System and Community-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
ACT	Assertive Community Treatment
BBH	Bureau for Behavioral Health
CANS	Child and Adolescent Assessment of Needs and Strengths
CBHC	Community Behavioral Health Center
CMHC	Community Mental Health Centers
CPS	Child Protective Services
MCO	Managed Care Organization
NSSP	National Syndromic Surveillance Program
NWI	National Wraparound Initiative
PBS	Positive Behavioral Support
SAMHSA	Substance Abuse and Mental Health Services Administration
SOC	System of Care
STAT	Stabilization and Treatment Home Model
TFC	Therapeutic Foster Care
WV DHHR	West Virginia Department of Health and Human Resources
WVU	West Virginia University
WVU OHA	West Virginia University Office of Health Affairs

1 Executive Summary

The System and Community-Level Evaluation results presented in this report include baseline data collected from July 2021 to February 2022 and are reflective of the state of services during that time period. Results are from the first year of a longitudinal evaluation 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 collection and assessment at the system- and community/provider-level. Data presented in this report were collected through surveys from over 1,400 providers, facility staff, and partners; 49 one-on-one interviews among key informants, and 36 focus groups with a total of 103 participants. Results are intended to provide a snapshot of the experiences and perspectives of people in the field during the data collection period. Data collection activities included:

System-level

- Analyzing state-wide hospital discharge data for child diagnoses related to serious emotional disorders for the populations of interest to the Evaluation.

- Conducting focus groups of administrators who interact with the WV children's mental health system in a sample of counties (2 focus groups per WV DHHR Bureau for Behavioral Health region [BBH], $n = 12$).

Community/Provider-level

- Administering two state-wide surveys: (1) Organization and Facility Survey to all administrators of child-serving mental health services of interest to the Evaluation, and (2) Provider Survey of all health providers and other professionals, such as social workers, juvenile justice professionals, and law enforcement, who interact with children experiencing mental health issues.

- Conducting key informant interviews of respondents to the Organization and Facility Survey selected by region (2 focus groups per BBH region, $n = 12$).

- Conducting focus groups of respondents to the Provider Survey selected by region (2 focus groups per BBH region, $n = 12$) and interviews of all judges who responded to the Provider Survey ($n = 32$; note: 2 judges interviewed did not complete the survey).

Key findings from the data collection activities are outlined below.

1.1 Summary of Key Findings and Recommendations

System-level

More in-home and community-based mental health services for children need to be implemented. The majority of health providers and professionals supporting the mental health continuum of care for children in WV believe all services of interest to the evaluation are beneficial; however, the majority also reported that none of the services have sufficient resources to meet community needs due to staffing issues.

Across all regions, there was consensus about the lack of children's mental health services in WV. Participants described this as a "supply and demand" issue where more services and providers are needed

than are available. Even in regions where services exist, the programs are unlikely to have adequate staffing and capacity to deliver the service. This often results in placements for children and youth wherever a bed is available instead of the most appropriate care setting, as wait times for various types of mental health services, residential and community-based, can range from three months to one year.

Evaluation findings consistently revealed that salary is the main barrier to provider recruitment and retention in mental health professions in WV. Shortage of mental health staff in WV limits the quantity and quality of services agencies can offer. Even where services are available, most organizations reported not having sufficient staff to provide the service at a quality level. Key informants consistently reported that mental health providers and staff can easily make the same or higher wages by working at grocery stores, gas stations, or in the fast-food industry. In addition to current wages competing with other, less emotionally challenging in-state professions, employees also leave WV to work in surrounding states like Maryland and Virginia, where they can receive higher salaries. Addressing the wage gaps for mental health staff in WV is a critical component to achieving a successful continuum of children's in-state mental health care.

The extensive licensing process for mental health professionals in WV is another consistently reported barrier for mental health staff recruitment. It was reported that the WV licensing process was confusing, lengthy, and sometimes professionals must pay out of pocket to receive supervision to become licensed. Therefore, mental health professionals are choosing to get licensed and practice in other states. It was also suggested to allow for "years of experience" to qualify individuals for licensure, instead of only formal educational attainment to alleviate the hiring challenges in the State.

Delivering wraparound services is hindered by confusion regarding the conflict-free case management model requirement for the Children with Serious Emotional Disorder Waiver. There is confusion among providers on how to administer the conflict-free case management model requirement for the Children with Serious Emotional Disorder Waiver. Providers have the perception that if a family uses mobile crisis response services, then they cannot use that same agency for wraparound services. More education and awareness around the conflict-free case management requirement is needed.

More intensive outpatient treatment is needed for children and youth to stay in their homes while receiving high levels of care and support. There was consistent feedback across providers that mental health issues faced by the children and youth are often "too severe" or "not severe enough" for the types of community-based services available in WV.

There are not enough mental health professionals in WV to do long-term, mental health diagnostic assessments; therefore, more children's mental health assessment services and staff to conduct assessments are needed in WV.

Community and Provider-level

There is a clear preference among providers to place children and youth in community-based settings over residential treatment when clinically appropriate. Multiple providers acknowledged there has been a recent shift in the State's prioritization of in-home or community-based services over residential services for children and youth that are clinically able to be treated in the home or community setting. However, it was also noted that children and youth are sometimes placed in shelters, residential treatment facilities, or out-of-state when it is not clinically necessary, because that might be the only option due to lack of community-based services and adequate staffing.

Providers agreed that the top four contributors of youth being sent to out-of-home placement are: (1) lack of community-based services, (2) lack of parental capacity to care for the children/youth, (3) clinical necessity, and (4) the unique needs of the youth that cannot be met in other service settings. These findings were consistent across provider types and regions.

There is a need for more WV DHHR multidisciplinary team staff to assist in the judicial process. Several judges discussed in interviews not being fully aware of the available community-based mental health programs for youth and having to rely on multidisciplinary teams to provide that information. This can be problematic if the personnel providing this information are working for agencies that are understaffed; judges specifically mentioned that WV DHHR is understaffed. Judges also stated they often do not receive reports from multidisciplinary teams in a timely manner, or they do not receive them at all.

Assertive Community Treatment and Children with Serious Emotional Disorder Waiver Wraparound services are the least known service across all health providers. More educational initiatives are recommended for health providers to bring awareness of access and use of these services.

More educational initiatives on the services of interest to the evaluation are recommended for health providers. The majority of health providers report having requested training on the National Wraparound Initiative, Assertive Community Treatment, Therapeutic Foster Care, mental health assessments and screenings, PBS, crisis response and stabilization, and trauma-informed care, but few reported having received these trainings.

More trainings in de-escalation and trauma education are needed for providers and families. Child Protective Services workers and PBS providers requested more training in de-escalation techniques and trauma education for working with youth to be incorporated into PBS and wraparound service trainings. It was noted that at-risk families/parents also need this training.

More information and training for law enforcement on working with Children's Mobile Crisis Response and Stabilization is recommended. The majority of law enforcement officers in WV are not aware of the Children's Mobile Crisis Response and Stabilization team in their area or network.

Expanding Family Resource Network collaborations could help overcome parent/family service awareness and knowledge barriers. In all regions, health providers reported that parents/caregivers had a lack of awareness about the types of services their child needed, or experienced confusion about the differences between various types of services available. They also reported collaboration with the Family Resource Network and holding information sessions had increased family and community awareness of services.

It is recommended to increase children's mental health care within WV school settings. Health providers reported that service providers, including youth social workers, often do not respond to health providers' attempts for outreach and referral. Health providers also reported that schools are safe and accessible places to offer and receive mental and behavioral health services, which might guard against system-wide barriers such as lack of knowledge or resources, or family hesitation with treatment.

1.2   Concluding Summary

The shortage of mental health providers and staff in WV, particularly those in positions that require licensure, limits the quantity and quality of services agencies can offer. Barriers to adequate workforce

capacity include significant staff turnover from burnout via high caseloads and low wages. The challenging nature of youth mental health work also contributes to staff turnover. Key informants consistently described how turnover affects program consistency and disrupts communication and coordination between providers and families. Duplicate requests for services or missed treatment opportunities often result in discouraging families and providers. Delivery of quality mental and/or behavioral health services to youth in WV seems predicated primarily on having enough staff. Without adequate staff, capacity is severely reduced, and programs cannot offer necessary services.

Overall, these findings indicate that the philosophy of providers referring to community-based mental health services to supplement or replace residential mental health treatment for youth is that there is a lack of information, resources and providers in the communities to support a continuum of care for community-based mental health for youth; therefore, the supporting processes and policies for referrals and follow-up to community-based mental health organizations for youth are lacking. Data from all evaluation data sources (i.e., judges, WV DHHR and partner agency staff, social workers, direct care providers, and organizational leadership) from all regions in WV support these findings. Consensus and saturation were reached within the qualitative data for these key findings.

2 Introduction

2.1 Evaluation Overview

The WV DHHR is implementing the Children's In-Home and Community-Based Services Improvement Evaluation Project (the Evaluation) 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:

1. Assertive Community Treatment (ACT)
2. Children's Mobile Crisis Response and Stabilization
3. Wraparound Facilitation Services: West Virginia Children's Mental Health Wraparound and Children with Serious Emotional Disorders Waiver Wraparound
4. Positive Behavioral Support (PBS)
5. Residential mental health treatment facilities
6. Statewide Children's Crisis and Referral Line

Therapeutic Foster Care (TFC) was included in data collection, analysis, and overall reporting, although TFC-specific findings are not presented in this report. During the data collection and reporting period, WV DHHR shifted strategy from TFC to the Stabilization and Treatment (STAT) Home Model that is planned to begin in fall of 2022. Baseline TFC data included in this report should be considered only for understanding needs across the system.

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

7. Executive Steering Committee
8. Workgroup Leads
9. Pathway to Children's Mental Health Services Workgroup
10. Home and Community Based Services Workgroup
11. Quality Assurance and Performance Improvement Workgroup
12. Outreach and Education to Stakeholders Workgroup
13. Workforce Workgroup
14. R3 (Reducing Reliance on Residential Services): Model of Care Workgroup
15. 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. Some highlights of these accomplishments are as follows:

2.2.1 2020 Accomplishments

- Generated complementary tasks across workgroups to implement the initiative.

- Organized the WV Child Welfare Collaborative that launched a web-based public knowledge repository (https://childwelfare.wv.gov/Pages/default.aspx).

- Developed an outcome-focused evaluation plan and logic model processes to guide the Evaluation in partnership with WVU Office of Health Affairs (WV OHA) (see more below).

- Obtained approval for and implemented the West Virginia's Children with Serious Emotional Disorder 1915(c) Waiver.

- Implemented a statewide Children's Crisis and Referral Line to provide a centralized resource for West Virginian children and families in crisis to receive immediate support by connecting them with Children's Mobile Crisis Response and Stabilization teams and other needed services. The statewide Children's Crisis and Referral Line is available 24 hours a day, 7 days a week, 365 days a year.

- Collaborated with Marshall University on a report outlining the needs of the State, in order to maintain a strong workforce to ensure the delivery of high quality mental and behavioral health services to children and their families.

2.2.2 2021 Accomplishments

- Drafted an Assessment Pathway document describing the pathway for access to mental and behavioral health services, with an emphasis on ways that children would be diverted from unnecessary placement in residential mental health treatment facilities. This includes the use of West Virginia Children's Mental Health Wraparound and the Children with Serious Emotional Disorders Waiver.

- Reorganized the Bureau for Children and Families into the newly formed Bureau for Social Services and the Bureau for Family Assistance. The Bureau for Social Services now oversees the child welfare system.

- Developed an Office of Quality Assurance for Children's Programs to operate centrally within the organization and work across bureaus with child-serving mental and behavioral health programs to reduce silos.

- Continued to meet training requirements for existing programs and services such as ACT, screening, and use of the Child and Adolescent Assessment of Needs and Strengths (CANS) tool.

- Initiated training and coaching contracts for Children's Mobile Crisis Response and Stabilization, West Virginia Children's Mental Health Wraparound, and PBS Services.

- Implemented a new data reporting system that enables the collection of record-level data for children receiving behavioral and mental health services.

- Reduced the number of children in residential mental health treatment facilities to 764 as of January 2022.

- Selected a new treatment model, the STAT Home Model, to be implemented in 2022.

- Accomplished statewide expansion of Children's Mobile Crisis Response and Stabilization services.

- Provided additional trainings for Children's Crisis and Referral Line staff to help ensure consistency in call quality and data collection, and to incorporate the Assessment Pathway screening into calls when appropriate.

- Completed a soft launch of the first phase of the implementation pathway on October 31, 2021. This launch emphasized service requests from families and children via the Children's Crisis and Referral Line referrals on behalf of families from primary care providers, deployment of Children's Mobile Crisis Response and Stabilization teams, and connections to West Virginia Children's Mental Health Wraparound services.

- Expanded PBS services in July 2021 to meet the increased demand of children in mental health crisis due to the COVID-19 pandemic.

- Created two memos outlining practices for the State's outreach and education efforts.

2.2.3 Evaluation Background

As a part of this work, WV DHHR engaged WV 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:

1. *System-level:* an examination focused on statewide trends and collaborations.

2. *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.

3. *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. The Evaluation activities for this report included both quantitative and qualitative data collection, as the evaluation framework is a mixed-methods approach. The quantitative work included developing, administering, and analyzing two surveys at the community and provider-level, one for organizations and facilities and another for health providers and other community stakeholders. The purpose of these surveys was to better understand the barriers to and facilitators of offering children's mental health services and care for all organization and facilities, health providers, and other community stakeholders who interact with children with serious emotional and behavioral needs in WV. The qualitative work included developing interview and focus group guides and protocols for qualitative data collection. Qualitative data for both the system- and community and provider-level were collected and analyzed from 24 focus groups with providers, 14 key informant organizational interviews, 32 judge and 3 law enforcement interviews, and 12 system-level focus groups with WV DHHR and partner agency staff.

The purpose of this report is to provide a detailed description of the baseline findings from the system- and community/provider-levels of the evaluation. Since this is the first year of the Evaluation, only baseline data are being reported, and assessments for change will occur in subsequent years. Baseline findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report and placeholders for this data have been included in this report for each respective evaluation question to be addressed then.

This report starts with an overview for each assessment level (system and community/provider) and briefly describes the data collection, analysis and descriptive findings for each level, respectively. Next, the synthesized quantitative and qualitative findings for all high priority initiative and workgroup specific evaluation questions are presented. Finally, quantitative findings for the medium and low priority initiative- and workgroup-specific evaluation questions, detailed quantitative data collection and analytic methods, qualitative methods and quantitative table indexes are presented in the appendixes of the report.

2.3   System-level Overview

The purpose of the system-level assessment is to assess the interaction between youth-serving stakeholders within the continuum of children's mental health care in WV and provide insights into their collaborative processes and outcomes. This assessment was achieved through qualitative primary data collection and analysis, and secondary data analysis via the National Syndromic Surveillance Program (NSSP) data. These data collection activities and analyses are described below in more detail.

2.3.1   National Syndromic Surveillance Data

The WVU OHA team analyzed the NSSP data to assess trends of mental health-related emergency department utilization and whether those trends have changed since the beginning of the in-home and community-based service expansion work. Mental health-related emergency department visits were isolated by ICD-10 codes of interest to the implementation work and the Evaluation. The complete analytic methods for the syndromic data can be found in Appendix C.

2.3.2   Focus Groups

A total of 12 System-level focus groups were conducted statewide, with 2 focus groups per BBH region. A maximum variation sampling model was used to select the county representatives from each region who would be invited to participate in the focus groups, purposively sampling from counties identified as having the highest and lowest rates of children placed in residential treatment facilities. Focus group participants included school staff, school administrators, WV DHHR county office staff, juvenile justice facility administrators, and sheriffs. Each focus group had an average of 3 participants (range 1-8). The complete methods for conducting and analyzing provider focus groups can be found in Appendix G.

2.4   Community and Provider-level Overview

The purpose of the community/provider-level assessment is to evaluate: (1) mental and behavioral health organizational service capacity and workforce facilitators and barriers in WV, (2) the barriers to and facilitators of mental and behavioral health screenings and referrals, and (3) the coordination and integration of mental and behavioral health services with other community-based organizations and stakeholders, such as law enforcement officers, court judges, attorneys, parole officers, and social services

case workers, among others working within the continuum of children's mental health services in WV. This assessment was achieved through quantitative and qualitative primary data collection from two statewide surveys, key informant interviews and focus groups. These data collection activities are described below in more detail.

2.4.1 Organization and Facility Survey

The purpose of the Organization and Facility Survey was to collect administration, workforce, and referral information from the organizations and facilities that provide behavioral and mental health services to children in WV. Data was collected via web and phone between July 26, 2021 and December 30, 2021. There were 86 completed survey responses (total sample completion rate of 54%) from leaders of behavioral and mental health service organizations, agencies, and facilities across the state of WV. An additional 18 facility administrators logged in to take the survey but were screened-out as ineligible due to not offering services of interest to the evaluation. Ten surveys were minimally completed and did not provide data sufficient for analysis. All Organization and Facility Surveys were completed via the web.

The complete methods for administering the Organization and Facility Survey can be found in Appendix B.

2.4.2 Organization and Facility Survey Respondent Descriptive Findings

Organizations and facilities responding to the survey provided services of interest to the evaluation across all WV regions, except for ACT services, which was missing representation in Regions 2 and 4 during the data collection period (Appendix D, Background, Table 1). The organizations and facilities offered varying amounts of services of interest to the evaluation, with some individual organizations offering multiple different services (Appendix D, Background, Table 2):

- *Assertive Community Treatment*: 14 organizations responded and offer 15 services statewide

- *Wraparound Facilitation Services*

    - *West Virginia Children's Mental Health Wraparound*: 24 organizations responded and offer 32 services statewide

    - *Children with Serious Emotional Disorders Wraparound*: 26 organizations responded and offer 56 services statewide

- *Children's Mobile Crisis Response and Stabilization*: 33 organizations responded and offer 48 services statewide

- *Positive Behavioral Support*: 35 organizations responded and offer 52 services statewide

- *Residential Mental Health Treatment Facility*: 20 organizations responded and offer 70 services statewide

The types of organizations and facilities responding to the survey included community-based health centers (*n* = 3) offering 9 different services, community mental health centers (CMHC) (*n* = 54) offering 114 different services, adoption agencies (*n* = 3) offering 6 different services, group homes (*n* = 4) offering 7 different types of services, schools (*n* = 5) offering 7 different types of services, hospitals (*n* = 2) offering two types of services, residential mental health treatment facilities (*n* = 6) offering 12 types of services, and other, non-disclosed (*n* = 2) offering 6 different types of services (Appendix D, Background, Table 2).

The roles of the administrative professionals responding to the survey included administrators (representing 41% of services), clinicians (representing 36% of services), coordinators (representing 12% of services), chief executive officers (representing 9% of services), and other, non-disclosed (representing 2% of services) (Appendix D, Modules, Table 3).

2.4.3 Organization and Facility Interviews

The purpose of the Organization and Facility Key Informant Interviews was to identify specific barriers to: (1) organizational capacity-building for mental and behavioral health services and (2) alignment with statewide changes related to improvements in workforce capacity which are critical for sustainability. A preliminary analysis of the Organization Survey informed the purposive sampling for the Organizational Interview participants. Selections were made to achieve representation in organization characteristics that included organization size, geographic location, and services offered. In total, 14 leaders from residential mental health treatment facilities and community-based organizations participated in the Organizational Interviews. Every BBH region had at least 2 representatives (Appendix D).

2.4.4 Provider Survey Summary

The purpose of the Provider Survey was to collect data from individual health providers and professionals who serve a role in the delivery of mental health services to WV children and youth, as well as law enforcement officers and other members of the legal and juvenile justice system. Data was collected by web and phone between July 26, 2021 and December 30, 2021. There were 1,351 completed survey responses obtained from service providers and persons involved in juvenile justice across the state of WV, including 1,063 surveys among mental health and primary care providers, social workers, probation officers, attorneys and judges and 288 surveys from law enforcement.

The survey began with a screening question to confirm the respondent had interacted with a youth who experienced a mental health crisis or had mental health difficulties in the last 12 months. Providers who responded "no" were screened-out as ineligible and no further questions were asked (n = 327 out of 1734 respondents). The remainder of the survey contained over 250 items divided into modules that were specific to different provider types and services offered, as reported by the respondent, such as HealthCheck, residential mental health treatment, PBS, and wraparound services. Demographic questions, such as age, gender, race/ethnicity, education, and WV service area (county) were collected of all respondents at the end of the questionnaire.

The law enforcement module was administered separately via direct outreach to law enforcement officers by a third-party contractor (a retired WV State Police Officer). Law enforcement agencies were contacted directly and asked to share the survey link with their officers. The survey for these professionals began with a screening question to confirm the respondent had interacted with a youth who was experiencing a mental health crisis in the last 12 months. A total of 469 law enforcement officers (15.1% of 3,110 total WV law enforcement officers) logged into the survey, 288 of whom were eligible and completed at least 70% of their survey questions (completion rate of 9.3%). An additional 138 officers were classified as ineligible and excluded because they did not work with youth in a mental health crisis in the past 12 months. There were another 37 officers excluded due to minimally completing the survey by answering less than 70% of the questions and 6 officers excluded because they accessed the survey but did not answer any question.

The complete methods for the Provider Survey administration can be found in Appendix B.

2.4.5 Provider Survey Respondent Descriptive Findings

The professional roles of the Provider Survey respondents included attorneys, behavioral analysts, case managers, case workers and other social service providers, counselors, judges, law enforcement officers, registered nurses or licensed practical nurses, licensed social workers, nurse practitioners or physician assistants, medical doctors or doctors of osteopathic medicine, probation officers, psychiatrists, psychologists, residential direct care staff, residential facility social workers, and school counselors (Appendix E, Background, Table 1); most respondents represented case workers and other social service providers (24%) and law enforcement officers (21%), and the least number of respondents represented residential facility social workers (< 1%), all nursing professions (1%), psychiatrists (1%) and behavioral analysts (1%).

The types of organizations and facilities employing respondents included community-based health centers (including Federally Qualified Health Centers), CMHC, departments of education, WV DHHR state and county agencies, group private health practice, group home/group residential facilities, juvenile justice agencies, social service representation in law enforcement offices, local school districts, private adoption agencies, pediatric healthcare, private or public hospitals (including inpatient psychiatric unit), residential mental health treatment facilities and state, county and city/municipality law enforcement offices (Appendix E, Background, Table 2a & 2b), with most respondents employed by local school districts (20%) and WV DHHR state (15%) and county (13%) government agencies, and the least employed by residential mental health treatment facilities, social service representation in law enforcement agencies, and private adoption agencies (< 1%, respectively).

Respondents to the provider survey were administered different questions depending on reported profession and services offerings. These provider type and service specific questions were grouped into question modules. There were specific modules for health providers in general (90 respondents), PBS providers (21 respondents), providers offering HealthCheck screenings (17 respondents), health providers delivering residential mental health treatment (5 respondents), wraparound (8 respondents), and ACT services (3 respondents), as well as modules specific to social service providers (826 respondents), probation officers (75 respondents), attorneys (42 respondents), court judges (30 respondents), and law enforcement officers (288 respondents) (Appendix E, Modules, Table 1).

Provider types responding to all health provider questions included behavioral analysts (8 respondents), registered/licensed nurses (1 respondent), nurse practitioners/physician assistants (17 respondents), medical doctors/doctors of osteopathic medicine (22 respondents), psychiatrists (10 respondents), psychologists (26 respondents), residential direct care staff (2 respondents), residential facility social worker (4 respondents) (Appendix E, Modules, Table 1).

Health providers responding to the survey were asked to indicate the services that they provide. Provider types responding to the survey who offer specific services of interest to the evaluation include:

- ***Positive Behavioral Support Services:*** behavioral analysts (7 respondents), nurse practitioners/physician assistants (1 respondent), medical doctors/doctors of osteopathic medicine (4 respondents), psychiatrists (2 respondents), psychologists (5 respondents),

residential direct care staff (1 respondent), and residential facility social worker (1 respondent) (Appendix E, Modules, Table 1).

- ▪ **HealthCheck Screenings:** nurse practitioners/physician assistants (7 respondents), medical doctors/doctors of osteopathic medicine (9 respondents), and psychiatrists (1 respondent) (Appendix E, Modules, Table 1).
- ▪ **Residential Mental Health Treatment Services:** psychiatrists (3 respondents) and psychologists (2 respondents) (Appendix E, Modules, Table 1).
- ▪ **Wraparound Services**: behavioral analysts (1 respondent), medical doctors/doctors of osteopathic medicine (1 respondent), psychiatrists (2 respondents), psychologists (2 respondents), and residential facility social workers (2 respondents) (Appendix E, Modules, Table 1).
- ▪ **Assertive Community Treatment Services:** registered/licensed nurse (1 respondent), psychiatrist (1 respondent), and psychologist (1 respondent) (Appendix E, Modules, Table 1).

The years of practice in WV for each health provider responding to the survey ranged from less than one to 45 years, with 16 years representing the median years of practice and 10 years representing the median year in current role across all professions (Appendix E, Background, Table 3). The different services provided included behavioral health and rehabilitation services (3%), counseling or therapy service (9%), case management (1%), education (4%), family medicine (21%), general medical practice (2%), juvenile justice (1%), pediatrics (21%), psychiatry (12%) and psychology (24%) (Appendix E, Background, Table 4). All health providers responding to the survey administered some type of mental health screening services to children (Appendix E, Background, Table 5).

Provider types responding to the social services module included case managers/case workers (326 respondents), counselors (95 respondents), licensed social workers (164 respondents) and school counselors (241 respondents). Providers classified as probation officers (75 respondents), attorneys (42 respondents), court judges (30 respondents) and law enforcement officers (288 respondents) received question modules specific for each provider type, respectively (Appendix E, Modules, Table 1).

2.4.6   Provider Focus Groups

The purpose of the Provider Focus Groups was to further explore key issues that were identified in the Provider Survey, and to gain a greater understanding of provider experiences and perspectives that might vary by region. The focus group questions were on perspectives of statewide implementation of services of interest to the evaluation, mechanisms for improving workforce capacity, and determinants of service delivery, referrals, and collaboration.

A total of 24 Provider Focus Groups were conducted. There were two types of Provider Focus Groups: Regional and Statewide. Regional focus group participants included 7 types of providers recruited from the Provider Survey: attorneys, general medical providers, law enforcement officers, mental health service providers, social service providers, probation officers, and wraparound facilitators. In the Provider Survey, individuals who expressed interest in participating in focus groups received an invitation and were grouped based on the BBH regions they served. Statewide focus groups included 3 types of providers: Children's Mobile Crisis Response and Stabilization staff, Crisis Hotline staff and residential mental health treatment facility staff. WVU OHA identified and reached out directly to these providers within each region.

2.4.7 Judge Interviews

The purpose of the judge interviews was to identify factors taken into consideration by judges when recommending placement for a child into residential mental health treatment, as well as factors that may facilitate community-based treatment over residential treatment. A census sample of the 73 circuit court judges that hear juvenile cases was attempted. Thirty-two judge interviews were completed. There were also 3 law enforcement interviews conducted. See Appendix F for additional information on interview methods.

2.5 Youth and Caregiver Level Overview

The assessment findings for Evaluation at the youth and caregiver level will be included in the July 2022 report.

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 1). Baseline findings for the youth and caregiver level of the Evaluation will be included in the July 2022 report.

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 Are all planned services available in each region? §

Expected Outcome:

- Increased (statewide) access to children's mental health prevention and treatment services Ⓢ

Baseline Findings:

WV DHHR has been working on building capacity to provide statewide services. However, all services of interest to the evaluation are not yet available in each region.

Organizations and facilities responding to the survey provided the services included in this evaluation across all WV regions, except for ACT services, which were missing representation in Regions 2 and 4 (Appendix D, Background, Table 1). To increase ACT statewide availability, BMS contracted with Mountaineer Behavioral Health in November 2021 to develop an ACT team in the Eastern Panhandle. ACT services will be available statewide once Mountaineer Behavioral Health is fully operational.

Surveyed organizations and facilities provided West Virginia Children's Mental Health Wraparound services across all regions (Appendix D, Background, Table 1). WV DHHR confirmed that the BBH now has statewide West Virginia Children's Mental Health Wraparound service coverage across six regions by five provider organizations. The provider organization located in Region 4 serves both Regions 1 and 4 out of the Clarksburg location.

Organizations and facilities responding to the survey provided Children with Serious Emotional Disorders Wraparound services across all regions (Appendix D, Background, Table 1). According to WV DHHR, as of January 2022 there are 22 provider organizations currently contracting with WV Managed Care Organizations (MCO) to provide the Bureau for Medical Services' (BMS) Children with Serious Emotional Disorder Waiver Wraparound program across all WV regions. Twelve providers are actively providing services to children and the remaining 10 (45%) approved providers have struggled with staffing challenges due to the pandemic, as well as national labor shortages. Key informant interviews revealed that despite the impact of COVID-19, Children with Serious Emotional Disorders Waiver Wraparound services continued to be available statewide via telehealth or safe in-person visits. However, key informant interviews also revealed that although services are technically available statewide, a significant lack of providers (especially those who are licensed for supervision) limits service provision and makes implementation difficult in most regions.

Organizations and facilities responding to the survey provided Children's Mobile Crisis Response and Stabilization services across all regions (Appendix D, Background, Table 1). WV DHHR also confirmed that Children's Mobile Crisis Response and Stabilization services are available in all six BBH regions, with two organizations providing services in Region 4. Key informant interviews and focus groups had concerns about coverage and capacity of the Mobile Response portion of the Children with Serious Emotional Disorder Waiver due to staffing shortages.

Key informant interviews and focus groups also indicated that there were perceived challenges with delivering mobile response services. There was a consistent view that the conflict-free case management model requirement for the Children with Serious Emotional Disorder Waiver prohibits families from using the same agency for both mobile response services and wraparound services. Administrators and providers are concerned there are not enough providers within regions or in the State to provide conflict-free case management.

Organizations and facilities responding to the survey provided PBS services across all regions (Appendix D, Background, Table 1). The PBS programs receive referrals directly from other agencies across the State,

as well as other programs across the BBH SOC. PBS programs are building workforce and systemic capacities for more agencies to serve children across the state.

3.1.2 Can WV families with children who need mental health services access those services in their communities? †

Expected Outcome:

- Increased accessibility of youth and caregiver mental health treatment services and support ①

Baseline Findings:

Organizations and facilities that offer West Virginia Children's Mental Health Wraparound, Children with Serious Emotional Disorder Waiver Wraparound, PBS, and residential mental health treatment offer these services to every region and every county in WV. However, key informant interviews and focus groups reveal that across all regions, staffing for each of these services is a barrier to full-service delivery. Key informants and focus groups revealed that while Children with Serious Emotional Disorder Waiver services are available statewide, implementation is difficult in most regions and services are limited by a significant lack of providers (especially those who are licensed for supervision. Also, key informants stated that the documents listing where Children with Serious Emotional Disorder Waiver services are offered do not take into consideration these services are only operating in a limited capacity due to staffing issues. For example, representatives from Region 1 and Region 5 reported that Children with Serious Emotional Disorder Waiver staffing shortages, particularly therapists, were impacting their ability to serve additional youth. Key informants also reported that they could provide services, but not up to the quality expected of them. Providers and families still perceive that approval and acceptance takes a long time, despite improvement and better-than-required turnaround. One implication is that if the mental or behavioral health services that families were currently receiving did not qualify for Children with Serious Emotional Disorder Waiver, then they needed to find new providers and start the process all over again, further delaying families receiving care and disrupting the therapeutic process.

