked the different places that maybe would accept her [sic] and give us help of some sort and, like I said—nowhere. It was always something, it was either she [sic] wasn't the right age or she [sic] didn't have the right diagnoses or she [sic] had too many diagnoses.*

Caregiver 10 states it took three years working with Youth 10's pediatrician to finally receive services, which led to Youth 10's direct placement in a RMHTF. She added, "and three years is a little bit too long. . . and I had asked for help, long before that, and never did get it. It was always an excuse, I mean there was a bunch of roadblocks, a bunch." Caregiver 10 has not been satisfied with services received in WV prior to Youth 10's residential placement. However, she is happy with youth's progress at the current RMHTF placement, sharing, "they're a really good facility. . . they've helped her out tremendously." She reports that Youth 10's communication is the major, ongoing challenge to treatment. Caregiver 10 does not feel very engaged with Youth 10 or their treatment due to distance and youth's option to call as they choose during the week. Caregiver 10 does participate in weekly virtual meetings with Youth 10 and their treatment team and tries to make quarterly treatment team meetings in-person or by phone. Caregiver 10 reiterates the need for more specialized mental health services for youth in WV and support in service-seeking. She shares her desire for DHHR to "listen to the family a little bit more," stating:

> *I think that would help tremendously. . . and try and investigate and see if there are places in WV that have places for these children that need the help. . . If they would just listen to us. . . because we adopted these kids. . . We care just as much for these kids as we do our own, absolutely, or we wouldn't have done that. . . So just listen a little bit more. Be more considerate to us that are trying to get these children help that need it."*

Caregiver 10 further describes the need for more residential and transitional services and ongoing support in the community:

> *There needs to be long-term facilities here in WV...The county I live in, I've already seen three, possibly four, [adult] rehab centers go up. There's not one children's place to help them, not one. I mean, not that would help my daughter [sic] because she's [sic] not of the right age. . .She [sic] still backslides some. . . I'm hoping that if they can get her [sic] on the right track... I'm hoping that there's somewhere in West Virginia that she [sic] could be placed—a group home for young teenagers, I don't know—because I know me and my husband would like to have her [sic] home, but with her [sic] problems, I don't know if she'll [sic] ever be able to come home, but I'd like to have her [sic] closer to home.*

Residential Youth-Caregiver Pair 10

Youth-Caregiver Pair 10 has experienced challenges securing treatment for Youth 10 prior to their current RMHTF placement, reportedly encountering policy restrictions (age, diagnoses) within the school system and DHHR for three years before receiving a RMHTF placement. Caregiver 10 reiterates the need for more specialized in-state services and longer-term facilities for youth. Youth 10 has multiple mental and behavioral health diagnoses and currently receives therapy three times a week and attends psycho-educational groups. Youth 10's documented communication issues seem to be a major challenge to engagement. Caregiver 10 does not feel very engaged with Youth 10 or their treatment processes due to Youth 10 not calling her during the week and long travel times preventing in-person visitation. However, Caregiver 10 participates weekly in family engagement Zoom meetings with Youth 10 and their treatment team. She also tries to make quarterly treatment team meetings in-person or by phone. Caregiver 10 is satisfied with Youth 10’s current placement, but both shared little about previous placements and services received during the interviews.

**Note: Youth 10 identified as “female” for sex at birth and self-described as “man or boy” at time of survey.*