Key informants also have the perception that specific requirements of Children with Serious Emotional Disorder Waiver restrict service offerings and referrals. For example, they have the misunderstanding that children in kinship care do not qualify for Children with Serious Emotional Disorder Waiver. There is a need for more education around eligibility, which includes all children who are medically eligible with a WV Medicaid card, ages 3 to 21. Another barrier to Children with Serious Emotional Disorder Waiver full-service availability is not having enough providers to deliver all of the services required by Children with Serious Emotional Disorder Waiver; for example, some key parts of the program, such as mobile response, are covered by BBH Children's Mobile Response and Stabilization rather than a local provider due to lack of staff in the region.

Key informants reported that in Region 2, PBS services are offered to individuals depending on their diagnosis and specific situation, but PBS is not offered as a standalone service via specific providers. Key informants in Region 3 noted that PBS is provided virtually and is useful for creating a roadmap and action plan for families. In Region 6, PBS is offered to children in the Intellectual Developmental Disabilities Waiver program, but efforts to expand to other mental health programs, including ACT and children's services, are underway. Region 6 needs more specialized staff (especially certified behavioral support specialists) with adequate training to fully implement PBS.

Key informant interviews and focus group participants discussed residential mental health treatment facilities experience challenges with serving youth and transferring youth out of residential care to community-based services. In Region 1, the closure of a short-term stabilization unit in Wheeling has created major challenges for linking youth with residential treatment, as there is no other in-state facility closer than Morgantown, and many parents are not able or willing to travel.

Although the residential mental health treatment facility services in Region 4 were only designed to accept residential placements from within the region, they often accept children from outside the region if they have an empty bed. A frequent problem mentioned within Region 4 is that children in WV DHHR custody who need residential placement typically must wait weeks or months to receive services. One barrier to residential placement for youth who need those services mentioned by a key informant was that some residential services do not accept certain insurances. Key informants also stated that there is a rule that shelters are not allowed to contact residential programs directly, so relationship building and communication between those services are not able to develop. This limits children in shelter homes from receiving residential treatment if needed.

For Regions 1, 4 and 5, key informants communicated the following reasons for placing children in residential facilities when they would be better served at home:

- **Region 1**: Youth who need short-term stabilization or who experience severe behavioral issues cannot access community-based service due to lack of availability of services. Respondents report that "there's nothing close." Additional context for lack of availability for community-based services include staffing issues and long wait times. For these reasons, key informants communicated that youth are placed in residential facilities – sometimes out of state –because residential facilities are the only option.

- **Region 4:** Lack of staffing leads to community-based services not being available. Children in WV DHHR custody who need to be discharged to foster homes or shelters often cannot find these services in WV, so they are placed out of state. However, in Region 4 a key informant notes that some community-based services, specifically Children with Serious Emotional Disorder Waiver services, have helped youth access and stay in the community rather than residential treatment. Therefore, the continued expansion of these services would increase the number of children served at home, rather than in residential care.

- **Region 5:** Region 5 has also experienced staffing issues similar to Regions 1 and 4, with services in the community not readily available. COVID-19 has impacted the accessibility of both community and residential treatment for youth and their families.

Wraparound programs use a team approach to bring more ideas on how to help children and families. Wraparound facilitators build strong support networks for families and promote community awareness of wraparound services. Because wraparound referrals are made by word of mouth, lack of awareness about wraparound services limits referrals and the ability to reach youth in need. Wraparound programs also cannot provide the long-term support that children on the autism spectrum need.

Children's Mobile Crisis Response and Stabilization services are offered in every region, but Regions 1, 2, 4 and 6 do not offer services to every county in those regions, according to organization and facility administrators responding the survey (Appendix D, Referrals, Table 1). Due to COVID-19, increases in youth experiencing mental health crisis have been observed, while available beds have decreased. Therefore, Children's Mobile Crisis Response and Stabilization services have been helpful in managing this increase in need. In Region 6, although staffing shortages exist (particularly for master's prepared therapists), agencies have prioritized staffing for mobile response to ensure adequate coverage of services. Qualitative data from key informants revealed staffing barriers due to the challenging and intensive nature of working with youth experiencing mental health crises, coupled with low pay. Staff retention issues were also reported due to a lack of understanding about the pay/reimbursement structure for mobile crisis work; for example, staff are only paid for being on call if they respond to a crisis on their shift. However, relationship building and networking has helped to increase awareness of and expand mobile crisis services throughout the State.

ACT services are not represented in Regions 2 and 4, and organizations and facilities in Regions 1, 5 and 6 do not serve every county in those regions (Appendix D, Referrals, Table 1). According to key informants, only one participating organization in Region 6 offers ACT services. This key informant described that due to the intensive nature of the program, including frequent touchpoints with clients, the staff know and understand the youth well and are informed about the services they need. The ACT program in Region 6 experienced significant challenges due to COVID-19, such as the disruption of transportation services that are an integral part of the program.

Overall, most health providers responding to the Provider Survey neither agreed nor disagreed that there are mental/behavioral health service providers available in their community where they can refer clients, and neither agreed nor disagreed that those service providers have the experience and expertise to support their clients (Appendix E, Skillset and Training, Table 2); only residential facility social workers agreed that service providers have the experience and expertise to support their clients.

Surveyed health providers mostly disagreed that there were adequate children's mental health services available in the areas where they work (Appendix E, Referral Polices, Table 4). This agreement varied by provider type with all providers somewhat disagreeing, except for residential facility social workers who neither agreed nor disagreed. Health providers also somewhat disagreed that service providers are generally aware of other service providers to support a continuum of mental healthcare for youth in WV (Appendix E, Referral Polices, Table 4). This disagreement was consistent across health provider types.

There was consensus in the key informant interviews and focus groups across all regions about the lack of children's mental health provider services in WV. Participants described this as a "supply and demand" issue where more services and providers are needed than are available. Even in regions where services exist, the programs are unlikely to have adequate staffing and capacity to deliver the service. This often results in placements for youth wherever a bed is available and wait times for various types of treatment can range from three months to one year. Providers described a severe lack of intensive outpatient services, which can serve as a middle ground between community-based/home-based services and residential treatment, where youth need a higher level of support while they remain in the home.

Participants across data sources described a process of needing to refer across state lines to get youth into counseling or treatment in a timely manner. Lack of awareness of available services is a barrier to

providing a continuum of care. However, it is less of an issue among service providers and more likely an issue with parents/families. An even greater challenge is staffing shortages and lack of service capacity, limiting access and provision of mental and behavioral health care for children and youth in WV.

Court judges overall neither agreed nor disagreed that there were in-home and/or community-based mental health services for juveniles with mental and behavioral health needs in their judicial district and that service provider agencies in their jurisdiction are accessible to the juveniles/caregivers they serve (Appendix E, Judges and Attorney, Table 1). This finding varied by regions: court judges representing Regions 1 and 2 disagreed that there were in-home and/or community-based mental health services for juveniles with mental and behavioral health needs in their judicial district, but court judges in Region 1 agreed that service provider agencies in their jurisdiction are accessible to the juveniles/caregivers they serve. According to interviews with court judges, they generally do not perceive that there are enough mental health services available for youth in WV. They note long wait lists and that many services are not accessible in rural communities, where many families face transportation barriers.

Overall, court judges disagreed that there are services that can meet the diverse mental health needs of juveniles in their circuit (Appendix E, Judges and Attorney, Table 1). Judges mentioned Safe at Home and other in-home services as beneficial for juveniles but noted there are not enough providers to meet their needs. Judges also discussed needing more services for family therapy and would like the ability to order these services, because counseling for parents and family members can help youth remain in their homes, as family issues often contribute to why they may be removed from the home in the first place. Judges also say they need residential mental health treatment facility services that are closer to home, more short-term shelters, and more foster care homes. One judge spoke at length about needing more beds for psychiatric stays. They mentioned the typical issues to send kids out-of-state to treat were sex offenses, violent behaviors, and autism. Some mentioned that having services provided in school as well as having therapists provide in-home services may be helpful. They also mentioned a need for more services for addiction, both for youth and families.

Social service providers and probation officers somewhat agreed that they are aware of services that can meet the diverse mental health needs of youth in their community, but they neither agreed nor disagreed that youth mental health agencies in their community are accessible to the youth/families they serve; these findings do not vary by social service prover type or by region (Appendix E, Social Services and Probation Officer, Table 1). All probation officers participating in focus groups reported issues with accessibility of services, primarily due to understaffing. The lack of sufficient staffing and low wages for youth service workers, especially those at WV DHHR, were noted as the main reasons for inaccessibility. There was consensus that services for severe cases are not accessible and even for initial consultations, both within or outside of the county, and that there is a three or four month wait to see a mental health professional. Other noted barriers included parents not wanting their child to receive services, transportation issues, and lack of reliable means of communication like cell phones and internet to navigate the system.

Service inaccessibility will often result in increased ED visits for mental and behavioral health services. When assessing trends from 2019 to 2021 for children and youth aged 21 and younger presenting to EDs across WV for complications related to the diagnoses used to describe the populations of children with serious emotional disorders of interest to the evaluation, there is a recent 6-month decline. As shown in Figure 1, the ratio of mental health-related ED visits to overall ED visits of children and youth aged 21

years and younger began increasing consistently since 2019 (2.81% to 4.39%) and reached its first peak in the first half of 2020 (5.31%), possibly due to the early impact of the COVID-19 pandemic. The ratio declined in the second half of 2020 (4.64%) before reaching its second peak in the first half of 2021 (5.56%), possibly associated with the third surge of COVID-19. The ratio has started to decline again in the second half of 2021 (4.70%). As children's in-home and community-based mental health and crisis stabilization services continue to expand across WV, the rates of ED usage to treat and stabilize children and youth with diagnoses for serious emotional disorders is expected to decline in response. Details on the diagnoses used in this assessment can found in Appendix C, Table 8-17.

Figure 1: Trends of Youth Mental Health-Related ED visits in West Virginia from 2019 to 2021
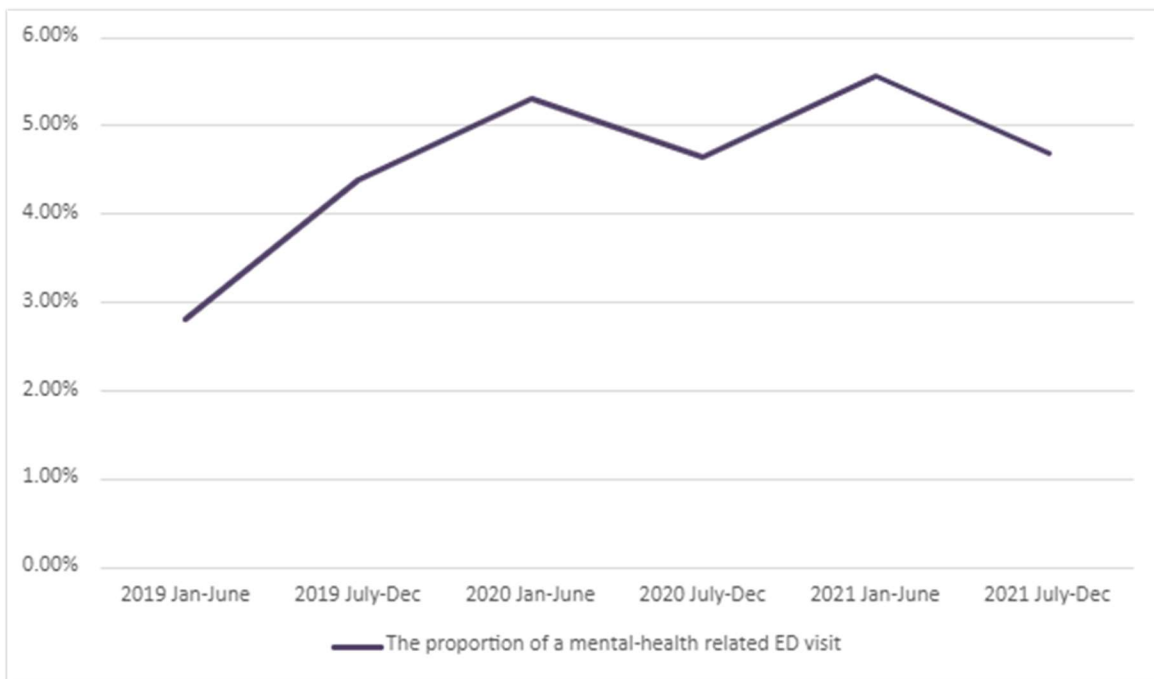
3.1.3 How has the length of time to access services changed? †‡

Expected Outcome:

- Decreased waiting periods for mental health services ① ☽

Baseline Findings:

Only 30% of organizations and facilities responding to the survey report having a waitlist for services included in this evaluation at the time of data collection. Waitlists vary by service type with residential mental health treatment facility organizations and facilities having the most client waitlists (45%) and organizations and facilities offering ACT services having the least (7%). Wait times also vary across services, with a median waitlist time of 30 days. ACT, Children's Mobile Crisis Response and Stabilization,

and West Virginia Children's Mental Health Wraparound days on waitlist was 14 days (Appendix D, Coordination, Table 1).

Waitlists for services also vary by region, with organizations and facilities in Region 2 reporting the most waitlists (52%) and Region 5 the least (31%). Median days on a waitlist also vary by region with Regions 2, 4 and 5 reporting the most days on a waitlist (37.2 days) across services and Region 1 reporting the least (14 days). Notably, regional variations by service type are vastly different, with Children's Mobile Crisis Response and Stabilization services in Region 2 reporting a 97 median day waitlist for services, and Children with Serious Emotional Disorder Waiver Wraparound services in Region 5 reporting a 60 median day waitlist for services. West Virginia Children's Mental Health Wraparound services report no waitlist for services in Regions 3 and 5 (Appendix D, Coordination, Table 2).

Judges, health providers, administrative key informants from organizations and facilities, and WV DHHR and partner agency staff in Regions 1 - 6 all spoke about long wait times for youth mental health services across the state. Rurality of location was mentioned as being associated with longer wait times, especially in Region 3. Participants mentioned that most services have a wait time of "weeks or months." One key informant mentioned there is about a 45-day approval period for youth in acute care to receive a bed in a residential setting. Others in Regions 1 and 4 stated that it can take weeks to months for residential placement and this can be shortened to around one month if the youth is sent out of state. Wait lists for individual or family therapy were perceived to be especially long—anywhere from a few weeks to six months for an initial consultation. Providers in Region 5 discussed wait times of one to eight months for shelter services.

Many health providers responding to the survey neither agreed nor disagreed that the average length of time from HealthCheck screening to follow-up is reasonable in WV. This finding varies by health provider type, with medical doctors and doctors of osteopathic medicine agreeing that the time from screening to follow-up is reasonable. This finding also varies by region with Regions 2 and 3 neither agreeing nor disagreeing, and the rest of the regions agreeing (Appendix E, Referrals, Table 6). This finding could not be corroborated with the qualitative data, as screenings and assessments were not discussed with great specificity in any interviews or focus groups.

Expected Outcome:

- Increased timely response to child crisis situations ⑤

Baseline Findings:

Data on timely response and timely referral to other services are not available at this time. Indicators have been added to the new reporting system and will be reported in the future.

3.1.4 How have waiting periods changed for mental health services? ‡ §

Expected Outcome:

- Decreased waiting periods for mental health services ① Ⓛ

Baseline Findings:

Frequency of waitlists and median days on waitlists for organizations and facilities responding to the survey are presented in evaluation question 2.1.2. Analysis of change for these waitlist times will take place in the next year of the evaluation.

Reports from key informant interviews and focus groups are consistent that waitlists exist across services and that wait times are perceived as long. In Regions 1 and 6, it was noted that closures of hospitals and residential facilities did result in less access to treatment locally, thus longer travel times for families, and usually longer waits for treatment. Some key informants and health providers were hopeful that there would be fewer, shorter, or no wait lists with the expansion of services like wraparound. However, some providers discussed that programs are so overburdened and busy with clients that they almost never hear back when they call to place a referral. Unless strong collaboration is established between agencies, these providers reported that it is unlikely that referrals and placements can be made in a timely manner.

Key informant interviews and provider focus groups specifically discussed wait times for Children with Serious Emotional Disorders Wraparound services. They stated that because not enough agencies are providing Children with Serious Emotional Disorder Wraparound, long approval times result in a slow process for families to receive services. If the services that families are currently receiving do not qualify for Children with Serious Emotional Disorders Wraparound, they need to find new providers and start all over again. The perception is that approval for Children with Serious Emotional Disorder Waiver can take several months, although according to WV DHHR actual wait time for approval from referral is 28 days.

WV DHHR reported that it is acting to improve its data collection and reporting system to address wait time as a barrier to access mental health services. WV DHHR contracts with Kepro to address Children with Serious Emotional Disorder Waiver program eligibility and enrollment. From July 2020 to June 2021, Children with Serious Emotional Disorder Waiver received 361 applications, of which 25.8% (93) were pending. To address the high level of pending cases, WV DHHR made changes to the Children with Serious Emotional Disorder Waiver programs in July 2021. New actions include using Kepro to assist families with completing the selection of an Independent Evaluator and reviewing application data to inform future data collection and provide more clarity in addressing access barriers. The timeline from receipt of application to eligibility determination was an average of 68.3 days. The average number of days from a Children with Serious Emotional Disorder Waiver eligibility determination to the first provision of Children with Serious Emotional Disorder Waiver Wraparound Facilitation was 57 days. The median was 42 days, meaning that half of members with Wraparound Facilitation services received their first service within 42 days after their eligibility determination and half received their first service more than 42 days after their eligibility determination. A quarter of children received their first service within 22 days. After WV DHHR implemented a new Children with Serious Emotional Disorder Waiver process in July 2021, the average time from receipt of application to eligibility determination reduced to an average of 29 days.

Due to the use of the combination of de-identified and aggregated data in reporting, length of time to access other community-based services are not available. WV DHHR is improving its data collection and reporting system to better capture information on service access time. To achieve WV Wraparound services alignment with the National Wraparound Initiative (NWI) model, WV DHHR is enhancing its data collection process by implementing Epi Info Interface within the BBH SOC to capture more service-level data, contracting with Marshall University to assess wraparound service fidelity, and contracting with

WVU OHA to provide an overall evaluation of the children's in-home and community-based services system.

WV DHHR also reports that for PBS services, data are only currently available for BBH direct services. Given the increased need for mental health services during the pandemic, PBS referrals also significantly increased. Currently, there is a waitlist of approximately 12 children for PBS services, but families have been prioritized based on need, and BBH meets regularly with the provider to troubleshoot workforce shortages and hiring barriers. BMS is also working to implement a PBS modifier code (expected in July 2022) that will allow PBS-related claims data to be captured for children receiving services through Medicaid.

The COVID-19 pandemic has affected service use and these initial Children with Serious Emotional Disorder Waiver service utilization data as home and community-based services are traditionally rendered in-person. The pandemic has reduced the prevalence of in-person services and has made some individuals and families more hesitant to seek care.

3.1.5 How has the capacity of the mental health service system workforce changed? ‡

Expected Outcome:

- Increased (statewide) access to children's mental health prevention and treatment services ⑤

Baseline Findings:

Almost half of the organizations and facilities responding to the survey report "yes" to having the number of staff required to serve all youth who need services (41%). These findings varied by region and service. Organizations and facilities in Region 1 were most likely to state they had adequate staff to serve all youth with mental health needs (67%) and Region 2 the least likely (19%). Out of all services of interest to the evaluation, organizations and facilities offering PBS services were the least likely to have the number of staff required to serve all youth across all regions (23%), and organizations and facilities offering PBS services in Region 2 (8%) the least. Organizations and facilities offering ACT and Children's Mobile Crisis Response and Stabilization services in Region 1 are the most likely to have the number of staff needed (100%, respectively) and Children with Serious Emotional Disorder Waiver organizations the least (0%). Within Region 2, surveyed organizations and facilities offering Children's Mobile Crisis Response and Stabilization, Children with Serious Emotional Disorder Waiver Wraparound, and WV Children's Mental Health Wraparound services reported not having the number of staff needed to serve all youth who need services (0%, respectively); only organizations offering PBS and residential mental health treatment services in Region 2 responded "yes" to having the number of staff needed to serve all youth who need services across all organizations in Region 2 offering services being evaluated (8% and 50%, respectively) (Appendix D, Workforce and Capacity, Table 1).

There was consensus across all data sources and in all regions that there is a need for more staff to deliver mental health services to youth. Staff recruitment and retention of staff were discussed as main contributors to service shortages and youth not getting the services they need. Multiple participants described barriers to hiring qualified staff and retaining them as the biggest issues limiting youth's access to behavioral health services.

Reasons for staffing issues were lack of competitive wages coupled with the challenging nature of youth mental health work. Even where services are available, most organizations reported not having enough staff to provide the service at a quality level. One provider stated that there might be two providers in the State for one thousand kids that need a service. Furthermore, experienced job applicants prefer to work in case management or clinics rather than performing direct home service. The current average age of direct care employees is early 20s. Younger applicants usually do not have experience working with children and youth and require more vigilance and training to provide adequate care. Requirements for licensing mental health professionals is a barrier to recruiting and retaining staff because applicants who were veterans of the system during challenging times (e.g., had Child Protective Service [CPS] reports or drug offenses), and now want to give back to the system as a career, are turned away.

Staffing challenges contribute to a cycle where the lack of services, especially shelter beds, pulls staff away from direct care to provide supervision for children in transition. This creates burnout among staff and intensifies the lack of capacity issues in organizations and facilities. For example, two mental health service supervisors in Region 1 reported taking 12-hour shifts staying in hotels with up to five youth on separate occasions in 2021. These types of situations cause staff to fall behind on their administrative responsibilities and experience burnout, and they eventually leave the workforce.

In Region 1, key informants and focus group participants reported that Children's Mobile Crisis Response and Stabilization lacks enough staff to make the program work. Across several regions, staff for autism support is severely needed. A Region 2 participant discussed having only one provider in the entire area for behavioral health wraparound that is managing all of the youth service cases for very large area. Community-based mental health organizations reported struggling to provide a competitive salary to their employees, especially in Region 2. The extensive licensing process for mental health workers in WV drives professionals to get licensed and practice in other states, such as Virginia and Maryland, where the licensure process is simpler. Specifically noted, was the length of time for licensure, the process was confusing and that sometimes professionals needed to use personal funds to pay to receive the supervision requirements needed to become licensed. This further contributes to the difficulty of staff recruitment.

A Region 2 key informant shared that their organization is entirely made up of part-time mental health professionals. Another key informant discussed efforts like sign-on bonuses to recruit nursing staff that could be helpful for mental health staff recruitment. Despite complaints related to the vaccine mandate and general staff turnover, some teams did report being fully staffed, but most are struggling. It was reported that positions with special credentialing requirements are especially difficult to fill, and one participant shared that their organization was making caseload adjustments according to employee's capacity to fulfill referrals and reduce wait time. An additional staffing issue discussed was about the lack of male providers. A key informant communicated, "we have a lot of children who don't feel comfortable with a female and would prefer a male, but we just don't have any male staff."

It was reported that special funding and grants helped support organizations in making wage adjustments and contracting new staff. Using contract employment has provided flexibility in hiring. Some organizations have made dramatic adjustments to floor wages, hoping to attract new workers, but still cannot compete with new businesses that are opening and the fast-food industry. Participants agreed that having school-based social workers was successful in making mental health services more accessible

to children, but insufficient workforce and high turnover among social workers remains a challenge to service delivery.

Focus group participants reported that PBS is a part of the toolbox for facilitators to engage with family and develop action plans. However, staff not fully understanding, practicing, and using PBS services is a barrier to implementation. One participant discussed that they are trying to expand PBS into mental health programs, including ACT and other services for children, but they need a certified behavioral support specialist and those positions are hard to hire. They note that hiring more specialized staff who are trained appropriately in PBS would be helpful for expanding services for children.

Over half (57%) of the organizations and facilities responded "yes" to having the capacity to serve all youth currently being referred to the facility. Children's Mobile Crisis Response and Stabilization services responded "yes" the most (79%) and PBS and West Virginia Children's Mental Health Wraparound the least (46%, respectively). Of those organizations reporting "no" to having the capacity to service all youth currently being referred to the facility, only 26% report that those needs are being met by other service providers in their regions. Across all regions and data sources, capacity to serve youth being referred is limited primarily by staffing issues. Specific issues affecting recruitment and retainment of staff include COVID-19, high turnover due to stress and burnout (especially among new and young hires who are not knowledgeable about the nature of mental health work), and low salaries. Licensing requirements in WV also create barriers to hiring additional staff. For example, one provider from Region 1 reported that adequate services, "just don't exist and if they do, they are so low staffed that they cannot provide at the level needed in WV where thousands of children need a service, but only two providers in the state offer the service." This notion was echoed by participants across data sources and regions.

Focus group participants in Region 1 shared that they have experienced success with Children's Mobile Crisis Response and Stabilization services. Children's Mobile Crisis Response and Stabilization is responsive to families' needs and is able to help parents de-escalate and provide them with short-term support and access to resources in the community. One social service provider shared that the Children's Mobile Crisis Response and Stabilization team can arrive in 45 minutes after calling in a request. However, providers were aware that hiring for Children's Mobile Crisis Response could be challenging. During a focus group, providers shared that they received reports from families who could not access Children's Mobile Crisis Response services. For example, during the data collection period, providers reported hearing from families that when they called Children's Mobile Crisis Response and Stabilization, they were directed to call 911 instead. Participants perceived that such incidents could discourage families in some regions from continuing to use Children's Mobile Crisis Response and Stabilization services.

In terms of PBS, qualitative data suggest that facilitators without adequate training or who are not able to frequently practice skills with families may not be using PBS to its fullest potential. For example, in Region 1, a key informant discussed using PBS effectively is heavily dependent on facilitators' understanding and practice and being able to use PBS skills with engaged families. Another participant who was a provider in Region 1 reported positive collaboration and engagement with providers from the PBS program, but they sometimes do not get a response when they reach out to other PBS programs.

There is consensus across regions and data sources that wraparound is exciting and has a lot of potential. Multiple providers and participants report utilizing wraparound services, but note that providers could receive more thorough training. Most participants report hoping that wraparound services increase

exponentially in the near future. in addition to training and staffing needs, reported barriers to implementing wraparound services at full capacity included lack of parent engagement due to illicit substance use and abuse, and lack of education about wraparound services in general.

Workforce staffing issues were identified across participants as a significant challenge statewide. Region 3 is experiencing major challenges to recruiting staff. Focus group participants report feeling fortunate to be as staffed as they are, but note staff shortages are occurring statewide, especially in Region 3 due to its remote and rural location. One participant shared that the organization added an extra position to serve more Children with Serious Emotional Disorder Waiver clients. Another participant reported that the pandemic and low salaries for mental health professionals amplified staff recruitment challenges. Participants shared that staffing was especially needed for therapists, facilitators, direct support workers, and youth care workers in shelters.

One key informant from Region 6 talked about pay grade adjustments that allowed them to hire more therapists. This person used the word "lucky" to describe how they felt about being able to find therapists, given the shortage of therapists throughout the state. Another informant discussed their CEO as being innovative, as well as receiving grants for recruiting and retaining staff as facilitators to their successes for staff recruitment. Their organization had received grants for positions which has resulted in more hiring and retention of staff due to their ability to offer a higher salary. They are also trying to get a higher rate of salary for therapists specifically, because therapists are harder to recruit. Additionally, COVID-19 caused many people to not be able to do the work the organization needed. The key informant stated that some people quit, because they couldn't find day care for their children, or they quit out of fear for their own health and safety. However, low salary offerings are still the major staffing barrier to many key informants in Region 6. They discuss being able to work at grocery stores or health insurance companies for the same salary. They also cannot compete with the wages in surrounding states, which causes some potential employees to leave WV. Two key informants in Region 6 reported issues with training and three informants were hiring staff who were new in the field, with both sets of employees needing extra training. Turnover is also seen in all levels of staffing and not in any particular role, although staffing needs seem to be at every level of education for mental health staff, from high school, bachelor, master, and psychologist levels. Key informants also do not feel they are getting adequate responses from applicants when they do have open jobs; therefore, it may take a while to fill open positions.

At the time of data collection, there was no reported capacity among providers for in-state residential mental health treatment (Appendix E, Capacity and Resources, Table 1). This finding is further evidenced by WV youth being placed out-of-state for residential mental health treatment. Few providers offering crisis intervention services report having service capacity, except for the medical doctors or doctors of osteopathic medicine responding to the Provider Survey. Capacity exists, but is limited, for individual therapy, group counseling, assessments, case management, care coordination, family counseling, intake evaluation, psychometric testing, treatment planning, parent/ caregiver training, staff training, outreach, and education. Providers report having capacity for medication management, wellness exams, HealthCheck screenings and other mental health screenings. Capacity for these services only slightly differ by provider type and region (Appendix E, Capacity and Resources, Table 2).

Focus group participants were asked whether youth were receiving too many assessments from multiple providers and the consensus was no. In fact, for some providers, the youth they saw had never had a mental health assessment previously. One provider stated that for over half of the kids referred to them,

it is their first time receiving an actual mental health assessment. Another provider stated that they have not seen a single child in foster care that has been offered a mental health assessment. On the other hand, some youths have had a current psychological evaluation, but Children with Serious Emotional Disorder Waiver requires an independent evaluation.

WV DHHR has been working on building capacity to provide statewide services. As noted earlier, at the time of data collection, there were 22 providers contracted with the MCO to provide Children with Serious Emotional Disorder Waiver services across WV. The majority (55%) are actively providing services to children; while 45% continue staffing recruitment efforts. BBH now has statewide Wraparound service coverage by five providers. The PBS program receives referrals directly from other agencies across the state as well as other programs across the BBH SOC. It is building workforce and systemic capacities for more agencies to serve children across the state. The expansion of ACT through a contract with Mountaineer Behavioral Health in November 2021 to ensure statewide availability was a significant change during the data collection period. The Children's Crisis and Referral has been available since Oct 2020 and operates statewide and 24 hours a day, 7 days a week. The implementation of the Assessment Pathway as well as media and outreach campaign are anticipated to increase the awareness and usage of the services. The Children's Mobile Crisis Response and Stabilization service is available in all six BBH regions and while staffing was not reported as an issue at the time of data collection, they noted that lack of applicants has been a historical issue.

Expected Outcome:

- Increased knowledge and skills related to evidence-based programming among the mental health workforce Ⓢ ① Ⓛ

Baseline Findings:

Over half of the organizations and facilities responding to the survey reported that the staff in their facility have the skills and training necessary to serve all youth who need services (53%). This finding varied by region and service type. Organizations offering ACT services responded "yes" the most (64%) to their facility having staff with the skills and training necessary and organizations offering PBS services responded "yes" the least (43%). Region 4 organizations responded "yes" the most to having staff with the necessary skill and training and Region 2 the least (Appendix D, Workforce and Capacity, Table 1).

There was consensus in the interviews and focus groups that more skills and training are needed for the mental health workforce, especially for new hires and young direct care employees, across various programs and services. Additionally, Region 6 noted that training takes time and supervision, which pulls resources away from other areas, such as direct service delivery, and thus it may take longer for a facility to be at full capacity while they are training their workforce. Providing ongoing training and support skills to the workforce was mentioned as important in order to make the biggest impacts with youth and families. In Region 5, it was noted that a variety of mental health trainings are offered to professionals who interact with youth (e.g., social workers, teachers, law enforcement), as well as foster families. It was also noted that CPS workers need more training on appropriate removals from families and assessing when a removal is necessary compared to being more traumatic for the children. An example was provided where a great aunt in kinship care had four children removed because they were molested by a neighbor, but the behavioral therapist thought the removal added additional trauma to the children, and that the great aunt was unaware that the children were in danger. In this situation, it was suggested that

family training on how to protect children from these types of dangerous situations and family therapy would have been more beneficial than removal.

One mental health provider mentioned that CPS workers and at-risk families/parents need PBS training, so they are going to offer PBS training for parents. Representatives from Region 2 stated that there are many PBS-type trainings offered in the region, but they would also like these trainings to include de-escalation techniques for youth with mental health issues. Of note, in Region 3, PBS does offer trainings on de-escalation that first responders and mobile crisis staff attend, and providers were aware that the West Virginia University (WVU) Center for Excellence in Disabilities offers multiple trainings. However, more training on using PBS skills for various mental health professionals is warranted, according to representatives from Region 3, because its success depends on facilitator knowledge and skills of PBS techniques and more specialized staff with adequate training are needed to fully implement PBS in Region 6.

Adequately preparing staff with de-escalation and intervention strategies was also noted as important for the wraparound workforce. Multiple providers and participants report utilizing wraparound services in Region 1, but note that providers could receive more thorough training. Most participants report hoping that wraparound services increase exponentially soon. There was agreement from representatives in Region 5 that wraparound is a great service that needs to be expanded, but providers need more training and to learn from others who have used wraparound and had positive experiences.

Health providers were most competent with mental health assessments and screenings, and the least competent in ACT service delivery, for those who had ACT service delivery aligned with their job responsibilities (Appendix E, Skillset and Training, Table 1). Of all health providers responding to the Provider Survey, almost half reported being not at all competent in the NWI model (44%) or ACT (46%). Very few health providers have received training in NWI or ACT, but almost half (53% or greater) have requested training on these services, but have not yet received the training. Almost half of health providers who conduct mental health screenings and assessments report being very competent in delivering these services (46% and 43%, respectively) and have also requested additional training in these areas. Similarly, forty six percent of Health providers offering PBS services are somewhat competent in delivering these services, with the majority of these providers requesting PBS training (56%).

Competency in skills varied by health provider type:

- **National Wraparound Initiative:** behavioral analysts and residential facility social workers report the most competency and medical doctors/doctors of osteopathic medicine report least.
- **Assertive Community Treatment:** residential facility social workers report the most competency and nurse practitioners/physician assistants report least.
- **Mental Health Assessment and Screenings:** psychiatrists and psychologists report most competency and nurse practitioners/physician assistants report least.
- **Positive Behavioral Support:** behavioral analysts report most competency and nurse practitioners/physician assistants report least.

Most health providers agree that they have the necessary skills and training to deliver evidence-based approaches to meet the mental health needs of the youth they serve, with residential facility direct care staff only somewhat agreeing (Appendix E, Skillset and Training, Table 2).

The majority of health providers agree that delivering an intervention as it was designed will enhance its effectiveness (Appendix E, Skillset and Training, Table 2).

Providers participating in focus groups across regions have requested and are interested in additional trainings, specifically on de-escalation and trauma education for new staff, when to remove children from the home for CPS workers, and what services are available in their communities. Providers report attending trainings when they are offered, but that understaffing and competing service delivery needs are barriers for agencies to offer requested trainings.

Individuals participating in interviews and focus groups consistently knew about wraparound and PBS services, noting them as important, and reporting that they need to be expanded throughout the state. A key informant from Region 6 who offers ACT services hopes to expand PBS into their ACT program. PBS was described as "very engaging" and two providers in Regions 1 and 2 reported utilizing PBS techniques.

WV DHHR has reported making several key accomplishments in terms of provider training. WV DHHR has provided training for all entities assisting with the Assessment Pathway to formalize the process and ensure accurate data collection. To improve PBS service capacity and quality, BBH is contracting with WVU Center for Excellence in Disabilities to provide training and consultation on PBS go agencies across the state. WV DHHR is contracting with Marshall University to provide wraparound facilitator training and Children's Mobile Crisis Response and Stabilization training. In addition, WV DHHR will be focusing on increasing capacity and training for residential mental health treatment facility providers in the coming year to better serve children with high level-of-care needs who are now being served out of state.

WV DHHR has also contracted with WVU OHA to plan and implement training for the health workforce treating children with severe emotional disorders, traumatic brain injuries, intellectual developmental disabilities, and other mental and behavioral health disorders, as well as mindfulness and resilience for providers. Through these educational components, improvements will be made to public education and outreach strategies, workforce trainings for Medicaid home- and community-based frontline healthcare workers using person-centered trauma informed care, as well as training for law enforcement on how to have safe interactions with persons having intellectual developmental disabilities and/or mental and behavioral health disorders.

Expected Outcome:

- Increased use of evidence-based mental health treatment services ① ①

Baseline Findings:

More service implementation is needed across all services, as the majority of health providers and professionals supporting the continuum of care for children with serious mental health disorders and issues believe that all services of interest to the evaluation are beneficial (ranging from 75% to 100% across services); however, the majority report that none of the services have sufficient resources to meet community needs (ranging from 9% to 31% across services) (Appendix E, Services and Programs, Table 4).

The majority of law enforcement officers report not being aware of the Children's Mobile Crisis Response and Stabilization team in their area or network (89%). Of the law enforcement officers who were aware of Children's Mobile Crisis Response and Stabilization services, 79% were aware of how to access the team

their area or network and 18% had worked with or responded with a Children's Mobile Crisis Response and Stabilization team in the past year (Appendix E, Law Enforcement, Table 2).

Providers and professionals participating in interviews and focus groups note the importance of evidence-based programs, especially for youth in foster care and PBS services. An administrator from Region 5 discussed implementing the Treatment Foster Care Pre-Service Training Curriculum—evidence-based treatment foster care training. Their facility partnered with external providers from other states to collect formative research and develop a multi-component program. The intervention is an intensive training for foster families about trauma and its impact on children and their brain development. The training is continually updated (it is currently in its fifth version) and in 2020 received an evidence-based designation by the California Clearinghouse for Child Welfare.

Another key informant described PBS services as evidence-based because they use a person-centered planning model and team planning and they focus on quality of life, behavioral and/or ability changes and outcomes throughout the process.

Expected Outcome:

- Increased [local] workforce capacity for mental health treatment and supports ⑤ ① ①

Baseline Findings:

While there were 57% of organizations and facilities across the state that responded "yes" to having the capacity to serve all youth currently being referred to the facility, there were differences across regions and services. Organizations and facilities in Region 4 responded "yes" the most (56%) and in Region 1 the least (36%). Of those organizations reporting "no" to having the capacity to serve all youth currently being referred to the facility, only 26% report that those needs are being met by other service providers in their region. This finding varies by region and service, with organizations and facilities in Region 3 reporting that those needs are being met by other service providers in the region the most (67%) and Region 6 the least (21%) (Appendix D, Workforce and Capacity, Table 1). Major barriers reported by key informants and focus group participants in Region 6 included a lack of providers, which impacts service delivery requirements of the Children with Serious Emotional Disorder Waiver, and that some key parts of the program such as mobile response are not able to be delivered in some regions. Key informants also report they could provide the needed services, but not up to the quality that is expected of them.

On average, organizations and facilities reporting not having the number of staff required to serve all youth who need services responded that salary ranges in WV impacted the recruitment of staff with the necessary skills and training "much." The rating of "much" was on a scale of 1-5, with 1 equal to a "great deal," 2 equal to "much, 3 equal to "somewhat," 4 equal to "a little" and 5 equal to "not at all." This finding was consistent across evaluation services (Appendix D, Workforce and Capacity, Table 2).

All organizations and facilities responding to the survey that reported not having staff with the skills and training necessary to serve all youth who need services responded, on average, that salary ranges in WV impacted the recruitment of staff with the necessary skills and training a "great deal." This finding varied by evaluation service, with salary ranges impacting the recruitment of Children's Mobile Crisis Response and Stabilization, Children with Serious Emotional Disorder Waiver Wraparound, PBS, residential mental health treatment facility, and West Virginia Children's Mental Health Wraparound service staff "a great deal" and ACT service staff "much" (Appendix D, Workforce and Capacity, Table 2).

On average, all organizations and facilities responding to the survey that reported not having the capacity to serve all youth currently being referred to your facility responded that administrative or legal processes such as Memorandums of Understanding or contracts contribute to their facilities lack of capacity to serve all youth being referred "somewhat," lack of services contribute to their facilities lack of capacity to serve all youth being referred "somewhat," and that lack of workforce contributes to their facilities lack of capacity to serve youth being referred "much." These findings varied by service; administrative or legal processing impacted ACT services capacity to serve youth "not at all," while Children's Mobile Crisis Response and Stabilization, Children with Serious Emotional Disorder Waiver Wraparound, and residential mental health treatment facility services were impacted "a little," and PBS and West Virginia Children's Mental Health Wraparound services were impacted "somewhat." Lack of services impacted residential mental health treatment facilities "a little" and lack of workforce impacted Children's Mobile Crisis Response and Stabilization and Children with Serious Emotional Disorder Waiver Wraparound services "a great deal" (Appendix D, Workforce and Capacity, Table 2).

When organizations and facilities were asked "are there particular staff capabilities, skillsets, or credentials that are hard to retain or fill" for mental or behavioral health staff, 75% responded "yes." Of those responding "yes, licensed therapists, psychologists, licensed social workers and Master-level staff were reported as the most difficult to hire, as many Bachelor-level staff do not qualify for licensure. It was also suggested to allow for "years of experience" to qualify individuals for licensure, instead of only formal educational attainment to alleviate the hiring challenges in the State. Hiring direct care staff and staff with credentials was noted to be difficult, due to pay, with organizations specifically reporting that pay rates in neighboring states (ex. Maryland, Pennsylvania) were higher, so "staff leave WV for more money in certain regions" and "there has been no increase in Behavior Support professional rates in over 8 years" (Appendix D, Workforce and Capacity, Table 3).

Interviews and focus groups consistently revealed that salary is the main barrier for provider recruitment and retention in the mental health profession in WV. Key informants frequently reported that mental health providers and staff can easily make the same or higher wages by working at grocery stores, gas stations, or in the fast-food industry. In addition to current wages competing with other, less challenging professions in-state, employees also leave WV to work in surrounding states like Maryland and Virginia, where they can receive higher salaries. Additionally, youth mental health work presents many unique challenges, including non-traditional work hours, constant crisis management, and working in a potentially violent environment. Across all participant types, there was consensus that mental health professionals, especially youth service workers, were not compensated enough for their hard work and the positive impact they had on children and families. For example, one key informant reported a lack of understanding among staff about the pay/reimbursement structure for Children's Mobile Crisis Response and Stabilization when they accept employment (i.e., staff are only paid for being on call if they respond to a crisis). Some key informants shared that they are using retention strategies like wage adjustment, contract employment, special grants, and sign-on bonuses, but they often struggle to offer a competitive salary. Mental health professionals report that they frequently see peers choosing to work in Maryland, Virginia, and Pennsylvania where they can get paid more and have lower caseloads.

The extensive licensing process for mental health professionals in WV creates another barrier for recruitment. Key informants reported that many professionals are willing to go through the licensing process, but that it was confusing, lengthy, and sometimes professionals must pay out of pocket to receive

supervision to become licensed. Therefore, mental health professionals are choosing to get licensed and practice in other states. In Region 2, a key informant reported that the organization was not able to offer Children's Mobile Crisis Response and Stabilization service despite registering to provide it for the Children with Serious Emotional Disorder Waiver program because they lacked licensed providers to supervise the Children's Mobile Crisis Response and Stabilization team. They also shared that per licensing requirement, the shelter could not hire anyone with a CPS investigation or arrest record. Some of these applicants grew up in the child welfare system, learned from their mistakes, and felt the need to give back. This participant felt that they had "much more authentic voices" but were not eligible for employment.

Across the state and at the local level, respondents reported no capacity among providers for in-state residential mental health treatment (Appendix E, Capacity and Resources, Table 1). Few providers offering crisis intervention services report having service capacity, except for medical doctors or doctors of osteopathic medicine responding to the Provider Survey. Capacity exists, but is limited, for individual therapy, medication management, assessments, case management, care coordination, family counseling, intake evaluation, psychometric testing and treatment planning. Providers report having capacity for wellness exams, HealthCheck screenings and other mental health screenings. Capacity for these services only slightly differ by provider region (Appendix E, Capacity and Resources, Table 2).

Interview and focus group participants across regions reported difficulties with youth receiving individual therapy and counseling due to long wait times and lack of providers. Other services (e.g., HealthCheck screenings, medication management, assessments, care coordination, family counseling, intake evaluation, psychometric testing and treatment planning) were not specifically discussed other than providers and staff confirm that these are the types of services they perform or offer. Key informants and providers agree that in-state residential treatment and crisis intervention services are extremely limited. They frequently stated that residential mental health treatment facilities do not have enough beds to place all youth in need, which often leads to out-of-state placements. When beds are available, staff shortages limit the number of youth a facility can admit. Although, some agencies in several regions have recently received and used grant funds to hire new staff, including contract therapists and counselors. There was also discussion about the need for each school in WV to have its own social worker and counselor.

Health providers neither agree nor disagree that they find staff turnovers affect their ability to deliver quality mental health and/or behavioral health to youth in WV (Appendix E, Referral Policies, Table 1). This finding varies by provider type with behavioral analysts, psychiatrists and residential facility social workers agreeing that staff turnover does affect their ability to deliver quality mental or behavioral health care. These findings also vary regionally, with Regions 5 and 6 having higher levels of agreement than Regions 1-4.

Interviews and focus groups revealed that mental health staff shortage in WV limits the quantity and quality of services agencies can offer. Barriers to adequate workforce capacity include significant turnover from burnout via high caseloads and low wages. The challenging nature of youth mental health work also contributes to staff turnover. Key informants described how turnover affects programming consistency and disrupts communication and coordination between providers and families. Duplicate requests for services or missed treatment opportunities are often the result, which is discouraging for both families and providers. One key informant described how foster parents wanted to discontinue services because they perceived their foster child was continually retraumatized from constantly changing clinicians.

Delivery of quality mental and/or behavioral health services to youth in WV seems predicated primarily on having enough staff. Without adequate staff, capacity is severely reduced and programs cannot offer necessary services. In Region 6, a superintendent discussed valuing mental health services in the school system to the extent that they reported going "way over our budget" to hire employees to address the mental health issues in their school system. They also communicated concern that subsequent leaders in that school system may not value mental health services to the extent that they do, so they emphasized it is critical to have as many state supported services in schools as possible.

WV DHHR has reported continuing its efforts to address workforce shortage in mental health services. Currently, BBH has 8 staff with an additional one approved to work on processing referrals related to Assessment Pathway. Among the 22 providers contracted with the MCO to provide Children with Serious Emotional Disorder Waiver services, 10 approved providers struggled with recruitment due to a lack of applicants. The current West Virginia Children's Mental Health Wraparound workforce capacity has an average of 82% occupancy rate statewide. Region 1, 3, and 4 have reached full program capacity while Region 2 reported 50% occupancy rate. Region 5 and 6 reported 67% occupancy rate. WV DHHR is developing a process for compiling Children with Serious Emotional Disorder Waiver Wraparound and Safe at Home agencies' Wraparound Facilitators and their caseloads. The PBS program is working on building both workforce and systemic capacity for more agencies to serve children in the state. BBH has 8 full-time equivalent staff in the PBS program and is focusing on recruiting one curriculum developer and two additional behavioral specialists. As previously noted, WV DHHR contracted with Mountaineer Behavioral Health to develop an ACT team in the Eastern Panhandle. The target date for hiring and training is May 2022 but might be impacted by the pandemic. For Children's Crisis and Referral Line, it has a 100% occupancy rate for crisis counselors, 67% for shift leads and 14 helpline specialists. Each BBH region offered increased staffing but noted that lack of applicants has been a historical issue. Currently, only Region 1 achieved 100% occupancy rate.

3.1.6 How has awareness of mental health services for children changed (families, mental health providers, medical providers, DOE staff, courts, police)? † ‡ § [state priority = medium]

Expected Outcome:

- Increased awareness and acceptance of mental health services and supports among child serving professionals ① ①

Baseline Findings:

All providers responding to the Provider Survey were least aware of ACT services and most aware of Children's Mental Health Wraparound out of all services evaluated (Appendix E, Services and Programs, Table 4). Of all providers responding to the Provider Survey (*n* = 1063), the following are aware of the evaluation services: ACT (17%), Children's Crisis and Referral Line (66%), Children's Mobile Crisis Response and Stabilization (51%), PBS (61%), Children's Mental Health Wraparound (67%), and Children with Serious Emotional Disorder Waiver Wraparound (51%).

Provider awareness of mental health services for children is displayed in Appendix E, Services and Programs, Table 4, for all providers except law enforcement officers, which can be found in Appendix E, Law Enforcement, Table 2. In summary:

- **Assertive Community Treatment**: 67% of residential social service workers are most aware, and registered/licensed nurses, nurse practitioner/physician assistant, residential direct care staff are the least aware (all 0%).
- **Children's Crisis and Referral Line**: residential facility social workers are the most aware (100%) and registered/licensed nurses, residential direct care staff are the least aware (0%).
- **Children's Mobile Crisis Response and Stabilization**: residential facility social workers are the most aware (100%) and registered/licensed nurses, attorneys, law enforcement officers are the least aware (0%, 10%, and 11%, respectively).
- **Positive Behavioral Support**: residential direct care staff and social workers, and behavioral analysts, are the most aware (100%, respectively) and registered/licensed nurses, medical doctors/doctors of osteopathic medicine and psychiatrists are the least aware (0%, 8% and 11%, respectively).
- **Children's Mental Health Wraparound**: residential direct care staff and social workers are the most aware (100%) and registered/licensed nurses, nurse practitioner/physician assistant, and medical doctors are the least aware (0%, 0% and 8%, respectively).
- **Children with Serious Emotional Disorder Waiver Wraparound**: behavioral analysts and social workers/case managers are the most aware (88% and 71%, respectively) and registered/licensed nurses, and medical doctors/doctors of osteopathic medicine are least aware (0% and 17% respectively).

Health providers neither agreed nor disagreed that they are aware of services that can meet the diverse mental health needs of youth in their network/area and that they are aware of well-trained service provider agencies to refer youth in their network/area (Appendix E, Referral Policies, Table 4). Responses varied by provider type with behavioral analysts, psychiatrists and residential service providers having a slightly higher level of agreement.

Court judges somewhat agree that, in general, service providers from mental health agencies are aware of other available services when caring for juveniles with mental and behavioral health needs (Appendix E, Judges and Attorney, Table 1). These findings vary by region, with Region 1 agreeing and Regions 2, 3, and 5 neither disagreeing nor agreeing.

Attorneys and guardian's ad litem neither agree nor disagree that, in general, service providers from mental health agencies are aware of other available services when caring for juveniles with mental and behavioral health needs (Appendix E, Judges and Attorney, Table 3). These findings are consistent across regions.

Interviews and focus groups revealed that providers in Regions 1 and 2 are aware of Children's Mobile Crisis Response and Stabilization. Three providers in Region 1 and one in Region 2 have had positive experiences with Children's Mobile Crisis Response and Stabilization, and report the services are responsive and helpful with keeping youth in the home. However, four providers have had issues getting the service available in their area. Therefore, Children's Mobile Crisis Response and Stabilization may not be readily available in all the locations it is reported to be. One provider reported that a family they worked with called Children's Mobile Crisis Response and Stabilization and were told to call 911 instead, which was very discouraging for the family. Providers in Region 5 were aware of Children's Mobile Crisis Response and Stabilization, but those in Region 6 were not. Other than one provider in Region 6, no other participants mentioned that they knew of or offered ACT services.

Providers typically receive information on community-based services via trainings, their departments, and/or through existing relationships with other providers and agencies in the youth mental health system.

A focus group representative from Region 1 recommended increasing awareness of services via guidance from case managers, wherein case managers could connect families to services and provide descriptions of what each service offers and help with possible treatment plans. This approach could improve communication between providers, case managers, and families via a collaborative relationship and treatment planning. In Region 5, a recommendation was made to have a place for parents and guardians to call or visit when they need assistance finding services for youth; therefore, expanding awareness of the Children's Crisis and Referral Line in Region 5 could be helpful in increasing family awareness of community-based services.

A lack of awareness and knowledge of existing services was mentioned as a significant barrier to referrals to treatment; although, relationship building and networking have helped to increase awareness of and expand Children's Mobile Crisis Response and Stabilization services. Particularly for wraparound, referrals are most often by word of mouth. Lack of awareness across communities about wraparound services limits access for youth who need services. The four probation officers who participated in the focus groups were aware of services to address mental and behavioral health needs for youth and described instances where they routinely interact with agencies and facilitate referrals for youth. One probation officer in Region 5 described an annual probation conference where mental health representatives speak about changes in the system and provide information on available services. They also mentioned that they learn about available services from the probation department and seminars and webinars offered by group homes and youth service agencies.

Health providers mostly disagreed that they found families/caregivers were generally aware of the community-based mental health services available in WV to meet their youth client's needs (Appendix E, Referral Polices, Table 4). In all regions, providers participating in focus groups perceived that parents and guardians had a lack awareness about the types of services their child needed or experienced confusion about the differences between various types of services. This is especially true if youth were receiving multiple services. In Regions 5 and 6, collaborations with the Family Resource Network and holding information sessions had increased family and community awareness of services. Therefore, expanding Family Resource Network collaborations could help overcome parent/family service awareness and knowledge barriers.

Interviews and focus groups with providers revealed that beyond lack of awareness, other factors limiting family access and engagement in youth mental health treatment include feeling worn down, fear of discussing mental health issues due to potential problems in court, and difficulty finding services in rural and remote areas.

WV DHHR reports continuing its outreach efforts to enhance service provider's awareness of community-based mental health treatment services. WV DHHR started an outreach to primary care providers about the Assessment Pathway in November 2021 to increase the number of primary care providers completing an EPSDT screen with mental health check. As the outreach continues, among 659 clinic sites, 214 have received educational materials and had discussions on mental health screening. It is anticipated that with this outreach effort, use and referrals via Children's Crisis and Referral Line will increase. Additional

outreach efforts for Children's Crisis and Referral Line include press releases and media campaigns. Additionally, BBH hosts monthly meetings with Children's Crisis and Referral Line provider to identify areas for improvement and assistance. Crisis Line staff are trained to incorporate the Assessment Pathway screening into class when appropriate to further connect individuals with services. WV DHHR has been in communication with residential mental health treatment facility providers to help ensure that ACT is included as a service for eligible youth in the discharge planning process.

Expected Outcome:

- Increased family awareness of youth mental health treatment services and supports among families receiving services ⑤ ① ⑬

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.7 How have the quality and timeliness of mental health assessments/screenings changed? ‡

Expected Outcome:

- Increased use of standardized and approved mental health screenings and assessments ① ⑬

Baseline Findings:

Of the health providers who responded to the survey (*n* = 90), 19% use HealthCheck for mental health screenings, 22% use a screening type other than HealthCheck and 81% of health providers reported not conducting any mental health screenings (Appendix E, Services and Programs, Table 1).

Of the health providers with experience making mental health referrals as a result of a HealthCheck screening, overall, they agree that their organization/agency makes referrals outside of their own organization/practice as a result of HealthCheck screenings and they neither agree nor disagree that the average length of time from HealthCheck screening referral to follow-up is reasonable (Appendix E, Referrals, Table 6). This finding varies by region, with Region 5 agreeing that the HealthCheck screening referral to follow-up time is reasonable.

Currently, there are four standardized tools for mental health screening that are recommended by WV DHRR and these vary by provider type. These screening tools include:

- WV's HealthCheck, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)program for Primary Health Care Providers.
- Youth Services staff through the BSS use the Functional Assessment Screening Tool to screen for mental health concerns.
- CPS staff uses the Ongoing Assessment as their screening tool when assessing for abuse and neglect.
- Mental health screening through the Bureau of Justice and Community Services uses the Massachusetts Youth Screening Instrument II (MYSI-II) as a screening tool.
- WV Judiciary, Division of Probation Services, also screens using the Massachusetts Youth Screening Instrument II (MYSI-II).

In the baseline year of data collection only HealthCheck was incorporated in the provider survey instrument as information on the additional screening tools was being finalized. During the baseline year, the Pathway to Children's Mental Health Services (Assessment Pathway) was developed and implemented. Additional aspects of the Assessment Pathway and associated screening tools will be incorporated into future iterations of the yearly Provider Survey.

Interviews and focus groups revealed that mental health screenings for youth could be expanded and improved. There is a need for more mental health screenings and services in schools and in physician's offices. One provider believes best practice dictates contacting the school or school counselor after youth mental health screenings are performed in a medical facility or clinic. Probation officers and school-based mental health practitioners commented on the quality of screenings in acute settings like EDs, stating that they are too brief and lack enough context to determine an accurate picture of youth's functioning and needs. These providers report that it is critical to contact family and other existing service providers in the child's life to gather information, and then work collaboratively to develop a treatment plan.

Focus group participants noted that there are not enough mental health professionals in WV to do long-term, diagnostic evaluations and assessments. It was reported that there is only one program that provides diagnostic evaluations in WV currently, and youth must be in detention in order to receive the assessment. Focus group participants agreed that diagnostic evaluations of 30 – 45 days that evaluate youth's psychological, social, and educational functioning are needed to obtain a full snapshot of the child's mental health status for providers to provide appropriate treatment and referrals. One provider discussed how, "anybody can be in Chestnut Ridge or wherever for three days and fake it." Often, only 3-hour assessments are completed that result in a diagnosis, medication change, and discharge to home that is inappropriate. Providers discussed how this is not adequate and youth "need longer term treatment than that, but not as long as residential"

Focus group participants reported that there are not enough crisis stabilization services in WV, especially in Wheeling where a hospital closed, and that Morgantown is too far for many families to travel to receive crisis stabilization. A focus group participant working at a residential mental health treatment facility stated that they do not ever admit a child into residential treatment who does not need residential services, and attributes this to doing a good job with mental health screening on the front end. Although it was noted that there is a need for more mental health screenings and services in schools and in physician's offices.

Providers in school-based settings are limited in the types of screenings and assessments they can perform. They do safety or risk assessments, such as for suicide or self-injurious behaviors, with students showing signs of anxiety or mental health issues, but then must recommend further evaluation elsewhere. One school-based social service provider discussed performing risk assessments and frequently needing to send youth with high ratings to health facilities and that some warrant hospitalization, but facilities are typically full and the youth does not receive the needed care. Other providers in school-based settings discussed that sometimes outside mental health agencies are contacted to come into the schools to perform initial screenings and assessments on the entire student population and/or individuals who might be identified as high risk, but that COVID-19 has stifled that process.

Types of assessments and screening tools mentioned in interviews and focus groups included Family Advocacy, Support and Training assessments, the Patient Health Questionnaire and General Anxiety

Disorder Questionnaire, as well as questions about alcohol abuse. Social service providers conduct CANS assessments and sometimes receive requests for needs assessments from WV DHHR. One social service provider mentioned working in a triage role and doing brief assessments, such as the Columbia Suicide Severity Rating Scale, the Brown Stanley Safety Plan, Self-Injury Inventory and Violence Risk Assessment Tool. Depending on the results, they send the youth out for more comprehensive psychological evaluations, but there are so few providers it can take over a month to receive those assessments and another month to receive results back before the youth can receive services.

WV DHHR has reported that currently the following entities in WV provide mental health screening: primary care providers, BSS Youth Services, BSS Child Protective Services, Division of Corrections and Rehabilitation, BJS, and West Virginia Judiciary, Division of Probation Services. To establish a baseline number of child screening by each screening entity, WV DHHR conducted a medical chart review of a random sample of Medicaid members between ages 0 and 20 for calendar year 2020, that had received a well-child visit. The screening number was an indication of the screening, not an identification of mental health needs. The medical chart review indicated that 80% of children received a mental health screening during their primary care provider visit. The average age for children to receive a screening in the sample was seven. The percent of children completing a mental health screening increased with age with 90% completing screenings for ages 19–20. For children in the custody of the Bureau of Juvenile Services (BJS) half of review period, while in the second half, screenings increased to an average of 98.5 per month. As the pandemic becomes less of an impact, an increase in screenings from BJS is expected. Due to data collection limitations, screening data for children involved in Youth Service, CPS and Probation were not included in the review. WV DHHR stated that outreach to primary care providers about the Assessment Pathway in November 2021, would increase the number of primary care providers completing an EPSDT screen with a mental health check.

3.1.8 How has the philosophy toward the use of community-based services changed among youth/caregivers, providers, and partner organizations (understanding the continuum of services)? † ‡ §

Expected Outcome:

- Increased acceptance among [youth/caregivers, providers, and partner organizations] of community-based mental health treatment as an alternative to residential mental health treatment facility placement ☺

Baseline Findings:

The majority of providers who responded to the survey reported that few of the services of interest to the evaluation have sufficient resources to meet community needs; however, attorneys and judges believe that the community-based mental health services being evaluated are beneficial (Appendix E, Services and Programs, Table 4).

Interviews and focus groups revealed that there is a clear preference among participants for community-based services over residential treatment, and multiple providers acknowledge a recent shift in the field to prioritization of in-home and community-based services. However, due to lack of beds and inadequate staffing, youth are sometimes placed in shelters, residential treatment facilities, or out-of-state because that might be their only option. One provider described that many youth experience issues that are either

too severe or not severe enough for the types of services available in WV. They stated that staff at WV DHHR helping with placements acknowledge programs in Virginia or Ohio might better suited for the youths' needs, but that now they are being forced to "funnel through West Virginia" and go through more administrative processes to get the youth other in-state access to treatment.

The majority of surveyed health providers neither agree nor disagree, with some agreeing somewhat, that WV DHHR prioritizes in-home and community-based care over out-of-home placement when youth might be better served at home, and that the policies and procedures for coordinating youth care with WV DHHR partners are clear (Appendix E, Referral Policies, Table 1). These findings vary by provider type, with registered/licensed nurse, residential direct care staff and residential facility social workers either disagreeing or somewhat disagreeing. Providers younger in age and with more education have higher levels of agreement. These findings do not vary overall regionally, but do vary regionally by provider type (Appendix E, Referral Polies, Table 2).

Social service providers and parole officers somewhat agree that WV DHHR and court judges support and prioritize in-home and community-based care over out-of-home placement when youth might be better served at home; this finding does not vary by region (Appendix E, Social Services and Probation Officers, Table 1).

All health providers believed that their organizations often or sometimes make referrals to community-based programs, and overall, their organization sometimes has clearly defined processes or policies for following-up with youth or their families/caregivers after a referral has been made to a community-based organization. Their organizations also sometimes had clearly defined policies for following-up with a new provider after a referral had been made to a community-based organization. These findings did vary slightly by health provider type and region, with Region 3 having a slightly lower frequency of agreement (Appendix E, Referral Policies, Table 3).

The four largest barriers to maximizing the referral network for youth referred to residential mental health treatment were: (1) lack of qualified providers within their network or areas, (2) lack of resources (ex. funding, staff), (3) lack of information about resources in the community, and (4) staff turnover. These findings are consistent across all provider types and regions (Appendix E, Referrals, Table 5).

Providers agree that the top four contributors of youth being sent to out-of-home placement when the youth might be better served at home are: (1) lack of community-based services, (2) lack of parental capacity, (3) clinical necessity and (4) the unique needs to the youth that cannot be met in other service settings (Appendix E, Out-of-Home Placements, Table 1). These findings were consistent across provider types and regions, with residential mental health social workers also agreeing that court ordered placements also contribute to out-of-home placement when the youth might be better served at home.

Court judges report agreement that they prioritize in-home and community- based mental health care over residential placement when juveniles would be better served at home and that there are juvenile court policies in place to help implement the recommendations made by the multidisciplinary treatment team (Appendix E, Judges and Attorney, Table 1). This agreement is consistent across regions. Court judges somewhat agree that WV DHHR multidisciplinary teams prioritize in-home and community-based mental health services over residential placement when juveniles would be better served at home and this agreement varies across regions, with Region 1 agreeing and Regions 2-6 somewhat agreeing.

Court judges somewhat agree that they receive the needed information from multidisciplinary teams to make appropriate placements for youth on delinquency or status offense case dispositions and to prioritize in-home and community-based mental health services over residential placement when juveniles would be better served at home (Appendix E, Judges and Attorney, Table 1). This finding varies by region, with judges representing Region 1 agreeing that they receive the information that they need and judges in Region 6 disagreeing. Out of all services of interest to the evaluation, those court judges who were aware of the service mostly required participation in residential mental health treatment services as part of a case disposition in the past 12 months, but also required some participation to WV Children's Mental Health Wraparound and Children with Serious Emotional Disorder Waiver Wraparound (Appendix E, Judges and Attorney, Table 2).

Interviews and focus groups found that mental health professionals in WV and judges perceive that their choice for youth mental health treatment frequently boils down to "a residential facility placement or nothing." When community-based services are not readily accessible, not connecting youth with the first available residential option means delaying mental health care entirely until the community-based services have an opening. This creates the potential for youth to not receive any treatment when they are in crisis, which risks worsening symptoms, with wait times for community-based services ranging from three to four weeks to six to eight months, and sometimes up to one year, depending on the type of service needed. On the other hand, some key informants working at residential mental health treatment facilities reported that youth do not receive residential-based treatment unless it is absolutely necessary.

Attorneys and Guardians ad litem responding to the survey reported that they:

- Somewhat agree that juvenile court judges prioritize in-home and community- based mental health care over residential placement when juveniles would be better served at home, but this agreement differs by region, with Region 4 attorneys neither agreeing or disagreeing (Appendix E, Judges and Attorney, Table 3).
- Somewhat agree that they are prepared to work with a juvenile with mental health needs and this agreement is consistent across regions, except for Region 4 where they agree that they are prepared to work with a juvenile with mental health needs.
- Neither agree nor disagree that they have the information they need to make appropriate recommendations to the courts on behalf of the juvenile they are representing and that juvenile mental health needs are appropriately considered in the court.
- Disagree with the statement that the protocols for handling a juvenile with mental health needs are clear. These findings are consistent across regions. Somewhat disagree that the juveniles they represent receive adequate mental health care
- Somewhat disagree that there are high-quality mental health services in their jurisdictions, except for Region 4 where they neither agree nor disagree
- Somewhat disagree that there are effective mental health service provider agencies in their jurisdictions, except for Region 4 where they neither agree nor disagree
- Somewhat agree that the services in their court jurisdiction do not meet the diverse mental health needs of juveniles (Appendix E, Judges and Attorney, Table 3).

Interview and focus group participants communicated that COVID-19 has also introduced new barriers to utilization of community-based services. Some families decided to discontinue community-based services due to the pandemic, some services were no longer offered, and the substantial increases in youth in crisis

because of COVID-19 has led to a general decrease in available beds and services available. However, key informants in Region 3 offering Children with Serious Emotional Disorder Waiver Wraparound, West Virginia Children's Mental Health Wraparound, and PBS report that despite the impact of the pandemic, these organizations continue to provide services, either through telehealth or safe in-person meetings

Interview and focus group participants also communicated that facilitator to community-based treatment include building strong relationships and communication between case managers and health providers. Where open and positive communication exists, services offered in the community are viewed as having a positive impact. Providers in Region 5 noted a shift in treatment, where more community resources are being offered after residential placement and information about referral pathways prioritize community-based options. Key informants from Region 5 explicitly described trying to reduce the reliance on residential services through their programs, and believe they are taking steps in the right direction, but a tremendous need for more services and providers exists to accomplish this.

Overall, these findings indicate that the philosophy of providers toward the use of community-based mental health services is supportive and accepting, but that there is a need for more resources, services and providers in WV communities to support a community-based continuum of care for youth. As such, it is possible that the supporting processes and policies for referrals and follow-up to community-based mental health organizations for youth are lacking in response to the gaps in services and mental health providers.

Expected Outcome:

- Increased awareness and acceptance of mental health services and supports among partner organizations ① Ⓛ

Baseline Findings:

Referral patterns reflect awareness and acceptance of community-based mental and behavioral services. Out of all services being evaluated, surveyed health providers mostly refer and receive referrals to residential mental health treatment facilities. Children with Serious Emotional Disorder Waiver Wraparound was the second most referred to service followed by PBS, and the least referred to program was ACT. Referrals to services varied by provider type, region and length of practice of the providers, with behavioral analysts, psychiatrists and psychologists referring to community-based services the most and psychiatrists the least, except for the Children with Serious Emotional Disorder Waiver Wraparound program. Psychiatrists and psychologists refer to residential mental health treatment facilities the most and behavioral analysts the least. Health providers in Region 4 refer to all services the most, except for ACT (which is limited to 18 to 21 year olds), and providers in Regions 5 and 6 refer to ACT services the most. The longer the provider has been in practice, the more they refer and receive referrals to all services (Appendix E, Referrals, Table 1).

Interviews and focus groups revealed barriers and facilitators to referral processes to community-based services across many levels. At the system-level, WV DHHR policies and eligibility criteria for programs such as Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound make referrals challenging. Client issues with insurance and Medicaid coverage also limit referrals. At the provider level, a lack of knowledge about services to refer to, lack of services available, and limited communication between providers can stifle the referral process. Some providers

discussed that community-based programs are so overburdened and busy with clients that they almost never hear back from these programs when contacted. Unless strong relationships and collaboration are already established between agencies, it is unlikely that referrals and placements can be made to community-based services in a timely manner. Furthermore, some referral pathways are perceived as being convoluted and lack streamlined systems; therefore, these challenges coupled with long wait times create multiple barriers to youth receiving community-based mental health treatment.

On the other hand, agencies have had success with streamlining referral processes internally and purposefully taking time to build awareness of other community-based services and referral sources. Externally, collaboration, relationship building, and community outreach can facilitate the referral process between different systems, agencies and community-based services. Early diagnosis, accurate and timely information-sharing and clear communication is another between-agency/service facilitator of community-based referrals.

Expected Outcome:

- Increased acceptance among education and criminal justice professionals of community-based mental health treatment as an alternative to residential mental health treatment facility placement among providers ☺

Baseline Findings:

As reported in 3.1.8, court judges indicated that they prioritize in-home and community-based services over residential when juveniles would be better served at home. Court judges agreed that court policies help implement recommendations made by the multidisciplinary team. However, court judges' perceptions of whether multidisciplinary teams prioritize in-home and community-based mental health services over residential placement when juveniles would be better served at home varied:

- Court judges from Region 1 agreed
- Court judges from Regions 2-5 somewhat agreed
- Court judges from Region 6 neither agreed nor disagreed.

Several judges discussed in interviews not being fully aware of the available community-based mental health programs for youth and having to rely on others to provide that information. This can be problematic if personnel providing information work for agencies that are understaffed; judges mentioned that WV DHHR specifically is understaffed. They stated that there is a need for more youth service workers who could assist with less extreme cases of mental and/or behavioral health issues to provide preventive services. Judges also stated that they often do not receive reports from multidisciplinary teams in a timely manner or they don't receive them at all. One judge stated, "How can you make a placement decision on a multidisciplinary team report that doesn't exist?"

A probation officer from Region 3 discussed having a very active and successful multidisciplinary team programs in their county. The judge that the participant works with requires a review of juvenile cases every 90 days and requires that a multidisciplinary team report be drafted before that review. Teams consisting of attorneys, the probation office, school personnel, mental health providers, and family members work together to provide updates and recommendations. The probation officer coordinates the multidisciplinary team meetings for the judge and summarizes the findings during court proceedings.

Judges reported in interviews that they assumed WV DHHR workers were being thorough with providing options for mental health services to judges, because judges do not have full awareness of all available youth mental health services. One judge stated that they require service providers to send updates directly to them instead of WV DHHR, because of not receiving service provider reports that are submitted to WV DHHR. Several judges report wishing they had more direct contact with service agencies, even if only to learn more about what mental health services they provide to youth.

Court judges responding to the survey somewhat agree that they receive the needed information from multidisciplinary teams to make appropriate placements for youth on delinquency or status offense case dispositions (Appendix E, Judges and Attorney, Table 1). This finding varies by region, with judges representing Region 1 agreeing that they receive the information that they need, and judges in Regions 2-6 somewhat agreeing. Although the court judges who were aware of the services being evaluation still mostly required participation in residential mental health treatment as part of a case disposition in the past 12 months, those court judges also required some participation to WV Children's Mental Health Wraparound and Children with Serious Emotional Disorders Waiver Wraparound (Appendix E, Judges and Attorney, Table 2).

Judges' interviews revealed that they prioritize community-based and in-home care and placements, but because services are so limited, youth frequently are placed out-of-home. Many judges identify family as problematic, both before and after residential treatment. Sometimes youth are sent to residential mental health treatment facilities in part because their family and homes are not safe (parental substance use was specifically noted) and/or the family is not helpful (or is completely resistant) in getting the youth needed treatment. Some mentioned instances where the youth was a danger to family members, but this was mentioned less often than the family being problematic for youth.

Judges also noted that transportation was a significant issue, both in general and because many services were not available locally. Many suggested the need to offer more in-home services, including therapy, as a way to deal with family transportation challenges. A few also mentioned possibly using telehealth, but noted that not all families have internet access.

Most Attorneys and Guardians ad litem somewhat agree, with those from Region 4 neither agreeing nor disagreeing, that juvenile court judges prioritize in-home and community- based mental health care over residential placement when juveniles would be better served at home (Appendix E, Judges and Attorney, Table 3).

In focus groups, attorneys agreed there was a lack of community-based treatment facilities in WV, especially for youth with significant mental health needs or violent tendencies. This sometimes results in them being placed out-of-state for treatment. However, an attorney in Region 1 mentioned that they were impressed with how well youth have done within residential treatment facilities. There were no attorneys representing Regions 2 – 6 participating in focus groups.

As reported in 3.1.8, most Attorneys and Guardians ad litem somewhat agree, and those from Region 4 agree, that they are prepared to work with a juvenile with mental health needs. However, Attorneys and Guardians ad litem disagreed that the protocols for handling a juvenile with mental health needs are clear, and neither agree nor disagree that they have the information they need to make appropriate recommendations to the courts on behalf of the juvenile (Appendix E, Judges and Attorney, Table 3).

In a focus group, an attorney in Region 1 discussed how their primary interactions with youth with mental health needs occur after they are summoned to delinquency petitions. There are currently no approved child forensic evaluators in the entire Northern Panhandle. This is a resource that is lacking, as these professionals are necessary to evaluate youth for their competency to stand trial.

When surveyed about their perceptions of the quality and adequacy of services available to youth, Attorneys and Guardians ad litem somewhat disagreed that:

- The juveniles they represent receive adequate mental health care,
- There are high-quality mental health services in their jurisdictions
- There are effective mental health service provider agencies in their jurisdictions.

These findings are consistent across regions, except for Region 4 where they neither agree nor disagree that there are high-quality mental health services in their jurisdictions and effective mental health service provider agencies in their jurisdictions. Attorneys and Guardians ad litem also somewhat agreed that the services in their court jurisdiction do not meet the diverse mental health needs of juveniles (Appendix E, Judges and Attorney, Table 3).

An attorney in a Region 1 focus group perceived that WV youth's mental health needs are not met due to the inability to access services. They described how some "old school" judges refuse to send youth out-of-state (due to personal opinions and cost), and then youth are sent to secured, WV DHHR-staffed group homes. This attorney believes youth in this situation are being "babysat" by underpaid staff versus receiving adequate treatment and care. Because facilities appear to be specialized and restrict access to youth with certain types of mental or behavioral issues, some children are not able to access treatment. For example, facilities that serve autistic children will not accept youth with violent tendencies. In turn, facilities that accept youth with a history of violence may not be equipped with the resources to also support autistic children, and thus they will not be accepted at certain facilities. Additionally, participants in Region 1 echoed perceptions heard in other focus groups that there are limitations on wraparound programs' ability to meet the long-term needs of children on the autism spectrum.

Law enforcement officers report neither agreeing nor disagreeing that they are prepared to work with a youth in mental health crisis and this finding does not vary by region. Overall, law enforcement officers somewhat agree that they would like to receive more training related to responding to a mental health crisis with a juvenile (Appendix E, Law Enforcement, Table 1).

One law enforcement officer stated during an interview that he receives very little training around working with youth with mental health needs and that most training comes from experience. Some basic trainings are offered through the Sheriff's department, but they are not perceived as very useful in the field and more specific training in mental health would be extremely beneficial. A challenge noted by this law enforcement officer included the lack of mental health support in schools, given the high rates of undiagnosed mental illness among school-age children.

On the other hand, another law enforcement officer stated that their department offers multiple mental health trainings, both in classrooms and online. A challenge noted by this law enforcement officer was the difference in referral procedures for adults versus youth. For adults experiencing mental health issues, law enforcement officers are able to utilize multiple referral systems, including hospitals. law enforcement officers can even transport adults in crisis to the hospital. However, they are unable to transport youth to

hospitals and instead must refer them to WV DHHR. Many times, the youth has already been referred to WV DHHR and has been denied services.

Law enforcement officers report needing training on working with Children's Mobile Crisis Response and Stabilization teams (67%), with only 3% reporting that they have received Children's Mobile Crisis Response and Stabilization training. Law enforcement officers also report needing resources or material guidance to work with Children's Mobile Crisis Response and Stabilization teams (65%) and protocols for when to call for CMS services when a juvenile is having an acute mental health crisis (56%) (Appendix E, Law Enforcement, Table 3). One law enforcement officer interviewed stated that they used Children's Mobile Crisis Response and Stabilization services before COVID-19, but they perceive that the service is not being used as frequently now. Another law enforcement officer did not recall using Children's Mobile Crisis Response and Stabilization and does not have any information/referral cards for the service. When they receive a domestic violence call involving children, they complete a form and refer the victim and/or children to WV DHHR or CPS.

In spring 2022, WV DHHR anticipates the implementation of a plan for outreach and education with judges pertaining to decreasing placements in residential mental health treatment facilities. Thus far, WV DHHR has established engagement with criminal justice professionals (law enforcement and members of the judicial branch of government) through the Child Welfare Collaborative. This open stakeholder forum provides an avenue to communicate community-based child mental health initiatives.

3.1.9   **How many juvenile justice petitions have been filed for children whose needs would have been better met by the mental health system? § [State priority = medium]

Expected Outcome:

- Decrease in petitions for juvenile justice in response to children's mental health crisis situations ☉

Baseline Findings:

WV DHHR is currently coordinating with Probation Services to establish a system for reporting juvenile petitions filed. This data source is still being determined.

3.1.10 How many mental health providers are available to treat children in WV? §

Expected Outcome:

- Increased mental health workforce for state ☉

Baseline Findings:

As noted in 3.1.5 regarding capacity of the workforce, just over 40% of the organizations and facilities responding to the survey report "yes" to having the number of staff required to serve all youth who need services. These findings varied by region and service. In Region 1, 67% of organizations and facilities said "yes" to having the staff numbers needed, the highest percentage across all regions. Region 2 had the lowest percentage, with 19%. Out of all services being evaluated, organizations offering PBS services reported the lowest percentage of "yes" responses to having the number of staff required to serve all youth (23%), with organizations offering PBS services in Region 2 (8%) reporting "yes" the least across all regions. These findings also varied by the services within those regions, with organizations offering ACT

and Children's Mobile Crisis Response and Stabilization services in Region 1 responding "yes" to having the number of staff needed the most (100%, respectively) and Children with Serious Emotional Disorder Waiver Wraparound organizations reporting "yes" the least (0%). Within Region 2, Children's Mobile Crisis Response and Stabilization, Children with Serious Emotional Disorder Waiver Wraparound and WV Children's Mental Health Wraparound services reported "yes" to having the number of staff needed to serve all youth who need services the least (0%, respectively); in Region 2, only organizations offering PBS and residential mental health treatment facility services responded "yes" to having the number of staff needed to serve all youth who need services across all organizations in Region 2 offering services of interest to the evaluation (8% and 50%, respectively) (Appendix D, Workforce and Capacity, Table 1).

Interviews and focus groups revealed that therapist shortages are a statewide problem and that recruiting staff in rural areas is especially difficult. Key informants talked about the "really difficult work" that impacts recruitment and retention of staff for Children's Mobile Crisis Response and Stabilization staffing barriers due to the challenging and intensive nature of working with youth experiencing mental health crises, coupled with low pay. Retention issues were reported due to a lack of understanding about the pay/reimbursement structure for mobile crisis work (e.g., staff are only paid for being on call if they respond to a crisis on their shift).

Due to COVID-19, increases in youth in mental health crisis have been observed, but available beds have decreased. Children's Mobile Crisis Response and Stabilization was noted to have been helpful in managing this shift. In Region 6, although staffing shortages exist (in particular obtaining master's level therapists), agencies have prioritized staffing for Children's Mobile Crisis Response and Stabilization to ensure adequate coverage.

Lack of short-term services and psychiatrists for youth with severe behavioral issues who need residential treatment is a barrier for residential mental health treatment facilities and other residential programs. For Region 4, which has two residential homes, barriers exist with recruiting BA and MA level staff, mostly due to the remote locations of the residential facilities. These facilities report that they are fully staffed currently, but hiring new staff is an issue. In addition to location, few applicants (especially those with master's level training) are interested in working with the population served by residential treatment programs, so they receive very few new applicants. Key informants from Region 5 discussed that the work in residential programs is very hard, extremely challenging and patients experience high acuity issues, which have been exacerbated by COVID-19. These issues make it even harder to find staff. Impacts of COVID-19 on residential mental health treatment facilities have been enormous "everything has to stop" when there is a COVID-19 outbreak. Hiring youth care workers to work with the staff has been a challenge in residential treatment as well. Key informants also reported that pay grade adjustments helped Region 5 obtain the therapists they needed in residential programs.

Most health providers responding to the Provider Survey reported overall agreement that they plan to remain with their current organization and in their current role for the foreseeable future (Appendix E, Plans, Table 1), except for residential direct care staff who only somewhat agreed to remain in their role for the next year and beyond. Health provider responses varied slightly across regions with providers in Regions 2 and 5, only somewhat agreeing that they plan to remain in their role for the next 3-5 years (Appendix E, Plans, Table 2). Responses also varied by provider type by region, with behavioral analysts in Regions 2 and 4 in less agreement about remaining in their current roles and organizations over time (Appendix E, Plans, Table 2).

Interviews and focus groups revealed that salary is the main barrier for provider recruitment and retention in the mental health profession in WV. Additionally, staff and providers with more experience in the profession typically prefer providing services in a clinic instead of providing in-home or residential treatment. Newer employees and recent college graduates need more training, supervision, and often enter the field unaware of the demands of the profession. This results in significant turnover, especially among young and candidates with less experience. They may begin their careers in WV, but often leave within a few years to a different state for higher wages and lower caseloads.

Mental health workforce capacity is a well-documented challenge for WV[1]. Efforts are currently under way to address workforce shortages in WV, including the efforts of the Workforce Workgroup associated with this initiative. The WV Behavioral Health Workforce and Health Equity Training Center in partnership with Marshall University has been established to address training needs for wraparound facilitators and Children's Mobile Crisis Response and Stabilization providers. In addition, WV DHHR received approval for a funding request to support the enhancement of provider capacity to deliver community-based services through the American Rescue Plan.

As described in 3.1.6, WV DHHR has reported ongoing efforts to recruit providers. A lack of applicants has made it challenging to recruit staff for the Children with Serious Emotional Disorder Waiver. The current West Virginia Children's Mental Health Wraparound workforce capacity has an average of 82% occupancy rate statewide. As of January 2022, West Virginia Children's Mental Health Wraparound staffing is as follows:

- Region 1, 3, and 4 have reached full program capacity
- Region 2 reported 50% occupancy rate.
- Region 5 and 6 reported 67% occupancy rate.

WV DHHR is developing a process for caseload management among Wraparound Facilitators with the Children with Serious Emotional Disorder Waiver Wraparound and Safe and Home agencies. Regarding the other services being evaluated, WV DHHR also contracted Mountaineer Behavioral Health to develop an ACT team in the Eastern Panhandle. The target date for hiring and training is May 2022 but might be impacted by the pandemic. The BBH PBS program is working on building both workforce and systemic capacity for more agencies to serve children in the state. For Children's Crisis and Referral Line, it has a 100% occupancy rate for crisis counselors, 67% for shift leads and 14 helpline specialists.

3.1.11 How has functioning changed for children receiving mental health services? †

Expected Outcome:

- Improved child functioning ① Ⓛ

Baseline Findings:

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[1] Health Professional Shortage Areas: Mental Health, by County, 2022. Rural Health Information Hub. Accessed March 23, 2022. https://www.ruralhealthinfo.org/charts/7

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.12 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:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

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

Expected Outcome:

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

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.14 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:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.15 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:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.16 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 ⑤

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.17 Were fewer children with serious mental health conditions needlessly removed from their family homes since May 2019? †

Expected Outcome:

- Increased children leaving residential mental health treatment facilities and Psychiatric Residential Treatment Facilities for family-like settings ⑤ ①

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

3.1.18 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 ①

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4 High-Priority Workgroup Specific Evaluation Questions: Baseline Findings[2]

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. As in previous sections, 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

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[2]Mental Health Screening, Workforce and Outreach workgroup evaluation questions are included in the Initiative Specific questions and do not include questions solely pertaining to each specific workgroup, respectively.

DHHR reported progress. 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 1). Baseline findings for the youth and caregiver level of the Evaluation will be included in the July 2022 report.

4.1 Wraparound:

4.1.1 Can WV families with children who need mental health services access wraparound services in their communities? † §

Expected Outcome:

- Increase in access (statewide) to children's mental health prevention and treatment services Ⓢ

Baseline Findings:

Organizations and facilities responding to the survey reported that both Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound offer services in every region and every county in WV (Appendix D, Referrals, Table 1). This finding was validated by telephone follow-up to each organization and facility. Information obtained through key informant interviews revealed that several barriers existed in service delivery, especially for Children with Serious Emotional Disorder Waiver Wraparound. Staff shortages continue to impact mental health service in WV. In Region 3, key informants shared that a wraparound position had to be moved to a different county to be filled and an extra position to serve Children with Serious Emotional Disorder Waiver clients was not able to be filled. Telephone follow-up also revealed that providers struggle with staffing in Region 1 and Region 5, and thus were not providing any new services in Children with Serious Emotional Disorder Waiver.

Focus group participants described Children with Serious Emotional Disorder Waiver as, "a good program in theory." The Children with Serious Emotional Disorder Waiver program offers specialized therapy to children with needs that might not be met by another program. However, implementation efforts have been challenging due to a significant lack of providers (especially those who are licensed for supervision) in most regions. Children with Serious Emotional Disorder Waiver requirements also limit services and referrals. At the time of data collection, if the services that families were receiving did not qualify for Children with Serious Emotional Disorder Waiver, then they needed to change providers despite already having an established rapport, disrupting the therapeutic process. For children in kinship care, there is a misperception that they are not qualified for Wraparound under the Children with Serious Emotional Disorder Waiver.

Focus group participants also communicated that the Wraparound program team approach brings more ideas on treatment and support, but that approach might not always be administered. Lack of awareness of and understanding about wraparound services across communities limits referrals and the ability to reach youth in need. For specific populations, such as children on the autism spectrum, participants stated that Wraparound programs cannot provide the long-term support that is need.

WV DHHR reported that they implemented the Children with Serious Emotional Disorder Waiver Wraparound program effective March 1, 2020. The program utilizes the NWI model and provides community-based services that enable children who would otherwise be placed in residential treatment facilities to receive care in their homes and communities. Of the 22 providers contracted with the MCOs to provide Children with Serious Emotional Disorder Waiver services across West Virginia, at the time of data collection, twelve were actively providing services to children. The remaining 10 approved providers have struggled with staffing challenges due to the pandemic as well as national labor shortages. From July 2020 to June 2021, Children with Serious Emotional Disorder Waiver programs received 316 applications, among which 198 applications were approved, 70 applications were denied, and 93 applications were pending. Of Children with Serious Emotional Disorder Waiver applicants, 48% were children ages 13 to 17, followed by 33% of children ages 9 to 12. From July 2020 to September 2021, WV DHHR reported that 138 children accessed Children with Serious Emotional Disorder Waiver services, and 106 children received independent evaluations for the Children with Serious Emotional Disorder Waiver, but did not access any other waiver services during the review period. The number of children accessing services has continued to increase over time while the units of service per children has remained relatively consistent.

From July 2020 to June 2021, BBH Children's Mental Health Wraparound served 310 children. Services were provided to individuals residing in 43 counties across the state by 5 regional providers. Counties with the highest number of children served included Berkeley (44), Kanawha (29), Wood (25), Raleigh (23), Monongalia (20), and Marion (20). Most of the children served were between 9 and 17 years of age. The age groups served by BBH Children's Mental Health Wraparound are younger compared to those in residential placement, indicating the opportunity for the program to reduce the risk of out-of-home placement.

4.1.2 How has wraparound service availability changed? §

Expected Outcome:

- Increase in access (statewide) to children's mental health prevention and treatment services Ⓢ

Baseline Findings:

In addition to statewide availability described in 4.1.1, key informants revealed that documentation demonstrates where Children with Serious Emotional Disorder Waiver Wraparound services are offered, if all providers are fully staffed. Therefore, this data represents the typical counties where services are offered, but due to staffing issues, the services are only limitedly operative. For example, the Huntington Office which serves Cabell, Wayne, and Putnam counties and the Weirton Office which serves Brooke and Hancock counties are severely understaffed, so they are not providing any new Children with Serious Emotional Disorder Waiver Wraparound services there. Other offices are currently understaffed with therapists and so the Wheeling office, which serves Ohio and Marshall counties, the new Martinsville office, which serves Wetzel and Tyler counties, and the Morgantown office, which serves Harrison, Marion, Monongalia, Preston, and Taylor counties are taking Wraparound Facilitation cases only.

Organization types offering WV Children's Mental Health Wraparound services were CBHC (4%), CMHC (79%), adoption agencies (4%), schools (4%), residential mental health treatment facilities (4%) and other (4%). Organization types offering Children with Serious Emotional Disorder Waiver Wraparound services were CBHC (8%), CMHC (73%), adoption agencies (4%), residential mental health treatment facilities (8%)

and other (8%) (Appendix D, Referrals, Table 2). All "other" responses are presented in Appendix C, Tables C-7 and C-8.

4.1.3 How has awareness among professional stakeholders related to eligibility/accessibility of wraparound services changed? ‡ §

Expected Outcome:

- Increased awareness and acceptance of mental health services and supports among child serving professionals ① Ⓛ

Baseline Findings:

About 67% of all providers are aware of WV Children's Mental Health Wraparound and about 51% of all providers are aware of the Children with Serious Emotional Disorder Waiver Wraparound (Appendix E, Services and Programs, Table 4). These findings vary by provider type, with residential direct care staff and social workers, case managers and social service providers, and behavioral analysts being the most aware of West Virginia Children's Mental Health Wraparound and medical doctors and nurses being the least aware. Behavioral analysts, case managers and workers, and social workers are the most aware of Children with Serious Emotional Disorder Waiver Wraparound and medical doctors and nurses are the least aware. Most focus group participants when asked directly about their knowledge or use of wraparound were aware of the services, except one participant from Region 5. It should be noted that other participants from Region 5 were aware of wraparound services and reported positive experiences. Information needs from participants included updated information about available services.

Health providers offering residential mental health treatment services neither agreed nor disagreed with the statement that their organization routinely collaborates with Wraparound services to plan to discharge clients (Appendix E, Out-of-Home Placements, Table 4). This finding varied by provider type and region with psychiatrists agreeing and psychologist disagreeing, and Regions 1 and 2 in more agreement than Regions 3-6. Interview and focus group participants in Region 1, mentioned that they collaborate with counselors at the Youth Service Center and Alternative Learning Center for wraparound services. Representatives from Region 3 stated wraparound referrals are made by word of mouth and thus lack of awareness about services limits referrals and the ability to reach youth in need. Region 4 participants discussed that collaborations with WV Children's Mental Health Wraparound services exist, specifically counseling centers in the area, but that they have extremely long wait lists. Qualifying youth can get counseling through juvenile drug court and WV DHHR involvement qualifies them for Safe at Home Wraparound. However, in contracts, a participant from another county in Region 4 stated there were no wraparound services to work within their area. Another service mentioned in Region 4 is Juvenile Victim-Offender Mediation. Professionals from Region 5 described weekly wraparound meetings to improve services and referral process. They stated it was a great service that should be expanded throughout the state. Representatives from Region 6 mentioned that having a licensed therapist on staff at the Youth Reporting Center allowed the agency to make referrals for Wraparound services such as Safe at Home. There are wraparound coordinators in Region 6 that work with families referred by CPS for substance abuse issues. There were no specific discussions about collaborations between wraparound services and medical or primary care providers.

WV DHHR reported partnering with Marshall University to provide wraparound services training and technical assistance to providers across WV and to complete an ongoing evaluation of wraparound service fidelity to the NWI standards. To date, Marshall University has established a contract with the University of Maryland to provide wraparound training to providers as well as to certify Marshall University staff as wraparound trainers. Fidelity reviews are anticipated to begin sometime in the second quarter of 2022. Quality sampling review (i.e., chart reviews) to evaluate the alignment of children and family support plans and services with CANS assessment results are anticipated to begin in the second half of 2022. Once routine fidelity and quality sampling reviews are initiated, Marshall University will publish reports on an ongoing basis. These reports will be incorporated into WV DHHR's quality committee review process.

4.1.4 How have wraparound providers' knowledge and skills changed? ‡

Expected Outcome:

- Increased awareness of mental health services and supports among child serving mental health professionals ⑤ ①

Baseline Findings:

Over half of the wraparound organizations and facilities responding to the survey report that the staff in their facility have the skills and training necessary to serve all youth who need services (Children with Serious Emotional Disorder Waiver Wraparound 62%; West Virginia Children's Mental Health Wraparound 50%). This finding varied by region. Organizations in Region 3 offering Children with Serious Emotional Disorder Waiver Wraparound services responded "yes" the most (67%) and in Regions 2 the least (17%). Organizations in Region 5 offering West Virginia Children's Mental Health Wraparound services responded "yes" the most (75%) and in Region 6 the least (11%). (Appendix D, Workforce and Capacity, Table 1). One focus group participant from Region 6 mentioned that having a licensed therapist on staff was needed to make referrals to wraparound. Otherwise, there was no additional discussion about skills and training for the wraparound workforce specifically in interviews or focus groups.

Overall, health providers report being not at all competent or being somewhat competent on the NWI model (Appendix E, Skillset and Training, Table 1). Sixty health providers reported requesting training on the NWI model, and of those sixty providers, only two providers reported receiving training. Out of all health providers, behavioral analysts, psychologist and residential facility social workers report being the most competent, but very few providers report being very competent (Appendix E, Skillset and Training, Table 1).

All health providers offering wraparound services agree that they understand the evidence behind the NWI model (Appendix E, Wraparound and ACT, Table 1). This finding varies by provider type and region, with psychiatrists and residential social workers having the most agreement and psychologists and nurses having the least agreement, and Regions 2, 5, and 6 having the most agreement and Regions 1, 3 and 4 having the least. Overall, the health providers neither agree nor disagree that they have the necessary skills to implement the NWI model and that they use the NWI tolls to monitor delivery on a case-by-case basis. These findings also vary by provider type and region, with psychiatrists and residential social workers having the most agreement and psychologists and medical doctors having the least agreement, and Regions 2, 5, and 6 having the most agreement and Regions 1, 3 and 4 having the least.

4.1.5 How has wraparound workforce capacity changed? §

Expected Outcome:

- Increased mental health workforce for the state ☺

Baseline Findings:

Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound organizations and facilities responding to the survey report "yes" to having the number of staff required to serve all youth who need services at 50% agreement for Children with Serious Emotional Disorder Waiver Wraparound and 38% for West Virginia Children's Mental Health Wraparound, statewide. These findings varied by region and service. Organizations offering Children with Serious Emotional Disorder services reported "yes" to having the number of staff required to serve all youth the most in Region 5 (53%) and the least in Regions 1 and 2 (0%, respectively). Organizations offering West Virginia Children's Mental Health Wraparound services reported "yes" to having the number of staff required to serve all youth the most in Region 5 (75%) and the least in Regions 2 and 6 (0%, respectively).

Information about Children with Serious Emotional Disorder Waiver Wraparound was not reported by interview or focus group participants in Region 1. In Region 2, a participant noted that only one provider was available in their area for WV Children's Mental Health Wraparound and that they must serve a very large area of seven or eight counties, so it is difficult for children to access those services. West Virginia Children's Mental Health Wraparound has also declined several children referred to them, stating that they are not safe enough in their homes to receive services. However, interview and focus group participants also communicated that there is no "step down" or "middle ground" option for children who might not need to be in residential treatment but also cannot safely be in the home. For this reason, many children cannot be cared for in the home with the currently accessible services due to severe or extreme behaviors; therefore, it is not safe for the care providers or parents in the home, there is no intensive outpatient or stepdown option, making residential treatment the only option.

In Region 3, participants reported several problems with Children with Serious Emotional Disorder Waiver, including not enough agencies providing services the program promises, resulting in long approval times. With only one agency that provides case management, the other agencies provide the other in-home services, and right now there's only a very limited number of agencies in WV that can provide this service. Additionally, at the time of data collection, if the services that families were receiving did not qualify for Children with Serious Emotional Disorder Waiver, then they needed to find new providers and start the approval process all over again, and participants reported the perception that the approval process for Children with Serious Emotional Disorder Waiver takes longer than it actually does. In Regions 3 and 6, there was a perception that the Children with Serious Emotional Disorder Waiver requirements limited services and referrals, specifically a misunderstanding that children in kinship care cannot also qualify for wraparound. Additionally, since it is a Medicaid funded program, the funds for Children with Serious Emotional Disorder Waiver are also limited. In Region 3, a key informant discussed the statewide therapist shortage problem and noted that operating at capacity to serve youth in rural areas is especially difficult. They described adding extra therapy and non-therapy positions to be able to serve more Children with Serious Emotional Disorder Waiver Wraparound clients and offer additional wraparound services, but not

being able to fill them due to low pay and rural location of the positions. Thus, services are available, but delivering those services—especially counseling and therapy—is unlikely due to lack of staff.

Region 4 participants note that the Children with Serious Emotional Disorders Waiver Wraparound program has helped youth stay in the community rather than be placed in residential treatment. They perceive that Children with Serious Emotional Disorders Waiver Wraparound is starting to make a positive impact, but that it can be difficult to enroll youth in the program, because it takes parents/families a while to fill out paperwork and then return that paperwork back to the agency to get their child services.

Representatives from Region 4 noted that wraparound services are not consistently offered, as youth return back to mental health facilities after being referred to community-based services without having had received the community-based services. There also is a lack of understanding from the families as to what wraparound services or Children's Mobile Crisis Response and Stabilization services entail. While their residential programs have enough staff, the community-based programs don't have enough employees to keep caseloads down. More staff to decrease individual caseloads would fix this issue. Additionally, there is confusion on the worker side on the process for obtaining licenses. There are workers willing to do the work, but the time and paperwork for licensing can make the ability to work in this field challenging.

In Region 6, a focus group participant noted that although the Children with Serious Emotional Disorder Waiver Wraparound services are rolled out, they have not formally started offering those services, but hope to offer these in-home services soon.

Over half of the organizations and facilities responding to the survey that offer Children with Serious Emotional Disorder Waive Wraparound services (62%) and West Virginia Children's Mental Health Wraparound services (50%) report "yes" to having the capacity to serve all youth currently being referred to the facility, but this finding varied by region. Organizations offering Children with Serious Emotional Disorder Waiver Wraparound services in Region 1 responded "yes" the most (62%) and Region 2 the least (25%). Organizations offering West Virginia Children's Mental Health Wraparound services in Region 5 responded "yes" the most (75%) and Region 4 the least (0%). Of those organizations offering Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound services reporting "no" to having the capacity to serve all youth currently being referred to the facility, only 30% of organizations offering Children with Serious Emotional Disorder Waiver Wraparound and 23% offering West Virginia Children's Mental Health Wraparound services report that those needs are being met by other service providers in the region. This finding varied by region, with Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities in Regions 2 and 6 reporting that those needs are being met by other service providers in the region the least (25%) and Region 3 the most (50%), and West Virginia Children's Mental Health Wraparound organizations and facilities in Region 6 reporting that those needs are being met by other service providers in the region the least (25%) and Region 3 the most (100%) (Appendix D, Workforce and Capacity, Table 1).

Interviews and focus group findings interchange staffing with capacity. According to those findings, there is limited capacity for service offerings across all services of interest to the evaluation because of statewide staffing issues.

Of the providers responding to the Provider Survey, mostly psychiatrists and residential mental health social workers provide WV Children's Mental Health Wraparound services across all regions (Appendix E,

Services and Programs, Table 3). For Children with Serious Emotional Disorder Waiver Wraparound, mostly psychiatrist and psychologists responding to the survey provide these services across all regions. Therefore, wraparound workforce capacity could be expanded by providing more trainings and opportunities for service delivery to behavioral analysts and residential facility social workers.

Of all providers aware of West Virginia Children's Mental Health Wraparound, the majority reported that the service does not have sufficient resources. This finding varied by provider type, with behavioral analysts reporting that the service did have sufficient resources (Appendix E, Services and Programs, Table 4).

In addition to the constraints mentioned in previous evaluation questions from interview and focus group participants, a participant from Region 2 noted that youth are eligible for wraparound services only if they have not had any involvement with WV DHHR. Therefore, more education about wraparound service eligibility may be needed, particularly in Region 2. Additionally, focus group participants from Region 3, as in other regions, noted that children on the autism spectrum need longer-term support than wraparound programs are able to provide.

Of all providers aware of Children with Serious Emotional Disorder Waiver wraparound, the majority reported that the service does not have sufficient resources (Appendix E, Services and Programs, Table 4). This finding varied by provider type, with nurses and residential facility social workers reporting that the service did have sufficient resources.

Discussions from interview and focus group participants in Region 3 revealed COVID-19 has impacted Children with Serious Emotional Disorder Waiver resources and services by limiting the number of services able to be offered in the home. While the transition to telehealth has ensured service delivery with Children with Serious Emotional Disorder Waiver Wraparound, the pandemic has also impacted staffing at the shelters.

As has been a common theme across all evaluation question findings, the main resource constraint for the key informants in Region 5 was understaffing due to low salaries, making implementation of Children with Serious Emotional Disorders Waiver difficult. A key informant in Region 5 stated that although they are being mandated to provide Children with Serious Emotional Disorder Waiver services, quality service cannot be delivered due to fragmented processes, systemic challenges, and not being able to hire staff.

The WV DHHR effort that is underway is to require all West Virginia Children's Mental Health Wraparound facilitators and all Safe at Home facilitators to be able to provide Children with Serious Emotional Disorder Waiver Wraparound. The reason for this change is to allow facilitators working with families to remain consistent when the family is enrolled in Children with Serious Emotional Disorder Waiver. As detailed in 3.1.1, as of January 2022, there are 22 providers contracting with WV MCOs to provide Children with Serious Emotional Disorder Waiver services across West Virginia. Twelve providers are actively providing services to children, but some providers are encountering staffing challenges due to the pandemic as well as national labor shortages. WV DHHR also reported that during the data collection period, the current BBH Wraparound workforce capacity has an average of 82% occupancy rate statewide. The 17 budgeted personnel have 14 current employees. Program capacity varies across regions: Region 1, 3, and 4 have full program capacity; Region 2 reported 50% occupancy rate; and, Region 5 and 6 reported 67% occupancy rate.

4.1.6 **How has fidelity to the NWI model changed? §

Expected Outcome:

- Increased fidelity to the NWI model ① ⓛ

Baseline Findings:

The fidelity review will be handled by Marshall University and begins in second quarter 2022.

As WV DHHR aligns services to meet the NWI model across agencies, efforts are underway to enhance data collection and upgrade systems to allow interconnectivity of data sets across WV DHHR for record-level data through the data store. WV DHHR has also contracted with Marshall University to assess fidelity, and WVU OHA to provide an overall evaluation of the children's home and community-based services system. WV DHHR will incorporate data shared from those collaborations in future reports as the data become available. A major accomplishment over the past year was the implementation of the BBH SOC Epi Info Interface that captures more service-level data and identified data that will result in enhanced reporting for subsequent reports.

4.1.7 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 ⑤ ① ⓛ

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.1.8 How did receiving Wrap around 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 ⑤ ① ⓛ
- All children appropriately assessed and placed in residential mental health treatment facilities ⑤ ① ⓛ
- Increase in children leaving residential mental health treatment facilities for family-like settings ⑤ ① ⓛ

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.2 Children's Mobile Crisis Response:

4.2.1 How has the availability of Mobile Crisis services changed? §

Expected Outcome:

- Increase in access (statewide) to children's mental health prevention and treatment services Ⓢ Ⓘ Ⓛ

Baseline Findings:

Organization and facilities responding to the survey offer Children's Mobile Crisis Response and Stabilization to all regions in WV; although, all counties in all regions were not served. In Region 1, Children's Mobile Crisis Response and Stabilization services are offered to Wetzel county only. In Region 2, Mineral county did not receive services. In Region 4, only Barbour, Harrison, Randolph, Tucker and Upshur counties received services (Appendix D, Referrals, Table 1).

Key informants and focus group participants Region 1, located in the Eastern Panhandle, utilize Genesis Mobile Crisis Response and Stabilization. In Region 2, two organizations are registered to provide Children's Mobile Crisis Response and Stabilization, but only one currently offers the service due to the other not having a licensed provider to offer supervision. The service is reportedly new for this region and participants are excited about it. A participant in the system-level focus group for Region 3 revealed that one barrier to service utilization was that families and youth must have an open case in order to use the Children's Mobile Crisis Response and Stabilization unit. A representative for Children's Mobile Crisis Response and Stabilization in Region 4 described comprehensive program coverage for youth throughout the region, specifically via the statewide crisis hotline 844-HELP-4WV number and Appalachia Community Health. System-level focus group participants in Region 4 were aware of Children's Mobile Crisis Response and Stabilization services but have never used them or heard of others using them. Region 5 representatives were well connected with Children's Mobile Crisis Response and Stabilization services and stated the agency was "fabulous" with getting referrals for outpatient, in-home, wraparound, and Safe at Home programs. In Region 6, FMRS provides Children's Mobile Crisis Response and Stabilization. Therefore, according to these findings, service expansion and education and outreach efforts for Children's Mobile Crisis Response and Stabilization need to be directed to Regions 2, 3 and 4.

The organization and facility types that offers Children's Mobile Crisis Response and Stabilization services are mostly CMHC (88%), followed by CBHC, schools, hospitals and residential mental health treatment facilities (1%, respectively) (Appendix D, Background, Table 2). Focus group participants discussed Children's Mobile Crisis Response and Stabilization being offered through Genesis Mobile Crisis Response and Stabilization in Region 1, Appalachia Community Health and another organization in Region 4 and FMRS in Region 6.

The majority of the organizations and facilities responding to the survey that offer Children's Mobile Crisis Response and Stabilization services (82%) services report "yes" to having the capacity to serve all youth currently being referred to the facility, but this finding varied by region. Organizations offering Children's Mobile Crisis Response and Stabilization services in Regions 1, 3 and 4 responded "yes" the most (100%) and Region 2 the least (33%). Of those organizations offering Children's Mobile Crisis Response and Stabilization services reporting "no" to having the capacity to serve all youth currently being referred to

the facility, only 17% report that those needs are being met by other service providers in the region. This finding varied by region, with Children's Mobile Crisis Response and Stabilization organizations and in Region 2 reporting that those needs are being met by other service providers in the region the most (50%) and Regions 5 and 6 the least (0%, respectfully (Appendix D, Workforce and Capacity, Table 1).

Interview and focus group participants shared mixed experiences about working with Children's Mobile Crisis Response and Stabilization. Some reported that Children's Mobile Crisis Response and Stabilization is responsive to families' needs and is able to help parents deescalate and provide them with short-term support and access to resources in the community. One provider in Region 2 reported that the organization offers statewide Children's Mobile Crisis Response and Stabilization service and responds to families' needs right after they call in. However, other providers in statewide service focus groups shared that they have received reports from families that they could not access Children's Mobile Crisis Response and Stabilization. Families reported that the service didn't seem to exist, and when they were able to speak with Children's Mobile Crisis Response and Stabilization staff on the phone, they were not offered any services and were directed to call 911 instead. Such incidents have discouraged families from continuing to use Children's Mobile Crisis Response and Stabilization.

Key informants attributed staffing barriers to low salaries, along with the "really difficult work" due to the challenging and intensive nature involved within working with youth experiencing mental health crises, coupled with low pay. Retention issues were reported due to a lack of understanding about the pay/reimbursement structure for mobile crisis work. In addition, Children with Serious Emotional Disorder Waiver complicates the service delivery of Children's Mobile Crisis Response and Stabilization. In Region 2, a key informant reported that the organization was not able to offer Children's Mobile Crisis Response and Stabilization service despite being registered to provide it for the Children with Serious Emotional Disorder Waiver program. Unfortunately, the service is currently unavailable due to the lack of licensed providers, a requirement for Children with Serious Emotional Disorder Waiver, to supervise Children's Mobile Crisis Response and Stabilization team. Key informants in Region 4 shared that Children's Mobile Crisis Response and Stabilization is not open to the public and can only be used by Children with Serious Emotional Disorder Waiver clients. Other providers discussed more comprehensive coverage through the statewide crisis hotline and Appalachian Community Health. In some regions, such as Region 4, Children's Mobile Crisis Response and Stabilization services acted more as a service liaison between a family currently receiving Children with Serious Emotional Disorder Waiver services and their therapists versus crisis resolution. It was also reported that the conflict free model that Children with Serious Emotional Disorder Waiver utilizes creates a challenge for accessing Children's Mobile Crisis Response and Stabilization services, because if a family signs up for Children's Mobile Crisis Response and Stabilization then they cannot use that same agency for Children with Serious Emotional Disorder Waiver Wraparound services. Providers strongly believed that provider availability is lacking in the area or in the state to provide conflict-free case management.

WV DHHR has reported that the Children's Crisis and Referral Line operates statewide and 24 hours a day, 7 days a week. It serves individuals age 0-21 in emotional distress or having a diagnosis of Serious Emotional Disorder or Serious Mental Illness and families who are in crisis and seeking referrals to community-based behavioral health services for children and young adults. From July 2020 to June 2021, the Children's Crisis and Referral Line received 320 calls directly (88 calls in the first half of the year and 232 calls in the latter half), average 27 calls monthly. At least one individual from 43 of the state's 55

counties called the Children's Crisis and Referral Line directly. 92% of contacts in the January-June 2021 period came via chat or text, highlighting the importance of this feature for children and families in need. However, it also presents additional challenges for capturing call-related data. Of individuals for whom the call was reported as an "emergency/crisis/urgent" call and had a response listed for referral, 47% were reported as being directly transferred to a Children's Mobile Crisis Response and Stabilization team via "warm transfer."

Children's Mobile Crisis Responses and Stabilization services were available statewide as of May 2021. On average, WV DHHR reported that crisis specialists provide on-site support within one hour of the request. From July 2020 to June 2021, seven Mobile Crisis Response and Stabilization providers served 833 children across six regions. More individuals were served in counties with the greatest populations, with the exception of the northern and eastern areas of the state. These areas were in early implementation phases during the reporting period, likely accounting for lower numbers of individuals served. It should be noted that often an individual in crisis is a parent or caregiver with a small child. In these cases, the child would also be enrolled in the program to help provide services for the family as a whole. Some of these instances may make up the nearly 2% of children ages 0 – 4. Mobile crisis services appeared to serve a greater percentage of adopted children (12%) and children identifying as LGBTQ+ (18%). Race and ethnicity data were comparable to West Virginia's population less than 20 years of age.

4.2.2   How have the mobile crisis teams changed? §

Expected Outcome:

- Increased number of mobile crisis teams ⓘ Ⓛ

Baseline Findings:

Children's Crisis and Referral Line has achieved 100% occupancy rate with crisis counselors. It currently has an 85% occupancy rate with helpline specialists and 67% occupancy rate with shift leads.

According to WV DHHR BBH, there are now 7 organizations contracted to conduct Children's Mobile Crisis Response and Stabilization across all BBH regions: Genesis Youth Crisis Center (Region 1; 1 team), University Health Systems (Region 2; 1 team), Westbrook Health Services (Region 2; 1 team), United Summit Center and Appalachian Community Health Center (Region 4; 2 teams), Prestera (Region 5; 1 team), and FMRS Health Systems (Region 6; 1 team). Additionally, organizations and facilities responding to the survey reported that there are 33 Children's Mobile Crisis Response and Stabilization services offered across the State. These Children's Mobile Crisis Response and Stabilization services represent a combination of BBH funded Children's Mobile Crisis Response and Stabilization and Children with Serious Emotional Disorder Waiver Children's Mobile Crisis Response and Stabilization services.

Children's Mobile Crisis Response and Stabilization teams continue to develop and expand reach; pilot services began in a limited number of counties in 2016 and have expanded to cover services statewide in the reporting period. Despite challenges in finding providers to cover Regions 1 and 2 of the state, Region 1 was able to begin providing services in December 2019, and the final portion of the state in need of coverage began services in May 2021. Region 4 has two providers and the main provider in Region 6 subcontracts with two other providers to assist with coverage. Children's Mobile Crisis Response and Stabilization service positions have been historically difficult to fill. Currently, only Region 1 achieved 100%

occupancy rate. Each BBH region has offered increased staffing, with five out six regions adding one staff. However, lack of applicants has been a historical issue.

4.2.3 How have QA/PI processes improved Children's Mobile Crisis Response services? §

Expected Outcome:

- Increased timely response to child crisis situations Ⓢ Ⓘ Ⓛ

Baseline Findings:

Data on Children's Mobile Crisis Response and Stabilization capacity are being refined to address CQI-related processes and needs. WV DHHR is contracting with Marshall University to develop training programs for both Children's Mobile Crisis Response and wraparound services. BBH, BMS, and BSS staff meet with Marshall University weekly to discuss continued planning efforts.

4.2.4 How has the length of time to respond to a child crisis situation changed? §

Expected Outcome:

- Increased timely response to child crisis situations Ⓢ Ⓘ

Baseline Findings:

Interview and focus group participants shared that when crisis calls get picked up by Children's Crisis and Referral Line, Children's Mobile Crisis Response and Stabilization is responsive to the needs of youth and families and can help parents deescalate situations, give short-term support, and provide access to resources in the community. Participants reported that Children's Mobile Crisis Response and Stabilization generally respond in a timely manner and one social service provider shared that Children's Mobile Crisis Response and Stabilization teams can arrive within 45 minutes of calling. However, providers also stated that they have received reports from families who could not access Children's Mobile Crisis Response and Stabilization. Families, providers and key informants report being told that mobile crisis services do not exist in some regions and when they were able to speak with staff on the phone they were not offered any services and were directed to call 911 instead. Therefore, it is probable that Children's Mobile Crisis Response and Stabilization services are not functioning in some regions due to challenges with staffing.

WV DHHR has reported that on average, the Children's Mobile Crisis Response and Stabilization specialist provides on-site support within one hour to family or individual requesting services through the centralized Children's Crisis and Referral Line or regional Children's Mobile Crisis Response and Stabilization. However, challenges still exist in providing services within an hour due to the rural geography of the state. Data on timely response and timely referral to other services are not available at this time. Indicators have been added to the new reporting system and will be reported in the future.

4.2.5 How has the average response time for crisis response services changed? §

Expected Outcome:

- Increased timely response to child crisis situations Ⓢ Ⓘ

Baseline Findings:

WV DHHR has reported that data on timely response and referral to other services are not available at this time. Indicators have been added to the new reporting system and will be reported in the future.

4.3 Positive Behavior Support:

4.3.1 How has the availability of PBS services changed? ‡

Expected Outcome:

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

Baseline Findings:

Organization and facilities responding to the survey offer PBS to all regions in WV and all counties in all regions are served (Appendix D, Referrals, Table 1). Interview and focus group participants confirmed that PBS services are offered to all regions in WV and in all counties. A provider involved with offering PBS stated that some counties are very active with service offerings, while others do not utilize PBS services even though they are required. Other providers in Regions 4, 5, and 6 stated they have not used PBS and rarely hear of others using it. However, another provider that works at a major mental health center that offers PBS was familiar with it. Therefore, it is recommended to target Regions 4, 5 and 6 for expanding PBS service offerings.

The organization and facility types that offer PBS services are mostly CMHC (63%), followed by schools (14%), CBHC and group homes (9%, respectively), residential mental health treatment facilities and "other" (3%, respectively) (Appendix D, Background, Table 2). All "other" responses are presented in Appendix C, Quantitative Data Analytic Methods, Table 8-3. Interview and focus group participants confirmed that PBS services are offered mostly via mental and behavioral health centers and schools.

Less than half of the organizations and facilities responding to the survey that offer PBS services report "yes" (46%) to having the capacity to serve all youth currently being referred to the facility, but this finding varied by region. Organizations offering PBS services in Region 3 responded "yes" the most (60%) and Region 5 the least (11%). Of the organizations offering PBS services and reporting "no" to having the capacity to serve all youth currently being referred to the facility, only 26% report that those needs are being met by other service providers in the region. This finding varied by region, with PBS organizations in Region 1 reporting that those needs are being met by other service providers in the region the most (50%) and Region 6 the least (14%) (Appendix D, Workforce and Capacity, Table 1). A key informant from Region 2 reported that PBS falls into the behavioral health services they offer, but that it is not offered by a specific provider or organization. Some providers in Region 5 had not heard of or used PBS while another provider whose mental health organization offers PBS, wraparound, and mobile crisis services was familiar with it and wants to expand PBS services to other children's mental health programming in their region. A provider in Region 6 discussed that PBS was offered through Marshall University's Autism Center and that one PBS staff member covered up to 15 counties to provide services. In Region 6, PBS is used with the Intellectual Developmental Disabilities waiver program population.

WV DHHR reported that PBS is provided through BBH Children's PBS program, as well as trained providers of other BBH, BSS, BMS, and Department of Education programs. The BBH PBS program has eight full-time equivalent staff and three vacancies. BBH is actively focused on recruiting to fill current vacancies including strategies to address the challenges in hiring a curriculum developer.

Current data on PBS service are only available for BBH direct services. Given the pandemic, there was an increased need for mental health services, and PBS referrals significantly increased. In the past year, WV DHHR reported that the number of children served monthly doubled, from 21 per month in July 2020 to 41 per month in June 2021. Similarly, the total child interactions monthly has increased, from 87 per month in July 2020 to 202 per month in June 2021. The average number of interactions per child remains fairly steady over the year, between four and six interactions per child per month.

4.3.2 Can WV families with children who need mental health crisis services access PBS services within their community? †

Expected Outcome:

- Increased accessibility of youth and caregiver mental health treatment services and supports ① Ⓛ

Baseline Findings:

All health providers either disagree or somewhat disagree that there are adequate children's mental health services available in the areas where they work (Appendix E, Referral Policies, Table 4). PBS services are offered in every WV region and every WV county (Appendix D, Referrals, Table 1)**.**

Less than half of the organizations and facilities responding to the survey that offer PBS services report "yes" (46%) to having the capacity to serve all youth currently being referred to the facility, but this finding varied by region. Organizations offering PBS services in Region 3 responded "yes" the most (60%) and Region 5 the least (11%). Of those organizations offering PBS services reporting "no" to having the capacity to service all youth currently being referred to the facility, only 26% report that those needs are being met by other service providers in the region. This finding varied by region, with PBS organizations in Region 1 reporting that those needs are being met by other service providers in the region the most (50%) and Region 6 the least (14%) (Appendix D, Workforce and Capacity, Table 1).

Interview and focus group participants reported that although there are waitlists for PBS services, the capacity to serve youth seems adequate among those offering services. Several participants discussed the multiple PBS trainings offered through the WVU Center for Excellence in Disabilities as readily accessible and helpful. A key informant from Region 2 stated that PBS falls into the behavioral health services they offer, but is not offered by a specific provider or organization.

4.3.3 How has coordination/communication between PBS providers and non-PBS providers changed? ‡ §

Expected Outcome:

- Increased integration of mental health services and supports with community health care organizations/agencies Ⓘ

Baseline findings:

Out of all organizations providing PBS services throughout the State, 46% operate using a joint supervision and 37% offer joint staffing. These finding vary by region, with organizations in Regions 2 and 4 offering the most joint supervision (69%, respectively) and Region 3 offering the least (30%). Organizations in

Region 1 offer the most joint staffing (50%) and organizations in Region 6 offer the least (0%) (Appendix D, Supervision and Staffing, Table 2).

Organizations and facilities responding to the survey that offer PBS services report participating in multiagency meetings with the least frequency as compared to all of the other services of interest to the evaluation. However, almost all organizations and facilities offering PBS services engage in some sort of collaborative activity, such as case consultation (71%), care coordination (40%), multidisciplinary team meetings (86%), release of information between agencies (74%), and coordinated planning across programs (51%), with only two (6%) organizations not engaging in any collaborative activities. However, the frequency of these types of collaborative engagements are higher among other service organizations (Appendix D, Coordination, Table 3).

Focus group participants also report that before COVID-19, PBS staff frequently attended case presentations to determine proper placements for at-risk youth. These collaborative meetings were attended by 20-30 stakeholders including social workers, WV DHHR staff, CPS staff, clinical coordinators, and representatives from agencies for potential placement. This likely spread awareness of PBS services with and between counties and regions. This was reported as an important opportunity for networking and collaboration, as well as an opportunity to ensure PBS services were available and accessible to youth in need. It is unknown how access and availability might be affected now since these meetings are no longer occurring.

In Region 2, providers discussed that PBS falls under the supportive counseling offered by their organizations, so communication with counselors, therapists, and social workers occurs. One statewide social service provider discussed engaging and fruitful collaboration with PBS, but that they do not always receive a response from staff when they attempt to get in contact with them. It was reported that Family Resource Networks commonly refer families and youth to PBS and that PBS is well-integrated in various school systems in several counties. Also, participants stated that Mental and behavioral health clinics that offer PBS can spread awareness via other staff and programs within the same organization.

Focus group participants also noted that different PBS plans in different settings (such as school versus home) that do not "meld" together can create a situation where children are not adequately supported across settings. An example given included a case manager outside of the school setting who described how he could not support youth with Autism in the school system, because they have different billing codes to do IEPs and a separate PBS plan that does not match the in-home PBS plan. Multiple, disjointed behavioral plans for youth across settings (i.e., the plans do not 'talk to each other') do not set youth up for success; therefore, implementing consistency for these plans across in-home and community-based settings is recommended.

Expected Outcome:

- Increased coordination/communication across child serving agencies ① ☺

Baseline findings:

Organizations and facilities offering PBS services that responded to the survey report collaborating with the department of education, child protective agencies and primary healthcare provider agencies the most and juvenile justice, juvenile parole or probation and community-based youth services the least (Appendix D, Coordination, Table 3).

Health providers report neither agreeing nor disagreeing with having regular communication with other youth services providers and non-mental health service organizations (ex. juvenile justice, educational providers) as a part of care coordination for youth with mental health issues (Appendix E, Referral Policies, Table 4). These findings varied by provider type, with behavioral analysts, nurses and residential facility social workers having higher levels of agreement.

Court judges neither agreed nor disagreed that service providers from different mental health agencies coordinate when caring for youth with mental and behavioral health needs (Appendix E, Judges and Attorney, Table 1). This finding varied across regions, with Region 1 agreeing, and Region 4 somewhat agreeing. No judges mentioned PBS services in their interviews and when asked specifically about whether they had heard of PBS, one judge from Region 4 and one from Region 6 said no.

Attorneys and guardians ad litem neither agree nor disagree that providers from different mental health organizations coordinate when caring for juveniles and their caregivers and this finding is consistent across regions, except for Region 1, where they somewhat disagree (Appendix E, Judges and Attorney, Table 3). They neither agree nor disagree that there is coordination among the courts and multidisciplinary teams for juveniles who are involved in neglect and deprivation cases and this finding is consistent across regions.

Social Service providers and probation officers somewhat agree that their organization encourages collaboration with mental health related youth-serving organizations and that they communicate with non-mental health service organizations. This finding does not vary by social service provider type or region. They both also neither agreed nor disagreed that service providers from different mental health agencies coordinate when caring for youth with mental health needs; this finding did not vary by social service provider type or region (Appendix E, Social Services and Probation Officers, Table 1. In focus groups, a school-based social service provider mentioned doing a points-based PBS program that uses rewards, setting expectations, and goal setting with students in their school. A Children's Mobile Crisis Response and Stabilization provider from Region 4 reported having their staff take PBS training for de-escalation techniques for first responders. They also mentioned that they have referred families to PBS programs and other PBS trainings, including other offerings by the WVU Center for Excellence in Disabilities. In Region 6 a social service provider mentioned not having interactions with PBS and probation officers did not discuss PBS.

Expected Outcome:

- Increased referral pathways across child-serving mental health programs and bureaus ⑤ ①

Baseline findings:

Of all PBS programs statewide responding to the survey, state organizations (71%) and schools (66%) refer to PBS services the most and pediatric facilities (14%) and CMHC (20%) refer to PBS the least (Appendix D, Referrals, Table 2). When assessing PBS referrals to and from other services of interest to the evaluation, PBS organizations and facilities receive referrals from both wraparound programs the most (37%, respectively) and ACT (9%) and Children's Mobile Crisis Response and Stabilization (14%) the least (Appendix D, Referrals, Table 3). Therefore, more education and outreach to pediatric and Children's Mobile Crisis Response and Stabilization organizations and facilities, and ACT and Children's Mobile Crisis

Response and Stabilization organizations about the referral process for youth to receive PBS services may be needed. As noted earlier, focus group participants reported that Family Resource Networks commonly refer families and youth to PBS and that PBS is well-integrated in various school systems in several counties. Mental and behavioral health clinics that offer PBS can spread awareness via other staff and programs within the same organization.

Psychologists and behavioral analysts make and receive referrals to PBS programs more than any other health provider type (Appendix E, Referrals, Table 1). Health providers in Regions 2 and 4, make and receive referrals to PBS programs the most, with providers in Regions 1 and 3 the least. Health providers with lengths of practice of 20 years or more make and receive more referrals to PBS programs. Increased provider education on PBS services for primary care and social workers, as well as all early career health providers may help expand the referral pathways for PBS services across child serving programs; although focus group participants report that there is often a wait list for PBS services. It was reported by focus group participants that a good way to find out about community-based service offerings, including PBS, is through Family Resource Networks, as they keep a formal list of available resources and referral sources. However, it was also reported that some Family Resource Networks do not adequately advertise and update the list of PBS services offered, which can impact or reduce referrals. Some participants in interviews and focus groups had not heard of or used PBS, which could also be a barrier to referrals. No providers from Region 1 mentioned referring to PBS and Region 3 only mentioned having it within the school system.

Social service providers and probation officers somewhat agree that their organization has clear protocols and internal processes for referring youth to mental health service providers when needed and this finding does not vary by region (Appendix E, Social Service and Probation, Table 1). Overall, about 60% of social service providers and probation offers refer to PBS. This finding varies by provider type and region, with licensed social workers referring to PBS the most (68%) and probation officers referring the least (50%), and these providers in Region 1 referring to PBS the most and Region 2 the least (Appendix E, Social Service and Probation, Table 2). Licensed social workers might refer to PBS more due to greater exposure to and awareness of the program, since several organizations report offering PBS as part of supportive counseling. Furthermore, the mental and behavioral health centers that offer PBS also likely have licensed counselors on staff, so existing relationships and collaboration might facilitate referrals. No obvious barriers to referrals were noted from Region 2 in focus groups or interview, although lack of awareness and knowledge of existing services was mentioned as a significant barrier to referrals to treatment across all focus groups. Some providers discussed that programs are so overburdened and busy with clients that they almost never hear back when they call for referrals and that unless strong relationships and collaboration is already established between agencies, it is unlikely that referrals and placements can be made in a timely manner.

WV DHHR has reported that the BBH PBS program receives referrals directly from other provider agencies across the state as well as other programs across the BBH SOC, including Wraparound facilitators and Children's Mobile Crisis Response and Stabilization teams.

4.3.4 How has ability and knowledge among wraparound facilitators and mobile crisis team members to independently deliver and incorporate PBS services into their care delivery changed? ‡

Expected Outcome:

- Increased knowledge and ability of providers and agencies, including wraparound facilitators and mobile crisis team members, to independently deliver and incorporate PBS services into their care delivery ⑤ ①

Baseline findings:

Interviews and focus groups described PBS as a valuable tool, especially for engaging youth on the Autism Spectrum, those who may be lower functioning, or those with behavioral issues. The quality of PBS service relies on the facilitators' knowledge of it and their ability to engage with families using it. Thus, training that ensures a rich understanding of PBS and helps facilitators build skills to engage families is critical. Staff not fully understanding, practicing, and using PBS was noted as a barrier to service implementation. Although, one provider in Region 6 stated that PBS is so valuable that they want to expand it into their other mental health programs such as ACT and with other children's services. A barrier to doing this is the lack of a certified behavioral support specialist. They note that having more specialized staff trained would help expand PBS into schools as well.

WV DHHR reports that PBS principles are widely used in services within BBH, BSS, BMS, and the Department of Education, even though PBS direct services are only currently available through BBH. BBH contracts with the WVU Center for Excellence in Disabilities to provide direct PBS services to high-acuity children and training and consultation on PBS to agencies across the state with the goal of increasing the number of agencies providing PBS as a part of services to support children with mental and behavioral health needs.

4.3.5 How has fidelity of PBS service delivery related to standards of practice changed? §

Expected Outcomes:

- Improved fidelity of PBS service delivery in the state with established standards of practice ① ⓛ
- Improved fidelity of PBS service delivery in the state with established standards of practice ① ⓛ
- Increased use of evidence-based mental health treatment services ① ⓛ

Baseline Findings:

Health providers report being somewhat competent in the delivery of PBS (34%) with 18% of providers being very competent. Over half of health providers (56%) have requested training on PBS and only 14% have received training. These findings vary by provider type, with behavioral analysts being the provider reporting the most PBS delivery competency (Appendix E, Skillset & Training, Table 1).

A key informant from Region 2 would like PBS to offer training on de-escalation strategies for youth. A provider offering PBS services noted that it is important to train CPS workers, as well as at-risk youth and their families, with PBS strategies to interact in a healthy, loving way and that this led to the development of a PBS for parents training. All schools in Pleasants County are Positive Behavior Interventions and

Supports schools, meaning they participate in the Positive Behavior Intervention and Supports program and have received training and program offerings to PBS skills.

All surveyed health providers who delivered PBS support in the last year to youth with mental health needs somewhat agreed that they received adequate training from WVU's Center for Excellence in Disabilities to prepare them to implement PBS (Appendix E, Skillset & Training, Table 3). This finding varied by provider type with psychiatrists having more agreement and medical doctors and residential facility direct care staff having less agreement. Providers somewhat agreed that based on the training they received they feel prepared to deliver PBS, with behavior analysts and residential facility social workers more in agreement and psychologists disagreeing. There is disagreement among providers that the PBS certification requirements for WV are clear and that PBS certification requirements have improved the quality of PBS service delivery in WV. These findings varied by provider type, with behavioral analysts agreeing that the PBS certifications for WV are clear, but the disagreement remained consistent across regions. Overall, health providers neither agreed nor disagreed that the PBS certification requirements make it too burdensome for providers to get credentialed, with psychiatrists agreeing that the certification requirement does make it too burdensome to get credentialed (Appendix E, Skillset & Training, Table 3).

Focus group participants revealed that PBS service training is of high quality and many mental health professionals and staff throughout WV have received PBS training. In Region 2, all Safe at Home staff have received PBS training and use it to work with youth and families in their homes to develop action plans. In Region 3, PBS does offer trainings on de-escalation that first responders and mobile crisis staff attend. The WVU Center for Excellence in Disabilities offers multiple PBS trainings. Although, more training on using PBS skills for various mental health professionals is warranted, according to representatives from Region 3, because its success depends on facilitator knowledge and skills of PBS techniques.

BBH has been working with WVU's Center for Excellence in Disabilities to enhance fidelity to the national model for PBS though provider certification, and by hiring a PBS curriculum developer. Fidelity monitoring is taking place as part of BBH's CQI work; data collection tools are still being developed and are expected to be available by next year.

4.3.6 How has the length of time to access PBS services changed? §

Expected Outcome:

- Increased timely response to child crisis situations ☺ ① ①

Baseline Findings:

Focus group participants revealed that there is a wait list for PBS services and that they often try to prioritize cases where youth might be discharged from residential mental health treatment facilities to bypass the waitlist and provide in-home services. Some PBS and wraparound clients have reportedly tried to access and utilize PBS but have not been successful.

PBS referrals significantly increased during the pandemic. At the time of data collection, there was a waitlist of approximately 12 children for PBS services, but families have been prioritized based on need, and BBH meets regularly with providers to troubleshoot workforce shortages and hiring barriers. BMS is

also working to implement a PBS modifier code in July 2022 to facilitate Medicaid billing for PBS-related claims and services. Data on BMS implementation are expected in 2023.

4.3.7 How has child functioning among PBS participants changed? †

Expected Outcome:

- Improved child functioning Ⓢ Ⓘ Ⓛ

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.3.8 How has academic engagement among PBS participants changed? †

Expected Outcome:

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

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.3.9 How has family engagement with mental health services changed after PBS 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:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.4 Assertive Community Treatment:

4.4.1 How has the availability of Assertive Community Treatment services changed? ‡

Expected Outcome:

- Increased access (statewide) to children's mental health prevention and treatment services Ⓢ Ⓘ

Baseline findings:

Out of all organizations and facilities responding to the survey, ACT services are not represented in Regions 2 and 4, and organizations and facilities responding to the survey in Regions 1, 5 and 6 do not serve every county in those regions (Appendix D, Referrals, Table 1). Out of all interviews and focus groups, only 1 provider in Region 6 mentioned offering ACT and no other regions or participants discussed it. This could also be a representation of low service awareness and knowledge among providers for ACT services. An additional participant in Region 6 revealed that although the facility's survey data reported that they offered ACT, they do not offer those services.

The organization and facility type that offers ACT services are mostly CMHC (86%), followed by CBHC (7%), and adoption agencies (7%) (Appendix D, Background, Table 2).

Expected Outcome:

- Increased local capacity for mental health treatment and supports Ⓘ

Baseline findings:

Out of all providers aware of the ACT services, the majority report that the service does not have sufficient resources, although judges and lawyers find the service to be beneficial (Appendix E, Services and Programs, Table 4).

The majority of the organizations and facilities responding to the survey that offer ACT services report "yes" (79%) to having the capacity to serve all youth currently being referred to the facility, but this finding varied by region. Organizations offering ACT services in Regions 1 and 3 responded "yes" the most (100%) and Region 6 the least (0%), with no ACT organizations or facilities responding to the survey for Regions 2 and 4 during the data collection period. Of those organizations offering ACT services and reporting "no" to having the capacity to service all youth currently being referred to the facility, 0% reported that those needs are being met by other service providers in the region. This finding did not vary by region (Appendix D, Workforce and Capacity, Table 1). According to the key informant in Region 6, the ACT program in Region 6 experienced significant challenges due to COVID-19. Most notably, COVID-19 impacted the transportation services that are an integral part of the program.

WV DHHR reported that from July 2020 to June 2021, ACT enrollment remained low throughout WV. The pandemic created a challenge for ACT enrollment as individuals might not want ACT staff in their homes. Overall, an average of five youth per month received services with nine total enrollments for the year. In the Eastern Panhandle., WV DHHR's contract with Mountaineer Behavioral Health (Mountaineer) in November 2021 will increase availability of ACT to ensure statewide coverage once Mountaineer is fully operational in summer 2022.

4.4.2 How has the acceptance of community-based mental health treatment (for ACT) 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:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.4.3 How has awareness of mental health services and supports among child-serving mental health professionals changed, including ACT eligibility? (e.g., primary care physicians, juvenile judges and probation, emergency room staff, foster care parents) ‡

Expected Outcome:

- Increased provider awareness of ACT services ① ☺
- Increased provider awareness of ACT eligibility ① ☺
- Increased awareness of process for ACT referrals and access ① ☺

Baseline findings:

Only 17% of all providers are aware of ACT services (Appendix E, Services and Programs, Table 4). Awareness of ACT services varies by provider type, with residential facility social workers and psychiatrists being the most aware and nurses, nurse practitioners, and residential direct care staff being the least aware. Out of all providers aware of the ACT services, the majority report that the service does not have sufficient resources, although all judges and lawyers find the service to be beneficial. In interviews and focus groups, the only provider that described the ACT program and appeared knowledgeable about it was in Region 6, where it was offered. In focus groups and interviews, other participants were asked if they were aware of or referred to ACT (and multiple other programs) and if they were not; therefore, no follow-up questions about those programs were asked.

Of providers offering residential mental health services, all somewhat agreed that their organization/agency routinely screens residential treatment patients for ACT eligibility (Appendix E, Out-of-Home Placement, Table 4).

Of all ACT programs statewide, Hospitals (93%) and schools (93%) refer to ACT services the most and CMHC refer to ACT the least (13%) (Appendix D, Referrals, Table 2). When assessing ACT referrals to and from other services, ACT organizations and facilities receive referrals from PBS services the least (13%) and West Virginia Children's Mental Health Wraparound the most (67%). Therefore, it is suggested that CMHC, PBS, Children's Mobile Crisis Response and Stabilization, residential mental health treatment facilities, and Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities would be good targets for increased education around ACT service offerings and eligibility.

Social service providers and probation officers refer to ACT services the least, but this finding varied by provider type and region (Appendix E, Social Services and Probation Officers, Table 2).

Surveyed health providers also refer or receive referrals from ACT services the least out of all of the services of interest to the evaluation. Psychologists and behavioral analysts make and receive referrals to

ACT programs more than any other provider type (Appendix E, Referrals, Table 1). Providers in Regions 5 and 6, make and receive referrals to ACT programs the most, with providers in Regions 1 and 2 the least. Referrals in Region 2 are expected to increase with the expansion of ACT services in that area. Providers with lengths of practice of 11 years or more make and receive more referrals to ACT programs. Increased provider education on ACT services for primary care and social workers, and all new health mental health providers may help expand the referral pathways for ACT services across child serving programs.

WV DHHR has reported being in communication with residential mental health treatment facility providers to help ensure that ACT is included as a service for eligible youth in the discharge planning process. Provider outreach has been historically conducted via in person and has been on hold since March 2020. In-person outreach meetings with providers to increase ACT usability will resume when it is deemed safe. WV DHHR is also taking additional efforts to increase enrollment in ACT. For example, policy manual revisions for residential treatment facilities and others will require ACT service staff to meet with eligible youth and families prior to discharge. Kepro completes ACT fidelity monitoring for WV DHHR and each provider is reviewed every 18 months.

4.4.4 How has child functioning among ACT participants changed? † §

Expected Outcome:

- Increased educational involvement ① Ⓛ
- Improved child functioning Ⓛ
- Increased medication compliance and self-management of psychiatric illness ①
- Increased engagement in the community, including the workforce, by 18-21-year-olds enrolled in ACT services Ⓛ
- Increase in independent living ability ① Ⓛ
- Decreased rate of non-compliance to treatment ① Ⓛ
- Decreased juvenile justice involvement ① Ⓛ
- Decreased hospitalizations and residential mental health treatment facility stays ① Ⓛ
- Increased level of clinical functioning (CANS, CAFAS)

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.4.5 Has the proportion of youth (ages 18–21) referred for ACT services (at residential mental health treatment facilities or Psychiatric Residential Treatment Facilities discharge) increased? †

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 Ⓢ ①

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.5   Reducing Reliance on Residential Treatment

4.5.1   How has the philosophy toward community-based services (including residential) among residential mental health treatment facility staff? (understanding the continuum of services) ‡

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 ⑤ ①
- Increased importance of engaging families in the care of their loved one while they are in residential mental health treatment facilities ⑤ ①
- Increased 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 ① ⑤
- Improved understanding among target audiences of appropriateness of residential mental health treatment facility usage as an integrated service within a continuum of care ① ⑤

Baseline Findings:

Residential mental health treatment facilities responding to the organization and facility survey report receiving referrals from WV state organizations the most (95%) and CMHC organizations the least (15%). Residential mental health treatment facilities report making referrals to CBHCs the most (65%) and CMHC (15%) the least (Appendix D, Referrals, Table 2). Out of all services of interest to the evaluation, residential mental health treatment facilities report receiving referrals from Children with Serious Emotional Disorder Waiver Wraparound programs the most (60%) and ACT programs the least (15%), and residential mental health treatment facilities report making referrals to West Virginia Children's Mental Health Wraparound the most (55%) and Children with Serious Emotional Disorder Waiver Wraparound services the least (30%) (Appendix D, Referrals, Table 2).

A residential mental health treatment provider noted during a focus group that there are no long-term care facilities for special and high-needs youth after they turn 18 years. Therefore, increasing education and awareness of ACT programs among residential mental health treatment facilities and ACT service delivery throughout WV is important to meet this need.

Another provider stated that when it comes to discharges from residential mental health treatment facilities, their responsibility is to ensure youth are served at the lowest level/tier of care possible and that their job is to give a recommendation for discharge when they feel youth can continue at that lower level of care. However, it is ultimately up to their department and the multidisciplinary team to decide what is the best appropriate placement. A significant issue that providers mentioned as a barrier to successfully

transitioning youths out of residential mental health treatment facilities is not having step-down placement options to help transition the youth to in-home and community-based care.

Focus group participants reported that one of the biggest issues that residential mental health treatment facility providers face is making referrals for youth who are ready for discharge and referring them down to lower levels of care. One provider stated that there is not typically a clear permanency plan in place, even though planning for permanent placement is supposed to occur upon admission. They stated that this rarely happens and is not followed through to completion; therefore, residential mental health treatment facilities can only make recommendations about when youth are ready to step-down to a lower level of care. Many times, the plan is for the child to return home, to kinship care, or foster care; however, if that plan is not firmly established upon admission, then the child might "flounder" in residential care. This provider discussed that keeping youth in residential care for long periods of time is frequently depicted in a negative light and thought to be the fault of residential mental health treatment facilities for "warehousing" children in residential care and not wanting to let them go. In contrast to this misperception, this provider described that reality is that the department or multidisciplinary team does not have any other place for them to go, or enough supportive services to refer the child, so they stay in residential treatment until a long-term placement plan is determined.

On the other hand, another residential mental health treatment facility provider discussed that because of good screening procedures on the front end, no child is admitted into residential care unless they truly need to be there. Other focus group participants believe that residential mental health treatment facilities are being overused almost exclusively because of lack of other types of services. One participant stated that "there is nowhere else to send kids and they need help, so they are sent to residential care and oftentimes out of state." This participant also stated that the youth need more intensive services than what is available in the community, such as intensive outpatient, to stay in their homes, and that community-based services are not staffed enough to be of use.

Residential facility direct care staff and social workers make and receive referrals to and from all community-based programs of interest to the evaluation (Appendix E, Referrals, Table 1). Residential facility direct care staff and social workers agree that their organizations encourage collaboration with other mental health youth-serving organizations (Appendix E, Referral Policies, Table 1), and they report agreement with having regular communication with other youth service providers and non-mental health service providers, as part of youth care coordination (Appendix E, Referral Policies, Table 4). However, they disagree that WV DHHR prioritizes in-home and community-based care over out-of-home placement when the youth might be better served at home (Appendix E, Referral Policies, Table 1). Residential facility direct care staff and social workers somewhat disagree that service providers are generally aware of other service providers to support a continuum of youth mental health care (Appendix E, Referral Policies, Table 4).

Focus group participants identified service gaps for youth with Autism and other issues that mean children may end up needing supportive care for their entire life, and that WV is not currently equipped to handle those situations. For parents fostering high-needs youth that require a great deal of assistance, this creates a situation where foster parents not only feel pressured to care for them, but to adopt that child and continue their personal care for their entire lifetime, which is a big life change. Looking not only at a child's current functioning, but what services they might need long-term is critical for engaging families and service providers in care of children after care in a residential mental health treatment facility.

Another residential mental health treatment facility provider discussed that foster parents do not want to adopt older children and so unless they can find in-home placements for some older children—which is difficult to do—residential treatment is the only other option. As noted above, it is also possible that a lack of a permanency plan and the need to find home placements for the children is prioritized over accessing other community-based services.

Facilitators to community-based treatment include strong relationships and communication between case managers and providers. Key informants from Region 5 explicitly described trying to reduce the reliance on residential services through their programs, and believe they are taking steps in the right direction. Still, there is a tremendous need for more services and providers to accomplish this.

Providers agree that the top four contributors to youth being sent to out-of-home placement when the youth might be better served at home are: (1) lack of community-based services, (2) lack of parental capacity, (3) clinical necessity, and (4) the unique needs of the youth that cannot be met in other service settings (Appendix E, Out-of-Home Placements, Table 1). These findings were consistent across provider types and regions, with residential mental health social workers also agreeing that court ordered placements also contribute to out-of-home placement when the youth might be better served at home. As described in 3.1.2, there was consensus across all key informant interviews and focus groups that even where services exist, regions struggle with staffing and workforce capacity. This often results in placements for youth wherever a bed is available and wait times for various types of treatment can range from three months to one year. Providers described a severe lack of intensive outpatient services, which can serve as a middle ground between community-based/home-based services and residential treatment, where the youth needs a higher level of support while they remain in the home. This often results in placements for youth wherever a bed is available and wait times for various types of treatment can range from three months to one year.

In all regions, providers reported that parents and guardians often lack awareness about the types of services their child needs or experience confusion about the differences between various types of services. This is especially true if youth are receiving multiple services. In Regions 5 and 6, collaborations with the Family Resource Network and holding information sessions have increased family and community awareness of services. As reported in 3.1.6, providers also report difficulty in engaging parents and guardians in the treatment of their youth, for example helping them understand the importance of counseling and therapy for youth with mental and behavioral health issues. Some parents or guardians may think the school-based systems will deal with whatever issues their youth has, without the parents needing to be a part of any treatment. Other parents and caregivers might also perceive stigma associated with mental health issues and treatment, and thus might not seek services. Negative experiences can also contribute to skepticism about initiating or continuing services. Some parents or guardians may think the school-based systems will deal with whatever issues their youth has, without the parents needing to be a part of any treatment. Health literacy may play a role in access and utilization of services. Beyond lack of awareness, other factors limiting family engagement in treatment include feeling worn down, fear of discussing mental health issues due to potential problems in court, and difficulty finding services in rural and remote areas.

Mental health professionals in the state, including judges, reported that they perceive that their choice for youth is frequently a "residential facility or nothing." When in-home options are not readily available and accessible, placing youth in the first available residential treatment might prevent delays in service

provision for children in crisis and prevent worsening symptoms. Youth with unique needs that might not be met in other service settings include older youth in foster care, those with a history of aggressive or destructive behaviors, Autistic youth, and those at risk for suicide or self-harm. One residential mental health treatment facility provider stated that youth do not receive residential-based treatment unless it is absolutely necessary. Wait times for community-based services range from three to four weeks to six to eight months, and sometimes up to one year, depending on the type of service needed. Residential facility social workers and direct care staff agree that families/caregivers are an essential part of the planning of services for the youth with whom they work (Appendix E, Out-of-Home Placement, Table 3). Residential facility social workers also agree that families/caregivers' opinions are considered in youth treatment planning, service delivery, and treatment goals. They also agree that they maintain regular communication with caregivers about the youths' progress/status as a part of service delivery. In contrast, residential direct care staff neither agree nor disagree with those statements. Therefore, more education and training on family engagement in care needs to be directed to residential care staff. In focus groups, residential mental health treatment facility staff did not provide much information about working with families/caregivers. They did mention difficult situations that occur when youth are ready to be discharged but do not have a biological (or foster or kinship) family that will accept them. This results in youth remaining in residential care much longer than they need to be. They referred to a shortage of families for many children in residential treatment.

Another issue discussed was lack of preparation for families, especially foster families, for children with high needs that need assistance and supportive care for their entire lifetime, such as those with intellectual disabilities or Autism. There is not only a lack of awareness about the longevity of needs for these youth, but also no long-term care facilities for youth once they become adults, which places undue burden on families.

Findings indicate that while providers' preference is to place youth in community-based services, many times these services are not available or finding home placements for the child takes priority. Additionally, intensive out-patient mental health services that would facilitate transferring youth with a higher level of need into the community are not available.

4.5.2 How has the philosophy toward community-based services (including residential) changed among stakeholders? (understanding the continuum of services) ‡ §

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 ⑤ ①
- Increased importance of engaging families in the care of their loved one while they are in residential mental health treatment facilities ⑤ ①
- Improved quality and timeliness of pre-placement mental health assessment ⑤ ① ⑫

- Improved understanding among target audiences of appropriateness of residential mental health treatment facility usage as an integrated service within a continuum of care ① ⓛ
- Increased 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 ① ⓛ
- Reduced number of placements made in residential mental health treatment facilities without a standardized, high quality mental health assessment conducted by an independent and qualified mental health professional ① ⓛ
- Reduced duplicate or repeat assessments of the same child ⓛ
- Improved data sharing and data access related to mental health system results ① ⓛ

Baseline Findings:

When asked to respond to the statement "I find that service providers are generally aware of other service providers to support a continuum of mental healthcare for youth and caregivers" most health providers disagreed (Appendix E, Referral Policies, Table 4); focus group findings support these data. Health providers discussed that service providers who work with youth with mental and behavioral health issues, especially in the school systems, are often underqualified. System-wide misunderstandings of the needs of children have been reported. There is also a lack of resources and so service providers, including social workers working with youth, often do not respond to health providers' messages. Health providers report that schools are safe and accessible places to offer and receive mental and behavioral health services, which might guard against system-wide barriers such as lack of knowledge of resources or family hesitation with treatment.

As reported in 3.1.5, participants in key informant interviews and focus group reported limited resources such as lack of staff, limited bed capacity, and lack of crisis services as contributors to out-of-state placements. Several agencies were able to obtain grant funds to hire new staff, including to contract therapists and counselors. Another solution identified by providers was for each school to have its own social worker and counselor.

Lack of awareness of available services is a barrier to providing a continuum of care, but this issue is minor compared to staffing shortages and lack of capacity limiting access and provision of care WV is currently experiencing. Lack of awareness of services is less of an issue among service providers and more likely an issue with parents/families. In all regions, providers perceived that parents and guardians often lack awareness about the types of services their child needs or experience confusion about the differences between various types of services. This is especially true if youth are receiving multiple services. In Regions 5 and 6, collaborations with the Family Resource Network and holding information sessions has increased family and community awareness of services.

The mental health staff shortage in WV limits the quantity of services agencies can offer. Barriers to adequate workforce capacity were detailed in section 3.1.5. These include high caseloads, low wages, and significant turnover from burnout Key informants went on to describe how turnover affects programming consistency and disrupts communication and coordination between providers and families, leading to gaps in services as well as service duplication that can sometimes retraumatize youth. Without adequate staff, capacity is severely reduced and programs cannot offer necessary services.

The need for more resources such as wraparound and Children's Mobile Crisis Response and Stabilization services in all counties throughout WV and more parent education and training were noted as other reasons for placing a youth out of the home for care (Appendix E, Out-of-home Placement, Table 2).

Court judges agreed that they prioritize in-home and community-based mental health care over residential placement when juveniles would be better served at home and that there are juvenile court policies in place to help implement the recommendations made by the multidisciplinary treatment team (Appendix E, Judges and Attorney, Table 1). This agreement is consistent across regions. Most court judges somewhat agree that WV DHHR multidisciplinary teams prioritize in-home and community-based mental health services over residential placement when juveniles would be better served at home, although this agreement varies across regions, with Region 1 agreeing and Region 6 neither agreeing nor disagreeing.

Judges mentioned Safe at Home and other in-home services as beneficial for juveniles, but noted there are not enough providers to meet their needs. Judges also discussed needing more services for family therapy and would like the ability to order these services, because counseling for parents and family members can help youth remain in their homes, as family issues often contribute to why they may be removed from the home in the first place. Judges also say they need residential mental health treatment services that are closer to home, more short-term shelters, and more foster care homes. One judge spoke at length about needing more beds for psychiatric stays. The issues they mentioned for having to send kids out-of-state for treatment typically involved sex offenses, violent behaviors, and autism. Some mentioned that having services in school may be helpful, as well as having therapists provide in-home services. They also mentioned a need for more services for addiction, both for youth and families.

As noted in 3.1.8, court judges somewhat agreed that they receive the needed information from multidisciplinary teams to make appropriate placements for youth on delinquency or status offense case dispositions (Appendix E, Judges and Attorney, Table 1). While in Region 1 judges agree that they receive the information they need, judges in Regions 2-6 only somewhat agree. Residential mental health treatment services were the most commonly required as part of a case disposition in the past 12 months. Judges, but also required some participation to WV Children's Mental Health Wraparound and Children with Serious Emotional Disorder Waiver Wraparound (Appendix E, Judges and Attorney, Table 2).

Several judges discussed not being fully aware of the available programs for youth and having to rely on others to provide that information. This can be problematic if personnel providing information work for agencies that are understaffed; judges mentioned that WV DHHR specifically is understaffed. They stated that there is a need for more youth service workers that could assist with less extreme cases of mental and/or behavioral health issues to provide preventive services. Judges also stated that they often do not receive reports from multidisciplinary teams in a timely manner or at all. One judge said, "How can you make a placement decision on a multidisciplinary team report that doesn't exist?" A probation officer from Region 3 discussed having a very active and successful multidisciplinary team program in their county. The judge he works with requires a review of juvenile cases every 90 days and requires that a multidisciplinary team review be performed before that review. Teams consisting of attorneys, the probation office, school personnel, mental health providers, and family members work together to provide updates and recommendations. The probation officer coordinates the multidisciplinary team meetings for the judge and summarizes the findings during court proceedings.

Judges assume that WV DHHR is being thorough with providing options for services to judges because judges do not have full awareness of all services available. One judge stated that they require service providers to send updates directly to them instead of WV DHHR, because the judge does not receive them if they are sent to WV DHHR. Several judges report wishing they had more contact with service agencies, even if only to learn more about what services they provide to youth.

Attorneys and Guardians ad litem somewhat agree that juvenile court judges prioritize in-home and community-based mental health care over residential placement when juveniles would be better served at home, but this agreement differs by region, with Region 4 attorneys neither agreeing nor disagreeing (Appendix E, Judges and Attorney, Table 3).

Attorneys agreed there was a lack of community-based treatment facilities in WV, especially for youth with significant mental health needs or violent tendencies. This sometimes results in them being placed out-of-state for treatment. However, an attorney in Region 1 mentioned being impressed with how well youth have done within residential treatment facilities.

As mentioned in 3.1.8, one attorney felt that some judges are fundamentally opposed to sending youth out-of-state facilities, opting instead to send youth to group homes that often lack the necessary staff to meet the needs of youth.

Overall, these findings indicate that the philosophy of providers referring to community-based mental health services to supplement or replace residential mental health treatment for youth is that there is a lack of information, resources and providers in the communities to support a continuum of care for community-based mental health for youth. Therefore, the supporting processes and policies for referrals and follow-up to community-based mental health organizations for youth are lacking. Qualitative data from all data sources (i.e., judges, WV DHHR and partner agency staff, providers, and organizational leadership) and across each region in WV support these findings. Consensus and saturation was reached within the qualitative data for these key findings.

WV DHHR has reported that their overarching goal is to reduce the reliance on residential mental health treatment facilities and increase community-based services for youth. Census trend data on children in state custody placed in residential settings in WV from January 2020 to October 2021 showed a continual decline, which is in alignment with WV DHHR's primary goal. The overall decline in census has primarily occurred at in-state facilities, whereas out-of-state facilities have remained stable.

WV DHHR reports that a residential mental health treatment facility provider's capacity statewide is adequate to meet the needs for the number of children placed compared to the number of licensed bed capacity. However, the level of care offered by each provider varies and, in some cases, may not meet the individual needs of the child. The focus over the coming year will be to increase provider capacity and training to serve children with high level-of-care needs who are now being served in out-of-state facilities. WV DHHR is working with subject matter experts on developing new models of care that will be implemented in the future to facilitate quality outcomes for children in residential placement.

Expected Outcomes:

- Increased compliance with medically necessary admission criteria in determining or extending residential mental health treatment facility placements. ⑤ ① ①

- Reduce use of residential mental health treatment facilities as the first placement option for older youth ① ①
- Reduce movement of children between residential mental health treatment facilities due to improved initial placements based on high quality mental health assessments ①
- Increase diversity, quality, capacity, and accessibility of services offered by residential mental health treatment facilities or their partners (including offering in-home and community-based services as an alternative) ⑤ ① ①
- Minimized length of stay in residential mental health treatment facilities as determined by individual's mental health needs ⑤ ① ①
- Reduced/eliminated residential mental health treatment facility placements for social reasons (i.e., controlling for safety, no place else to go, to finish educational programs) ①

Baseline Findings:

The majority of health providers (40%) never follow-up after an initial referral has been made to a residential treatment program (Appendix E, Referrals, Table 3), with psychologists being the provider type that follows up the most and residential direct care staff and social workers the least. Focus group reports support these findings. Unless existing referral pathways (such as sharing of medical records) is in place, or a provider directly follows up after a referral, they often do not know the outcome of the referral.

Providers agreed that the top four contributors of youth being sent to out-of-home placement are: (1) lack of community-based services, (2) lack of parental capacity to care for the children/youth, (3) clinical necessity and (4) the unique needs of the youth that cannot be met in other service settings. These findings were consistent across provider types and regions (Appendix E, Out-of-Home Placements, Table 1). These findings were consistent across provider types and regions, with residential mental health social workers also agreeing that court ordered placements also contribute to out-of-home placement when the youth might be better served at home. Overall, key informants in Region 5 reported trying to reduce the reliance on residential through their programs, and feel like they are taking steps in the right direction. However, there is still more need for services and providers to get to the next level of keeping youth out of residential. None of the key informants reported relying solely on residential services, unless it was absolutely necessary.

4.5.3   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. ⑤ ①
- 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 ① ①
- Improved understanding among target audiences of appropriateness of residential mental health treatment facility usage as an integrated service within a continuum of care ① ①
- Increased importance of engaging families in the care of their loved one while they are in residential mental health treatment facility ⑤ ①

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.5.4 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 ⑤ ① ①

Baseline Findings:

The assessment findings for the youth and caregiver-level of the Evaluation will be included in the July 2022 report.

4.6 Conclusion

Findings from this mixed methods evaluation reveal significant barriers to community-based treatment for youth with serious mental and/or behavioral health needs despite the prevailing philosophy among various stakeholder groups that youth are usually better served in their homes and communities. The programs of interest to this evaluation are offered throughout WV and perceived positively among members of the mental health workforce. However, across all regions, staffing issues prevent full service delivery. Youth and their families are frequently unable to access available services in their communities due to provider shortages and high staff turnover. Service gaps are more pronounced in highly remote and rural parts of the state.

Providers are open and willing to deliver community-based services but understaffing limits training and professional development opportunities. Strong relationships and collaborations within and across programs can facilitate the continuum of care necessary to keep youth in their homes and communities. Up-to-date information on program offerings, streamlined referral processes and pathways, and expanded educational initiatives are recommended to increase awareness of and access to available services.

Youth who have experienced an acute crisis, are in foster or kinship care, or have high level-of-care needs, might be referred to residential treatment or out-of-state facilities due to lack of available beds and long wait times for community-based services. More intensive community-based outpatient services are needed for youth to receive adequate treatment while remaining in their communities.

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. As in previous sections, evaluation questions are organized by question, expected outcome(s) 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/Caregiver-levels) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term; Table A-1). Evaluation questions for the overall initiative are presented first, then followed by evaluation questions specific to each workgroup. Baseline findings for the youth and caregiver level of the Evaluation will be included in the July 2022 report.

Table 5-1: 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)

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 well-integrated are mental health services with community healthcare organizations? ‡ §

Expected Outcome:

▪ Increased integration of mental health services and supports with community healthcare organizations/agencies Ⓢ Ⓘ Ⓛ

Baseline Findings:

Increased communication and coordination among organizations and providers lead to better service integration. Joint supervision and staffing models can introduce common standards and expectations, as well as facilitate communication and coordination within and across organizations and facilities that share

supervisors and/or providers and staff. Organizations and facilities indicate that 64% used joint supervision (Appendix D, Supervision Staffing, Table 1). The greatest percentage of organizations and facilities that used joint supervision are ACT (86%) and West Virginia Children's Mental Health Wraparound (83%), whereas PBS (46%) used it the least. Responses varied across regions and programs. Region 5 organizations and facilities used joint supervision the most, and organizations and facilities in Region 4 the least. Children's Mobile Crisis Response and Stabilization locations reported the greatest variation in joint supervision use (ranging from 9% in Region 4 to 100% in Regions 1 and 3).

Approximately half of the service organizations and facilities in this Evaluation (48%) used joint staffing (Appendix D, Supervision Staffing, Table 1). CMHW organizations and facilities West Virginia Children's Mental Health Wraparound locations (71%) used joint staffing the most. Findings varied regionally; Region 5 used joint staffing the most and Region 3 least. Findings also varied by service, with Children's Mobile Crisis Response and Stabilization representing the greatest and fewest percentage of organizations and facilities that used joint staffing across regions. Joint supervision and staffing can help when funding for full time employees is not available. However, too much reliance on joint supervision and staffing can be burdensome for existing providers. The goal should be to retain current staff while continuing to expand and diversify the workforce when possible, which aligns with WV DHHR priorities.

Service integration is also facilitated by care coordination. Most providers reported that they were somewhat or very competent at coordinating care, although 18% said that it is not applicable to their jobs (Appendix E, Skillset & Training, Table 1). There were 23 providers (26% of those asked) who helped coordinate care over the last 12 months, 46% of whom stated that they currently have the capacity to continue to do so (Appendix E, Capacity & Resources, Table 1). Of those, healthcare providers were the only ones to consistently report the capacity to coordinate care across regions (Appendix E, Capacity & Resources, Table 2).

Communication is a large driver of care coordination. Social workers, probation officers, behavior analysts, residential mental health treatment facility social workers and residential mental health treatment facility direct care staff somewhat agreed that they communicate with other providers as a part of care coordination; other providers neither agreed nor disagreed (Appendix E, Social Services & Probation, Table 1; Appendix E, Referral Policies, Table 4). Similar trends emerged when asked about communication and care coordination with non-mental health organizations such as juvenile justice and educational agencies.

Organizations and facilities coordinate with non-mental health entities, but levels of coordination varied (Appendix D, Coordination, Table 3). For example, most organizations and facilities (84%) coordinate with CPS, the Department of Education (80%), and primary care agencies (71%). The percentage of organizations and facilities coordinating with non-mental health organizations by service is as follows:

- All ACT organizations and facilities coordinate with the Department of Education, law enforcement, and primary healthcare provider agencies, whereas the fewest percentage of ACT organizations and facilities (57%) coordinate with community-based youth services.

- Most Children's Mobile Crisis Response and Stabilization organizations and facilities coordinate with CPS and primary healthcare provider agencies (91% respectively). The fewest percentage of Children's Mobile Crisis Response and Stabilization organizations and facilities coordinate with juvenile justice (52%).

- All West Virginia Children's Mental Health Wraparound organizations and facilities coordinate with CPS, most (96%) coordinate with the Department of Education, 92% with juvenile parole or probation, followed by juvenile justice, law enforcement, and community-based youth services (83% respectively), and 75% coordinate with primary healthcare providers.

- The greatest percentage of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities (88%) coordinate with CPS and the smallest percentage of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities (81%) coordinate with the Department of Education.

- Most PBS organizations and facilities (80%) coordinate with the Department of Education. PBS organizations and facilities were least likely to coordinate with juvenile justice (37%).

- Most residential mental health treatment facilities (90%) coordinate with the Department of Education and juvenile justice. The fewest percentage of residential mental health treatment facilities (50%) coordinate with community-based youth services.

- Children's Crisis and Referral Line data for coordination with non-mental health organizations and facilities are being developed in collaboration with BBH and will be included in future iterations of this report. Data from the WV DHHR report indicate that between January and June of 2021 less than 2% of calls were made by medical professionals and individuals from the legal system.

A substantial amount of coordination occurs with non-mental health organizations. Of those evaluated, coordination with non-mental health organizations is highest among WV Children's Mental Health Wraparound and Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities. In terms of specific collaborative activities that promote service integration, most organizations and facilities (92%) participate in multiagency meetings; 4 were unsure, and 2 (one participant representing Children with Serious Emotional Disorder Waiver Wraparound and one from PBS) stated that they "never" participate in multiagency meetings (Appendix D, Coordination, Table 3). Many organizations and facilities (42%) participate in monthly multiagency meetings, 15% of organizations and facilities participate twice a month, and 22% participate in weekly multiagency meetings (Appendix D, Coordination, Table 3).

Other collaborative activities reported by service organizations and facilities include participation in multidisciplinary team meetings (89%), case information sharing (80%), and case consultation (72%), followed by coordinated planning and scheduling (58% and 48% respectively, Appendix D, Coordination, Table 3). These findings also vary by service. For instance, 8% of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities and 6% of PBS organizations and facilities did not engage in any of the coordination activities listed in the survey, and less than half (40%) of PBS organizations and facilities coordinate schedules with other organizations.

WV DHHR has several system-level mechanisms, such as braided funding and cross-bureau collaborations, that they are applying to help promote service integration.

5.1.2   How have referral pathways changed? ‡ §

Expected Outcomes:

- Increased referrals across mental health providers Ⓢ

- Increased referral pathways across child-service programs and bureaus Ⓢ Ⓘ

Baseline Findings:

Most providers make referrals, but some feel that their organization's referral policies could be clearer, especially when it comes to exchanging referrals with community-based organizations (Appendix E, Skillset & Training, Table 2; Appendix E, Referral Policies, Table 3). Organizations and facilities commonly exchange referrals with the State, schools, hospitals, and community-based health centers (Appendix D, Referrals, Table 2). Of those evaluated, the greatest number of referrals are exchanged with residential mental health treatment facilities and the Children with Serious Emotional Disorder Waiver Wraparound, followed by West Virginia Children's Mental Health Wraparound, PBS, and Children's Crisis and Referral Line, and few referrals are exchanged with ACT (Appendix D, Referrals, Table 3; Appendix E, Referrals, Table 1).

Increased use of WV DHHR's Assessment Pathway and the Children's Crisis and Referral Line is expected to increase referrals to services across the system. Of particular importance is the continued increase in the usage of services that help keep children in their homes and communities whenever it is clinically safe to do so. Data on timely referrals to services and timely responses to referrals are not currently available. Expected outcomes have been added to new reporting systems and will be included in future reports.

5.1.3 Are the community-based programs associated with the initiative meeting their desired outcomes? ‡

Expected Outcome:

- Increased [local] workforce capacity for mental health treatment and supports Ⓢ Ⓘ Ⓛ

Baseline Findings:

Providers surveyed for this evaluation offer first-hand insights into current workforce capacities. As reported for the high-priority questions, providers' perceptions of capacity varied by provider type and service (Appendix E, Capacity & Resources, Tables 1 and 2). Some capacity exists for conducting wellness exams, screenings, and assisting with medication management. Medical doctors and doctors of osteopathic medicine also report some capacity to provide individual therapy, group counseling, assessments, case management, care coordination, family counseling, intake evaluation, psychometric testing, treatment planning, parent/caregiver training, staff training, and outreach and education.

Organizations and facilities indicate that across services, only 41% of organizations and facilities have adequate staff, 53% agree that they have the staff with the necessary training and skills, and 57% have the capacity to serve the youth receiving referrals to obtain services (Appendix D, Workforce & Capacity, Table 1). Participants reported the greatest challenges with workforce capacity in Regions 2 and 3. While regional variation exists, in general, the greatest challenges with workforce capacity are reported by PBS and West Virginia Children's Mental Health Wraparound. Of the service organizations and facilities lacking workforce and capacity (Appendix D, Workforce & Capacity, Table 2):

- Organizations and facilities report that salary ranges in West Virginia have "a great deal" or "much" to do with challenges with hiring and retaining both adequate numbers of staff and staff with the necessary training and skills.

- Lack of services somewhat affects capacity issues among Children's Mobile Crisis Response and Stabilization, PBS, and West Virginia Children's Mental Health Wraparound organizations and facilities.

Additionally, 75% reported that there are staff capabilities, skillsets, or credentials that are hard to recruit and retain (Appendix D, Workforce & Capacity, Table 3). All services reported the need for more staff with graduate degrees that would qualify them for licensure. In particular, service organizations and facilities stated that they need licensed social workers and therapists. Additional service-specific needs and challenges were reported as follows:

- 86% of ACT organizations and facilities reported challenges with hiring and retention, and in addition to the above, organizations and facilities need more licensed psychologists and licensed practical nurses.

- 91% of Children's Mobile Crisis Response and Stabilization organizations and facilities reported challenges with hiring and retention, stating the additional need for licensed psychologists and traditional healthcare providers.

- 88% of West Virginia Children's Mental Health Wraparound organizations and facilities reported challenges with hiring and retention, stating the additional need for providers with new and/or innovative approaches to mental and behavioral health for children and youth with complex needs. They also expressed a need for providers who have been cross trained in multiple services.

- 85% of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities reported challenges with hiring and retention, including the need for more traditional healthcare providers and direct care staff.

- 66% of PBS organizations and facilities reported challenges with hiring and retention, stating additional needs for a variety of providers, including in-home support providers and those with knowledge of how to teach and engage families.

- 75% of residential mental health treatment facilities reported challenges with hiring and retention, stating the additional need for trained providers with experience helping patients with advanced, complex needs.

Most providers intend to stay in their current role and at their current organization for the foreseeable future, except for residential mental health treatment facility direct care staff who somewhat agreed (Appendix E, Plans, Tables 1 and 2). Nevertheless, both recruitment and retention should continue to be a high priority, especially given that some providers feel that turnover affects care quality, including behavioral analysts, psychiatrists and residential mental health treatment facilities social workers, and providers in Regions 5 and 6 (Appendix E, Referral Policies, Table 2).

Baseline data for other desired outcomes of the initiative related to child and family wellbeing are going to be the focus of this Evaluation's July 2022 report.

WV DHHR has been working to build capacity among child-serving organizations and facilities. Increasing the number of providers, particularly those with credentials and/or specialized training and skills, should lead to enhanced capacity. While great efforts are being made to build staff capacity, WV DHHR reports

that the historical trend in an overall lack of applicants continues to be pervasive and has the potential to affect goals surrounding the expansion of services, especially among ACT and PBS.

5.1.4 How have referral pathways changed between traditional and mental health providers? ‡

Expected Outcome:

- Increased referrals from traditional healthcare providers to mental health providers Ⓘ Ⓛ

Baseline Findings:

Healthcare providers infrequently make referrals for community-based services (Appendix E, Referrals, Table 1). In the last 12 months, the greatest percentage of healthcare providers (16%) sent referrals to RMHFTs, followed by 15% who called the Children's Crisis and Referral Line (Appendix E, Referrals, Table 1). Healthcare providers did not exchange referrals with ACT, nor did they receive referrals from PBS or West Virginia Children's Mental Health Wraparound in the last 12 months (Appendix E, Referrals, Table 1). Organizations and facilities reported higher rates of referrals, as approximately a third of service organizations and facilities had exchanged referrals with pediatric service locations in the last 12 months, and well over half with hospitals and private health practices respectively (Appendix D, Referrals, Table 2). These findings varied by service and type of healthcare facility:

- ACT exchanged the greatest number of referrals with hospitals (93% of ACT organizations and facilities received referrals and 87% made them), followed by Children's Mobile Crisis Response and Stabilization (79% of organizations and facilities received referrals and 76% made them) and West Virginia Children's Mental Health Wraparound (79% of organizations and facilities received referrals and 75% made them). Approximately half of the remaining service organizations and facilities exchange referrals with hospitals.

- Most of the referrals exchanged with pediatric offices were from West Virginia Children's Mental Health Wraparound and Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities (>50% of organizations and facilities respectively); PBS organizations and facilities exchanged the fewest referrals with pediatric offices (14% of PBS organizations and facilities gave and received referrals respectively).

- Many referrals exchanged with private health practices came from ACT, Children's Mobile Crisis Response and Stabilization, and West Virginia Children's Mental Health Wraparound organizations and facilities.

When taken together, only a handful of healthcare providers exchanged referrals with behavioral and mental health services over the last 12 months. When healthcare providers made referrals, most were to residential mental health treatment facilities and the Children's Crisis and Referral Line. On the other hand, organizations and facilities suggested that a fair number of referrals are exchanged between medical facilities and community-based services such as West Virginia Children's Mental Health Wraparound, the Children with Serious Emotional Disorder Waiver Wraparound, ACT, and Children's Mobile Crisis Response and Stabilization. WV DHHR is working to reduce the reliance on residential mental health treatment facilities as well as medical facilities for services that children and youth might be able to receive at home and in their communities; increased screening and assessment by healthcare providers may help to achieve this goal.

A "no wrong door" approach for entering the children's mental health system relies on referrals and care coordination across different types of health providers. This includes traditional healthcare providers who can help identify needs and expedite service delivery by screening children and youth in their care. WV DHHR initiated outreach activities in November 2021 to increase use of the HealthCheck screenings and mental health checks by healthcare providers. As of January 2022, 214 of 659 sites received educational materials. As part of this outreach strategy, WV DHHR endeavors to increase healthcare providers' awareness of the Children's Crisis and Referral Line. In doing so, more referrals should be made between healthcare providers and the Children's Crisis and Referral Line, which should (a) strengthen referral pathways from the Children's Crisis and Referral Line to other services within the child welfare system, and (b) reduce the number of referrals submitted directly to BBH. Next year's report will be able to identify any changes in traditional healthcare providers' awareness of practices.

5.1.5 How have communication and working relationships between mental health and traditional healthcare providers changed? ‡ §

Expected Outcome:

- Enhance quality and frequency of communication between mental health and traditional healthcare providers Ⓘ Ⓛ

Baseline Findings:

Communication between mental health and healthcare providers is paramount to facilitating referral processes and ensuring the timely coordination of quality care. This Evaluation captured both communication quality and frequency. Healthcare providers (n = 40) neither agreed nor disagreed that they communicate regularly with other providers, with nurse practitioners and physician assistants somewhat disagreeing (Appendix E, Referral Policies, Table 4). That said, health systems seem to promote quality communication among traditional healthcare and mental health providers. Healthcare providers agreed that their organizations encourage collaborations with other organizations and facilities in the children's mental health system, except in Region 3 where medical doctors and doctors of osteopathic medicine neither agreed nor disagreed (Appendix E, Referral Policies, Table 2).

Traditional healthcare providers reported that their organizations send referrals to community-based programs with some regularity (Appendix E, Referral Policies, Table 3). Organizations and facilities reported particularly strong referral pathways between hospitals, private health practices, and ACT, Children's Mobile Crisis Response and Stabilization, and Children with Serious Emotional Disorder Waiver (Appendix D, Referrals, Table 2). Regular use of screenings, such as HealthCheck, will continue to help facilitate referrals and working relationships among healthcare providers and mental health providers. Currently 41% of nurse practitioners, physician assistants, medical doctors, and doctors of osteopathic medicine use HealthCheck (Appendix E, Services & Programs, Table 1), most of whom agreed that their organizations made referrals as a result of HealthCheck, and neither agreed nor disagreed that the average length of time to follow-up after the screening is reasonable (Appendix E, Referrals, Table 6).

Organizations and facilities report a substantial amount of collaboration between community-based services and primary healthcare provider agencies (Appendix D, Coordination, Table 3). However, healthcare providers were the only type of provider to report some capacity to coordinate care in every

region. It is also worth noting that the number of available providers was low, ranging from 1-3 healthcare providers in any given region (Appendix E, Capacity & Resources, Tables 1-2).

WV DHHR reports that many service referrals are submitted directly to BBH. Increased awareness of the continuum of available services, especially those available in the community, should foster greater communication and collaboration among healthcare providers and mental and behavioral service providers. Increased reliance on the Assessment Pathway, including utilization of the Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound, and increased awareness and use of the Children's Crisis and Referral Line and other community-based services should also enhance referral pathways within and across child-serving organizations and facilities.

5.1.6 How have coordination and communication among agencies and bureaus changed? ‡ §

Expected Outcome:

- Increased coordination and communication across child-service agencies Ⓢ

Baseline Findings:

Referral pathways indicate that communication and coordination occurs across the children's mental health system. The strongest referral pathways were reported among community-based services and the State, schools, and community health centers, and with non-mental health organizations such as CPS and the Department of Education (Appendix D, Referrals, Table 2; Appendix D, Coordination, Table 3). Of those evaluated, the strongest referral pathways were reported among West Virginia Children's Mental Health Wraparound, the Children with Serious Emotional Disorder Waiver Wraparound, and Children's Mobile Crisis Response and Stabilization, as well as residential mental health treatment facilities and PBS (Appendix D, Referrals, Table 3; Appendix E, Referrals, Table 1). The weakest referral pathways were reported among ACT. Communication and coordination are paramount for maintaining and strengthening these referral pathways. Most providers (80%) work for organizations that encourage follow-ups after referrals are made, many of whom are registered and licensed practical nurses, RMTF social workers and residential mental health treatment facility direct care staff (Appendix E, Referral Policies, Table 5). Social workers and probation officers reported the greatest capacity to provide follow-ups to confirm that referrals have been completed (70-91%; Social Services & Probation, Table 2). Aside from referrals, service facilities commonly collaborated by participating in multiagency meetings, participating in multidisciplinary team meetings, sharing case information, and consulting on cases (Appendix D, Coordination, Table 3).

WV DHHR quality review committee meetings foster cross-functional, cross-bureau discussions about the strengths and opportunities for improvement across the children's mental health system. The Child Welfare Collaborative also promotes partnerships among stakeholders. The increasing amount of braided funding for services, and widespread support for the Assessment Pathway are also indicative of the collaboration occurring across State agencies and bureaus.

5.1.7 How have standards changed for mental health services? ‡ §

Expected Outcome*:*

- Improved standards and enhanced alignment across agencies for children's mental health services Ⓢ Ⓘ Ⓛ

Baseline Findings:

Care standards are often introduced and reinforced through the use of evidence-based practices and training that promote those practices. Providers responding to the survey agreed that delivering an intervention with fidelity enhances its effectiveness and that they deliver evidence-based care (Appendix E, Skillset & Training, Table 2). Providers also agreed that they have the training necessary to function in their current roles (Appendix E, Skillset & Training, Table 2). Many providers expressed an interest in expanding their knowledge and skills as well. Many of the training programs requested by providers support service integration, including cross-training in different services (e.g., in West Virginia Children's Mental Health Wraparound, PBS), care coordination, and the administration of screenings and assessments. Similarly, law enforcement officers expressed an interest in additional training focused on encounters with juveniles, including training on how to work with Children's Mobile Crisis Response and Stabilization teams (Appendix E, Law Enforcement, Tables 1 & 3).

There are several opportunities to increase the alignment of provider perspectives. For example, providers varied in their awareness of the BMS' policy manual for delivering services to children and youth, with behavior analysts, psychologists, and residential mental health treatment facility social workers somewhat agreeing that they are aware, residential mental health treatment facility direct care staff somewhat disagreeing, and the remaining providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 1). Behavior analysts, psychologists, psychiatrists, judges, social workers, and probation officers somewhat agreed that WV DHHR prioritizes in-home and community-based care over out-of-home placement when youth might be better served at home; other providers neither agreed nor disagreed (Appendix E, Referral Policies, Table 1; Appendix E, Judges & Attorney Guardian, Tables 1 & 3). Court judges agreed that they (the judges) prioritized in-home and community-based treatment over residential mental health treatment facilities when children and youth would be better served at home (Appendix E, Judges & Attorney Guardian, Tables 1). Probation officers agreed, and social workers and attorneys somewhat agreed that judges make this a priority (Appendix E, Social Services & Probation, Table 1; Appendix E, Judges & Attorney Guardian, Table 3). Targeted provider outreach might help to increase their awareness of the roles they play, and of the expansion and improvements being made across the children's mental health system to ensure that children and youth can remain in their homes and communities for treatment, whenever it is clinically safe to do so.

WV DHHR promotes the use of standardized, evidence-supported screenings, assessments, and services to children and youth. For example, WV DHHR recommends the continued use of 4 standardized screening tools: EPSDT, Family Advocacy, Support and Training, Ongoing Assessment, MYSI-II. WV DHHR also reports that provider screenings have increased in recent years.

WV DHHR is working to enhance fidelity to national evidence-driven models for services, including ACT, West Virginia Children's Mental Health Wraparound, and PBS. BMS confirms fidelity to ACT national standards before approving authorized providers. BBH has been working with WVU's Center for Excellence in Disabilities to enhance fidelity to the national model for PBS, and with Marshall University to enhance fidelity to the NWI among West Virginia Children's Mental Health Wraparound providers, through training and certifications.

5.1.8   How engaged are stakeholders with WV DHHR bureaus and mental health programs? ‡ §

Expected Outcome:

- Increased engagement of stakeholders (community, advocacy, providers) with programs and bureaus Ⓢ Ⓘ Ⓛ

Baseline Findings:

Survey response rates reported in the Survey Methods Report indicated that engagement expectations were met among child serving organizations and facilities, with the completion rate for the Organization and Facility survey at 54%, but engagement could be improved among child serving health providers. Completion rates varied substantially across provider types for the Provider Survey, with Judges having the highest completion rates (41%), followed by case managers or caseworkers (38%); the lowest completion rates were among nurse practitioners or physician assistants (1.1%) and pediatric or primary care providers (1.5%). Therefore, increased collaboration with professional organizations for health providers in WV promoting the importance of these evaluation efforts and the WV DHHR implementation and expansion work is recommended.

Many stakeholders involved with the children's mental health system expansion and improvement work are engaged in planning, improvement, and evaluation efforts. For example, the Child Welfare Collaborative was developed by WV DHHR in partnership with multiple stakeholders, including WVU OHA, BerryDunn, and Marshall University. This collaborative is an open and independent group of stakeholders who endeavor to share information, ideas, and feedback to promote improvements to the child welfare system. This includes quarterly meetings that in recent sessions have been attended by 80+ stakeholders from across the state. Participants include commissioners, deputy commissioners, WV DHHR program sponsors and project managers, partners from WVU OHA and Marshall University, members of community-based organizations, and unaffiliated members of the community. These meetings provide virtual space for planning discussions and updates on topics such as the Assessment Pathway.

5.1.9 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 Ⓘ Ⓛ

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

5.1.10 How has 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 Ⓘ Ⓛ

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

5.1.11 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 Ⓛ

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6 Appendix A Continued, Medium and Low-Priority Workgroup Specific Evaluation Questions: Baseline Findings[3]

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. As in previous sections, 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-levels) and the timeframe for the anticipated outcome (short-term, intermediate, and long-term; Table 1A). Baseline findings for the youth and caregiver level of the Evaluation will be included in the July 2022 report.

6.1 Wraparound

6.1.1 How has the length of time to access wraparound services changed? ‡

Expected Outcome:

- Decreased waiting period for mental health services Ⓛ

Baseline Findings:

Organizations and facilities reported that 29% of all West Virginia Children's Mental Health Wraparound organizations and facilities have waitlists, with a median wait time of 14 days (Appendix D, Coordination, Table 1). However, this varied greatly by region (Appendix D, Coordination, Table 2).

- Region 1 (n = 6): Two organizations and facilities (33%) have a waitlist. The median wait time is 8.5 days, with many children receiving services within 5-12 days.

- Region 2 (n = 4): Three organizations and facilities (75%) have a waitlist. The median wait time is 30 days, with children getting services in as few as 2 weeks but some may wait 45 days or longer for services.

- Region 3 (n = 2): Neither has a waitlist.

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[3] Evaluation questions for the mental health screening workgroup are captured in the initiative specific evaluation questions.

- Region 4 (*n* = 3): One (33%) has a waitlist with a wait time of 5 days

- Region 5 (*n* = 8): None of the organizations and facilities have a waitlist.

- Region 6 (*n* = 9): Two organizations and facilities (22%) have a waitlist. The median wait time is 8 days, with many children receiving services within 2-14 days.

In summary, there was no wait time for West Virginia Children's Mental Health Wraparound services in Regions 3 or 5. Region 2 had the greatest percentage of West Virginia Children's Mental Health Wraparound organizations and facilities with waitlists, and the wait time was longest among these organizations and facilities, sometimes 45 days or more.

The WV DHHR report outlines several efforts that are currently underway to enhance West Virginia Children's Mental Health Wraparound service capacity and workforce. The Children with Serious Emotional Disorder Waiver is helping fund additional West Virginia Children's Mental Health Wraparound providers, and the MCO is offering monetary incentives to expand services. BBH will also continue to explore whether and what services might be offered over the phone or with virtual communication tools to help make sure children and youth can get the services they need.

Marshall University will capture the length of time to access West Virginia Children's Mental Health Wraparound services as part of the fidelity monitoring being conducted in collaboration with the University of Maryland. Reports containing the fidelity data are expected later this year. Additional measures are also under development in BMS and BBH's database management systems. These data will be included in next year's report.

6.1.2 How has coordination/communication between wraparound providers and non-wraparound providers changed? §

Expected Outcomes:

- Increased coordination and communication across child serving agencies Ⓢ Ⓘ Ⓛ
- Increased referral pathways across child serving mental health programs and bureaus Ⓢ Ⓘ

Baseline Findings:

There are 24 West Virginia Children's Mental Health Wraparound organizations and facilities represented in the Organization and Facility Survey, 83% of which used joint supervision arrangements and 71% of which had joint staffing arrangements; however, findings varied by region (Appendix D, Supervision Staffing, Tables 1-2). Use of joint supervision ranged from 50% of organizations and facilities in Regions 2 and 3 to 100% in Region 6. The use of joint staffing ranged from 0% of organizations and facilities in Region 3 to 88% in Region 5. In addition to considerable usage of joint staffing and supervision, CHMW organizations and facilities express interest in providers who cross-train with other services (Appendix D, Workforce & Capacity, Table 3).

Most West Virginia Children's Mental Health Wraparound organizations and facilities coordinate their care. In fact, 92% of West Virginia Children's Mental Health Wraparound organizations and facilities reported that they consult on cases, 88% share information about their clients with other child-serving organizations and facilities, 75% engage in coordinated planning, and 63% coordinate their schedules with other services (Appendix D, Coordination, Table 3). Some of these findings also varied by region. For

example, 100% of West Virginia Children's Mental Health Wraparound organizations and facilities participated in multidisciplinary team meetings in Regions 1-5, but only 67% participated in Region 6 (Appendix D, Coordination, Tables 3-4).

Most West Virginia Children's Mental Health Wraparound organizations and facilities coordinate with non-mental health organizations (Appendix D, Coordination, Table 3). All West Virginia Children's Mental Health Wraparound organizations and facilities coordinate with CPS, and most with the Department of Education and juvenile parole or probation, with some regional variation among the remaining types of non-mental health organizations. The fewest percentage of West Virginia Children's Mental Health Wraparound organizations and facilities coordinate with primary healthcare provider agencies in Region 2 (25%) and with law enforcement and community-based youth services (33% respectively) in Region 4 (Appendix D, Coordination, Tables 3-4).

Most CHMW organizations and facilities exchanged referrals with schools and hospitals, as well as the State and juvenile justice (Appendix D, Referrals, Table 2). More than half of judges (57%) required participation in West Virginia Children's Mental Health Wraparound as part of case disposition, with regional variation—a greater percentage of judges in Regions 3 and 5 used West Virginia Children's Mental Health Wraparound to this end (Appendix E, Judges & Attorney Guardian, Table 2). There are also several psychiatrists and psychologists in Regions 1 and 2 who used West Virginia Children's Mental Health Wraparound as part of their discharge planning (Appendix E, Out-of-Home Placements, Table 4).

Of the services included in this evaluation, 71% of West Virginia Children's Mental Health Wraparound organizations and facilities made referrals to Children's Mobile Crisis Response and Stabilization, half to other West Virginia Children's Mental Health Wraparound organizations and facilities, 42% to PBS, and a third to Children with Serious Emotional Disorder Waiver Wraparound (Appendix D, Referrals, Table 3). Approximately half of West Virginia Children's Mental Health Wraparound organizations and facilities received referrals from services included in this evaluation, except ACT (17%) and PBS (21%). Specific referral pathways from the last 12 months between West Virginia Children's Mental Health Wraparound and other services in this evaluation are as follows:

- **Assertive Community Treatment**: 17% of West Virginia Children's Mental Health Wraparound organizations and facilities received referrals from ACT and 25% of West Virginia Children's Mental Health Wraparound organizations and facilities made referrals to ACT. Many ACT organizations and facilities (67%) received referrals from West Virginia Children's Mental Health Wraparound, and 40% of ACT organizations and facilities made referrals to West Virginia Children's Mental Health Wraparound.

- **Children's Mobile Crisis Response and Stabilization**: 50% of West Virginia Children's Mental Health Wraparound organizations and facilities received referrals from Children's Mobile Crisis Response and Stabilization locations, and 71% made referrals to West Virginia Children's Mental Health Wraparound. Slightly less than half of Children's Mobile Crisis Response and Stabilization organizations and facilities (45%) received referrals from CMHW and 58% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to CMHW. Children's Mobile Crisis Response and Stabilization locations (45%) received referrals from West Virginia Children's Mental Health Wraparound and 58% of Children's Mobile Crisis Response and

Stabilization organizations and facilities made referrals to West Virginia Children's Mental Health Wraparound.

- **West Virginia Children's Mental Health Wraparound**: 58% of West Virginia Children's Mental Health Wraparound locations received referrals from other West Virginia Children's Mental Health Wraparound locations and 50% made referrals to other West Virginia Children's Mental Health Wraparound locations.

- **Children with Serious Emotional Disorder Waiver Wraparound**: 46% of West Virginia Children's Mental Health Wraparound organizations and facilities received referrals from Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities and 33% of made referrals to Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities. Thirty eight percent of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities received referrals from West Virginia Children's Mental Health Wraparound and 27% made referrals to West Virginia Children's Mental Health Wraparound.

- **Positive Behavioral Support**: 21% of West Virginia Children's Mental Health Wraparound organizations and facilities received referrals from PBS and 42% made referrals to PBS. More than a third (37%) of PBS organizations and facilities received referrals from West Virginia Children's Mental Health Wraparound, and 26% of PBS organizations and facilities sent referrals to West Virginia Children's Mental Health Wraparound.

- **Residential mental health treatment facilities**: 50% of West Virginia Children's Mental Health Wraparound locations received referrals from residential mental health treatment facilities and 29% of West Virginia Children's Mental Health Wraparound locations made referrals to residential mental health treatment facilities. Slightly more than half (55%) of residential mental health treatment facilities received referrals from West Virginia Children's Mental Health Wraparound and 55% of residential mental health treatment facilities also made referrals to West Virginia Children's Mental Health Wraparound.

It is expected that these referral pathways will strengthen with the ongoing implementation of the Assessment Pathway and the expansion of services and workforce capacity.

6.1.3   How has coordination/communication among the wraparound programs changed? §

Expected Outcome:

- Improved standards and enhanced alignment across agencies for children's mental health services Ⓢ Ⓘ Ⓛ

Baseline Findings:

Data from this evaluation indicate that approximately half of West Virginia Children's Mental Health Wraparound referrals are exchanged with other West Virginia Children's Mental Health Wraparound organizations and facilities in the last 12 months (Appendix D, Referrals, Table 3). Many West Virginia Children's Mental Health Wraparound organizations and facilities (46%) receive referrals from Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities, and a third of West Virginia Children's Mental Health Wraparound organizations and facilities make referrals to Children with Serious Emotional Disorder Waiver Wraparound (Appendix D, Referrals, Table 3). Of the 26 Children with

Serious Emotional Disorder Waiver Wraparound organizations and facilities captured in the Organization and Facility Survey, 38% received referrals from West Virginia Children's Mental Health Wraparound, and 27% made referrals to West Virginia Children's Mental Health Wraparound. A substantial number (69%) of referrals are also exchanged among Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities (Appendix D, Referrals, Table 3).

The Evaluation focuses on two types of wraparound services, those funded by BMS under the Children with Serious Emotional Disorder Waiver and those with braided funding as a part of BBH's SOC, West Virginia Children's Mental Health Wraparound. The scope of services under Children with Serious Emotional Disorder Waiver have changed since the Evaluation was designed. As a result, distinctions between funding streams for West Virginia Children's Mental Health Wraparound were not made in the baseline year of data collection. Additional data fields to capture West Virginia Children's Mental Health Wraparound funding are currently being developed and will be included in future reporting. WV DHHR has also requested additional data from Kepro that captures referral processes between Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound. These data will be incorporated into future reports once they are available.

6.1.4 How has the quality and timeliness of CANS assessment for the wraparound program changed? §

Expected Outcome:

- Routine use of standardized and approved mental health screenings and assessments ⑤ ① Ⓛ

Baseline Findings:

This evaluation question contains two important components: (1) the quality of CANS assessments administered by West Virginia Children's Mental Health Wraparound providers, and (2) the timeliness of CANS assessments for children enrolled in West Virginia Children's Mental Health Wraparound. These data are in the early stages of development and will be included in next year's report. As outlined in the WV DHHR report, the quality of CANS assessments administered by West Virginia Children's Mental Health Wraparound providers will be captured by Marshall University using a sampling review process. Also referred to as fidelity reviews in the WV DHHR report, quality sampling will begin in Quarter 2 of 2022 and includes ongoing chart reviews evaluating alignment and linkages among recommendations derived from CANS and actual services and supports provided to children and families in need. The first report of the quality review data is expected in the second half of 2022. These data will be integrated into WV DHHR's quality committee review process. The Marshall University CANS quality data will also be included in future iterations of this report and will serve as the baseline for which trends in the quality for CANS assessments can be compared over time.

The NWI provides guidance for the timeliness of CANS assessments. In alignment with the NWI, a new enrollee in West Virginia Children's Mental Health Wraparound must have a CANS assessment from the last 90 days, or a new CANS assessment should be scheduled within 2 days of the referral to West Virginia Children's Mental Health Wraparound. Additional CANS assessments are recommended at 6-month intervals thereafter.

Data capturing the timeliness of CANS assessments by BBH-funded West Virginia Children's Mental Health Wraparound facilitators are being collected in Epi Info, a secure database management and storage

system used for BBH's SOC. Data collected in the Epi Info system include, but are not limited to, child and family demographics, referrals, and services and supports received. Epi Info was launched in October 2021; therefore, BBH does not yet have sufficient baseline data to include in this report. Medicaid or Kepro data will be included in future reports to capture CANS assessments completed by West Virginia Children's Mental Health Wraparound facilitators funded by Children with Serious Emotional Disorder Waiver, but these data are also still in the process of being developed.

Data on the use of standardized screening and assessment tools are reported as part of several other evaluation questions. Briefly, most providers find screenings and assessments applicable to their job (Appendix E, Skillset & Training, Table 1). Almost half of providers who conduct screenings (46%) and assessments (43%) reported being very competent in delivering these services (Appendix E, Skillset & Training, Table 1). Yet, more than half have requested training in these services and less than half have received it (Appendix E, Skillset & Training, Table 1). Some providers (19%) use HealthCheck for mental health screenings, and 22% use a different screening tool other than HealthCheck (Appendix E, Services & Programs, Table 1).

Fidelity to the NWI requires quality and timely CANS assessments. The NWI-driven training and fidelity monitoring being conducted by Marshall University should result in higher rates of CANS assessments upon enrollment in West Virginia Children's Mental Health Wraparound, as well as routine CANS assessments for children receiving long-term West Virginia Children's Mental Health Wraparound services.

6.1.5 How has knowledge of the NWI model among wraparound providers changed? §

Expected Outcome:

- Increased knowledge of the NWI model among wraparound staff ☺ ①

Baseline Findings:

Approximately 70% of providers reported that the NWI is applicable to their jobs (Appendix E, Skillset & Training, Table 1). However, only 18% feel somewhat comfortable and 7% are very comfortable with their competency. Behavior analysts and RMTF social workers report the highest level of competence in the NWI and RMTF direct care staff, medical doctors and doctors of osteopathic medicine reported the least. Most providers (67%) express an interest in obtaining training on the NWI, but few (2%) have received it (Appendix E, Skillset & Training, Table 1). The West Virginia Children's Mental Health Wraparound training being rolled out by Marshall University will likely be well received, especially given providers' general agreement that they deliver evidence-based care and that fidelity to an intervention enhances its effectiveness (Appendix E, Skillset & Training, Table 2).

There were 8 participants who identified themselves as WVCMHW West Virginia Children's Mental Health Wraparound providers in the Provider Survey (Appendix E, Wraparound and ACT, Table 1). Trends in the responses showed that providers from most regions agreed or somewhat agreed that they understand the evidence behind the NWI, have the necessary skills to implement the NWI, and used the NWI to monitor care delivery; providers from Region 3 neither agreed nor disagreed (Appendix E, Wrapround & Act, Table 1).

West Virginia Children's Mental Health Wraparound is an integral component of the Assessment Pathway and the main point of entry into the children's mental health system. Knowledge of and adherence to the NWI helps to ensure that services are high quality and will connect children with the care that they need. WV DHHR is partnering with Marshall University to support fidelity to the NWI with certified West Virginia Children's Mental Health Wraparound trainers.

6.1.6   How have wraparound providers' knowledge and skills changed?

Expected Outcome:

- Increased knowledge and skills related to evidence-based programming among mental health workforce ⑤ ①
- Increased knowledge and skills related to evidence-based programming among the mental health workforce ⑤ ①

Baseline Findings:

Knowledge of the NWI varied across providers responding to the survey. Behavior analysts and residential mental health treatment facility social workers reported the most competency in the NWI, and medical doctors and doctors of osteopathic medicine reported the least (Appendix E, Skillset & Training, Table 1). Only a handful of West Virginia Children's Mental Health Wraparound providers were captured in the Provider Survey, most of whom agreed or somewhat agreed that they understood the evidence behind the NWI, that they have the skills necessary to implement the NWI, and that they monitored cases using NWI tools, with providers from Region 3 neither agreeing nor disagreeing (Appendix E, Wraparound & Act, Table 1).

6.1.7   How engaged are WV families in wraparound treatment? † ‡

Expected Outcome:

- Increased child/family active engagement in mental health treatment services and supports ⑤ ① ⓛ
- Increased Youth and caregiver active engagement in mental health treatment services and supports ⑤ ① ⓛ

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.1.8   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 ⑤

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.1.9 How has the use of wraparound services changed? †

Expected Outcome:

- Increased accessibility of child/family mental health treatment services and supports ⑤
- Increased accessibility of Youth and caregiver mental health treatment services and supports ⑤

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.2 Children's Mobile Crisis Response

6.2.1 How well-integrated are Children's Mobile Crisis Response services with community healthcare organizations? ‡

Expected Outcome:

- Increased integration of mental health services and supports with community health care organizations/agencies ⑤ ① Ⓛ

Baseline Findings:

Half of the surveyed providers (51%) were aware of Children's Mobile Crisis Response and Stabilization; however, awareness varied across provider types. All residential mental health treatment facility social workers were aware of Children's Mobile Crisis Response and Stabilization services, whereas 0% of registered and licensed practical nurses, 10% of attorneys, and 17% of medical doctors and doctors of osteopathic medicine reported awareness of Children's Mobile Crisis Response and Stabilization (Appendix E, Services & Programs, Table 4). Eleven percent of health providers received a referral from Children's Mobile Crisis Response and Stabilization in the last 12 months (Appendix E, Referrals, Table 1). Sixteen providers (19%) made a referral to Children's Mobile Crisis Response and Stabilization in the last 12 months, 25% of whom were behavior analysts and psychologists, respectively, and 19% are residential mental health treatment facility social workers (Appendix E, Referrals, Tables 1-2). More than a third of those providers accessed Children's Mobile Crisis Response and Stabilization weekly (38%), the rest reported using Children's Mobile Crisis Response and Stabilization monthly or several times a year (19% respectively; Appendix E, Referrals, Table 2).

Joint supervision and joint staffing are common among Children's Mobile Crisis Response and Stabilization organizations and facility locations. The Organization and Facility Survey captured both BBH Children's Mobile Crisis Response and Stabilization services and Mobile Response services that are offered out of the Children with Serious Emotional Disorder Waiver programs. Sixty four percent have joint supervision arrangements and 52% have joint staffing arrangements; however, findings varied by region (Appendix D, Supervision Staffing, Table 1-2). Use of joint supervision ranged from 9% of organizations and facilities in Region 4 to 100% in Regions 1 and 3. Use of joint staffing is lowest in Region 4 (9% of organizations and facilities) and highest in Region 1 (100% of organizations and facilities).

Many Children's Mobile Crisis Response and Stabilization organizations and facilities coordinate with other services (Appendix D, Coordination, Tables 3-4). All Children's Mobile Crisis Response and Stabilization organizations and facilities participate in multiagency meetings, and 82% participate in these meetings at least once a month. Regional variation indicated that some organizations and facilities in Regions 5 and 6 (40% and 50% respectively) participate in multiagency meetings every quarter; the remaining organizations and facilities participated in multiagency meetings on a monthly, bi-monthly, and weekly basis. Most Children's Mobile Crisis Response and Stabilization organizations and facilities (94%) also participated in multidisciplinary team meetings, 79% of organizations and facilities consult on cases, 85% share information about their clients with other organizations, and 64% plan and coordinate their schedules with other facilities.

Most Children's Mobile Crisis Response and Stabilization organizations and facilities exchanged referrals with the State, schools, private healthcare practices, private or public hospitals, and community-based health centers (Appendix D, Referrals, Table 2). Children's Mobile Crisis Response and Stabilization organizations and facility locations also coordinated with non-mental health providers and organizations, such as primary healthcare agencies (91%), CPS (91%), the Department of Education (79%), and law enforcement (76%), with some regional variation (Appendix D, Coordination, Table 3). As described in greater detail below, of the services included in this evaluation, 58% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to West Virginia Children's Mental Health Wraparound in the last 12 months, nearly half (48%) made referrals to other Children's Mobile Crisis Response organizations and facilities, and 42% made referrals to ACT. Slightly less than half of Children's Mobile Crisis Response and Stabilization organizations and facilities (45%) received referrals from West Virginia Children's Mental Health Wraparound, and 39% from other Children's Mobile Crisis Response and Stabilization and Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities respectively. The fewest percentage of Children's Mobile Crisis Response and Stabilization organizations and facilities exchange referrals with PBS (Appendix D, Referrals, Table 3).

As mentioned, Mobile Response is offered through the Children with Serious Emotional Disorder Waiver. Although eligibility slightly differs for BMS Children with Serious Emotional Disorder Waiver and BBH Children's Mobile Crisis Response and Stabilization, the services offer comparable support to children, youth, and families. Efforts are underway to make distinctions among these two services in future reports.

WV DHHR is working to facilitate referrals for Children's Mobile Crisis Response and Stabilization teams through the Children's Crisis and Referral Line. BBH is also in the planning stages with Marshall University and the University of Maryland to enhance current Children's Mobile Crisis Response and Stabilization training standards.

Connections between Children's Mobile Crisis Response and Stabilization and the Children's Crisis and Referral Line are captured in the continuous quality improvement data being collected by BBH in collaboration with WVU OHA as part of the BBH SOC Evaluation. These data will be included in next year's report.

6.2.2 What are the working relationships between Children's Mobile Crisis Response services and traditional medical providers? ‡

Expected Outcomes:

- Enhanced communication between mental health and traditional healthcare providers Ⓢ Ⓘ Ⓛ
- Enhanced working relationship between mental health and traditional healthcare/medical providers and child serving professionals Ⓛ
- Increased referrals from traditional healthcare providers to mental health providers Ⓛ

Baseline Findings:

Children's Mobile Crisis Response and Stabilization teams provide on-site support for individuals requesting immediate services. Due to the diverse needs of children and families seeking support, Children's Mobile Crisis Response and Stabilization teams must be equipped with knowledge and resources that represent the continuum of care, including having working relationships with healthcare service providers. In order to establish robust working relationships, healthcare providers also need to be aware of Children's Mobile Crisis Response and Stabilization services.

Forty healthcare providers responded to the Provider Survey. Only 8% were aware of Children's Mobile Crisis Response and Stabilization services, and only 5% made referrals to Children's Mobile Crisis Response and Stabilization in the last 12 months (Appendix E, Services and Programs, Table 4; Appendix E, Referrals, Table 2). It is worth noting that 11 healthcare providers (28%) called the Children's Crisis and Referral Line in the last 12 months, which might be how they typically access their local Children's Mobile Crisis Response and Stabilization teams (Appendix E, Services and Programs, Table 4). On the other hand, organizations and facilities reported frequent interactions between Children's Mobile Crisis Response and Stabilization and medical facilities. Most Children's Mobile Crisis Response and Stabilization organizations and facilities (91%) coordinate with primary healthcare provider agencies, but this varied greatly across regions (Appendix D, Coordination, Table 3). Well over half of Children's Mobile Crisis Response and Stabilization organizations and facilities in Regions 2-5 coordinated with primary healthcare provider agencies, but the single organization in Region 1 does not (Appendix D, Coordination, Table 4). When asked about the types of medical facilities with which Children's Mobile Crisis Response and Stabilization organizations and facilities exchange referrals, 88% of Children's Mobile Crisis Response and Stabilization organizations and facilities indicated that they receive referrals from group or solo private health practices, 79% from hospitals, and 42% from locations offering pediatric services (Appendix D, Referrals, Table 2). Similarly, 79% of Children's Mobile Crisis Response and Stabilization organizations and facilities make referrals to solo private practitioners, 76% refer to hospitals, and 33% to locations offering pediatric services (Appendix D, Referrals, Table 2).

As mentioned, WV DHHR is working to increase healthcare providers' awareness and utilization of the Children's Crisis and Referral Line and Children's Mobile Crisis Response and Stabilization. Future reports will be able to determine whether these referral pathways change over time.

6.2.3 How has coordination and communication between Children's Mobile Crisis Response and community-based organizations changed? ‡ §

Expected Outcomes:

- Improved timely coordination and engagement of community/state services as needed Ⓢ Ⓘ Ⓛ
- Increased awareness of mental health services and supports among child serving mental health professionals Ⓢ Ⓘ Ⓛ

- Increased coordination and communication across community-based organizations (e.g., law enforcement, homeless coalition, social workers) ① ①

Baseline Findings:

Most Children's Mobile Crisis Response and Stabilization organizations and facilities coordinate with other community-based organizations (Appendix D, Coordination, Table 4). All Children's Mobile Crisis Response and Stabilization organizations and facilities participate in multidisciplinary team meetings, 94% participate in multidisciplinary team meetings, 85% share information about clients with other services, 79% consult on cases, and 64% plan and coordinate their schedules with other services (Appendix D, Coordination, Tables 3). The percentage of Children's Mobile Crisis Response and Stabilization organizations and facilities that coordinate with other organizations and facilities varied by region and activity (Appendix D, Coordination, Table 4). For example, many of Children's Mobile Crisis Response and Stabilization organizations and facilities in Regions 4, 5, and 6 participate in multiagency meetings on a quarterly basis, whereas organizations and facilities in Regions 1, 2, and 3 participate more frequently, on a monthly, bi-monthly, and weekly basis.

Only 11% of law enforcement officers responding to the survey were aware of the Children's Mobile Crisis Response and Stabilization team in their area (Appendix E, Law Enforcement, Table 2). Most of the law enforcement officers were aware of Children's Mobile Crisis Response and Stabilization worked in Regions 4 and 5 (Appendix E, Law Enforcement, Table 2). Of those law enforcement officers with awareness of their local Children's Mobile Crisis Response and Stabilization teams (n = 33), 79% knew how to access those teams, 2 placed calls to the Children's Crisis and Referral Line and 6 had worked with a Children's Mobile Crisis Response and Stabilization team in the last 12 months (Appendix E, Law Enforcement, Table 2).

Many law enforcement officers (67%) expressed the need for training on how to work with Children's Mobile Crisis Response and Stabilization teams, and 65% would like resources and materials on Children's Mobile Crisis Response and Stabilization services to use as a reference (Appendix E, Law Enforcement, Table 3).

6.2.4 How have the hotline staff changed? ‡ §

Expected Outcome:

- Increased capacity for mental health treatments and supports ⑤ ① ①

Baseline Findings:

The Children's Crisis and Referral Line is available 24 hours a day, 7 days a week, 365 days a year. WV DHHR reports that as of January 2022 the occupancy rate for crisis counselors at the Children's Crisis and Referral Line is 100% (2/2 positions filled). The Children's Crisis and Referral Line has a budget for 16.5 full time employees for helpline specialists, 14 of which are filled (85% occupancy rate). The Children's Crisis and Referral Line budget also includes 3 shift lead positions, 2 of which are filled (67% occupancy rate).

Two-thirds of providers responding to the survey were aware of the Children's Crisis and Referral Line (Appendix E, Services & Programs, Table 4). However, only 31% feel that it has sufficient resources to meet youth's needs (Appendix E, Services & Programs, Table 4). As mentioned in the WV DHHR report, this may be more indicative of providers' concerns about the availability and capacity of other community-based

services to which the Children's Crisis and Referral Line sends referrals, rather than concerns about the capacity of the Children's Crisis and Referral Line. These concerns should be alleviated as greater capacity is built across the children's mental health system.

6.2.5 How well do Children's Mobile Crisis Response services communicate with traditional medical providers? ‡

Expected Outcome:

- Enhanced communication between mental health and traditional healthcare providers Ⓢ Ⓘ Ⓛ

Baseline Findings:

Surveyed healthcare providers infrequently exchanged referrals with Children's Mobile Crisis Response and Stabilization services. Only 15% made referrals to the Children's Crisis and Referral Line in the last 12 months, and 5% to Children's Mobile Crisis Response and Stabilization (Appendix E, Referrals, Table 1). Only 5% of healthcare providers received referrals from the Children's Crisis and Referral Line and 5% from Children's Mobile Crisis Response and Stabilization in the last 12 months (Appendix E, Referrals, Table 1). However, healthcare organizations and facilities reported higher rates of referrals. Most Children's Mobile Crisis Response and Stabilization organizations and facilities (88%) received referrals from private health practices, 79% received referrals from hospitals, and 42% from facilities offering pediatric services (Appendix D, Referrals, Table 2). Similarly, as noted in 6.2.2, 76-79% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to solo or group private practices, 76% to hospitals, and 33% to facilities offering pediatric services. Coordination with primary care facilities varied by region (Appendix D, Coordination, Table 4). The single Children's Mobile Crisis Response and Stabilization organization in Region 1 does not coordinate with primary care facilities, otherwise more than 60% of Children's Mobile Crisis Response and Stabilization organizations and facilities in Regions 2-6 collaborate with primary care facilities, with the greatest percentage (100%) of coordination reported in Region 5. Collaborative activities by Children's Mobile Crisis Response and Stabilization included participation in multiagency meetings, participation in multidisciplinary team meetings, case consultation, information sharing, and coordinated planning (Appendix D, Collaboration, Table 3).

WV DHHR has been working to improve healthcare providers' awareness and use of Children's Mobile Crisis Response and Stabilization by way of the Children's Crisis and Referral Line. WV DHHR reports aligned with these evaluation findings, as WV DHHR data has only 1% of referrals to the Children's Crisis and Referral Line between January and June of 2021 originating from healthcare professionals.

6.2.6 What are the referral pathways between Children's Mobile Crisis Response and other service providers? §

Expected Outcome:

- Increased referral pathways across child-serving mental health programs and bureaus Ⓢ Ⓘ

Baseline Findings:

Children's Mobile Crisis Response and Stabilization most frequently exchanges referrals with the State, schools, private healthcare practices, private or public hospitals, and community-based health centers

(Appendix D, Referrals, Table 2). Children's Mobile Crisis Response and Stabilization organizations and facilities also coordinate with non-mental health organizations such as CPS and the Department of Education, with some regional variation (Appendix D, Coordination, Table 4).

For the other services included in this evaluation, referral pathways over the last 12 months to Children's Mobile Crisis Response and Stabilization were as follows (Appendix D, Referrals, Table 3):

- **Assertive Community Treatment**: 21% of Children's Mobile Crisis Response and Stabilization organizations and facilities received referrals from ACT and 42% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to ACT. Many ACT organizations and facilities (40%) received referrals from Children's Mobile Crisis Response and Stabilization, and 80% of ACT organizations and facilities made referrals to Children's Mobile Crisis Response and Stabilization.

- **Children's Mobile Crisis Response and Stabilization**: 39-48% of organizations and facilities exchanged referrals with other Children's Mobile Crisis Response and Stabilization organizations and facilities.

- **West Virginia Children's Mental Health Wraparound**: 45% of Children's Mobile Crisis Response and Stabilization organizations and facilities received referrals from West Virginia Children's Mental Health Wraparound and 58% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to West Virginia Children's Mental Health Wraparound. Half of West Virginia Children's Mental Health Wraparound organizations and facilities made referrals to Children's Mobile Crisis Response and Stabilization and 71% made referrals to Children's Mobile Crisis Response and Stabilization.

- **Children with Serious Emotional Disorder Waiver Wraparound**: 39% of Children's Mobile Crisis Response and Stabilization organizations and facilities received referrals from Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities and 21% of organizations and facilities made referrals to Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities. Approximately a third (31%) of Children with Serious Emotional Disorder Waiver Wraparound organizations and facilities received referrals from Children's Mobile Crisis Response and Stabilization and 50% made referrals to Children's Mobile Crisis Response and Stabilization.

- **Positive Behavioral Support**: 15% of Children's Mobile Crisis Response and Stabilization organizations and facilities received referrals from PBS and 39% made referrals to PBS. Only 14% of PBS organizations and facilities received referrals from Children's Mobile Crisis Response and Stabilization, and 26% of PBS organizations and facilities made referrals to Children's Mobile Crisis Response and Stabilization.

- **Residential mental health treatment facilities**: 36% of Children's Mobile Crisis Response and Stabilization organizations and facilities received referrals from residential mental health treatment facilities, and 24% of Children's Mobile Crisis Response and Stabilization organizations and facilities made referrals to residential mental health treatment facilities. Approximately a third of residential mental health treatment facilities (30%) received referrals from Children's

Mobile Crisis Response and Stabilization and 45% of residential mental health treatment facilities made referrals to Children's Mobile Crisis Response and Stabilization.

These data suggest that the strongest referral pathways exist between Children's Mobile Crisis Response and Stabilization and both wraparound programs. Many ACT organizations and facilities and residential mental health treatment facilities also made referrals to Children's Mobile Crisis Response in the last 12 months. Children's Mobile Crisis Response and Stabilization organizations and facilities received the fewest referrals from PBS (15%).

Provider referrals to Children's Mobile Crisis Response and Stabilization varied by provider type. The greatest percentage of providers who made referrals to Children's Mobile Crisis Response and Stabilization in the last 12 months were residential mental health treatment facility social workers (100%) followed by other social workers (61-70%) and behavior analysts (60%; Appendix E, Referrals, Table 1; Appendix E, Social Service & Probation, Table 2). None of the residential mental health treatment facilities' direct care staff made referrals to Children's Mobile Crisis Response and Stabilization in the last 12 months (Appendix E, Referrals, Table 1). Most of the providers who sent referrals to Children's Mobile Crisis Response and Stabilization reported doing so weekly (38%), with many of the remaining providers sending referrals monthly or several times a year (19% respectively; Appendix E, Referrals, Table 2).

WV DHHR's implementation of the Assessment Pathway is intended to assist Children's Crisis and Referral Line staff with screening and connecting children and families with home and community-based services, including Children's Mobile Crisis Response and Stabilization.

6.2.7 How routinely are standardized and approved assessments used by Children's Mobile Crisis Response services? §

Expected Outcome:

- Routine use of standard and approved mental health screenings and assessments Ⓢ Ⓘ Ⓛ

Baseline Findings:

Data on screenings and assessments completed by the Children's Crisis and Referral Line and Children's Mobile Crisis Response and Stabilization are currently being developed by BBH and are expected to be available for next year's report. In general, half of WV health providers (64%) assess and evaluate youth, 43% conduct intake evaluations and assessments, and 29% offer wellness exams (Appendix E, Capacity & Resources, Table 1). Many providers (40-46%) feel competent in delivering these services, and many have requested additional training (Appendix E, Skillset & Training, Table 1).

WV DHHR is promoting the use of standardized mental health screenings and assessments such as HealthCheck and CANS. WV DHHR has completed training with the Children's Crisis and Referral Line to help implement the Assessment Pathway to ensure that timely screenings and assessments are conducted. Referrals to Children's Mobile Crisis Response and Stabilization from the Children's Crisis and Referral Line and Assessment Pathway might result in screenings and assessments already being in place. Children's Mobile Crisis Response and Stabilization teams might find it logistically challenging to conduct screenings and assessments, especially when they are providing services to multiple people who are in crisis (e.g., several children or a child and their family). While screening and assessment data are still being developed, WV DHHR has been capturing crisis plan completion rates for children and youth receiving

Children's Mobile Crisis Response and Stabilization. Data indicate that 75% of clients receiving Children's Mobile Crisis Response and Stabilization services have a crisis plan in place.

6.2.8 How engaged are stakeholders with Children's Mobile Crisis Response services? §

Expected Outcome:

- Increased engagement for stakeholders (community, advocacy, providers) with programs and bureaus Ⓘ Ⓛ

Baseline Findings:

Most health providers who responded to the survey recognized the importance of crisis intervention and stabilization, with only 14% suggesting that it is not applicable to their jobs (Appendix E, Skillset & Training, Table 1). Many social workers (61%) and 33% of probation officers were aware of Children's Mobile Crisis Response and Stabilization, more than half of whom (52%-70%) made referrals to this service (Appendix E, Social Services & Probation, Table 2). The utilization of Children's Mobile Crisis Response and Stabilization by probation officers and social workers is slightly higher in Region 4, which might be related to the fact that there are 2 BBH Children's Mobile Crisis Response and Stabilization teams in that region. Also, a substantial number of providers expressed interest in crisis intervention and stabilization training:

- Two-thirds of providers requested training in crisis response and stabilization (Appendix E, Skillset & Training, Table 1).

- Most social workers and probation officers agreed that they would like training in how to respond to youth in mental health crisis (Appendix E, Social Services & Probation, Table 1).

- Half of law enforcement officers would like training on how to de-escalate situations involving juveniles, 43% on how to respond to mental health crises, and most (67%) express the need for training on when and how to work with Children's Mobile Crisis Response and Stabilization teams (Appendix E, Skillset & Training, Table 1; Appendix E, Law Enforcement, Table 3).

Children's Mobile Crisis Response and Stabilization teams are trained to de-escalate situations and provide immediate support, for example, to develop crisis relief and stability plans with families. The goal is to have Children's Mobile Crisis Response and Stabilization teams arrive within one hour of a call. There are 7 BBH Children's Mobile Crisis Response and Stabilization teams that provide statewide coverage; however, geography and the rurality of some WV regions make the one-hour standards difficult to meet. Additionally, Children's Mobile Crisis Response and Stabilization teams have reported difficulty in staffing in the interviews and focus groups.

WV DHHR has made significant efforts in ensuring crisis intervention and related services are available statewide. The Children's Crisis and Referral Line and Assessment Pathway are expected to help facilitate connections to the Children's Mobile Crisis Response and Stabilization teams when immediate in-person services are needed. This will help ensure that children and families can get the help they need in their homes and communities. Data from this evaluation also indicate that providers and organizations are committed to and interested in expanding crisis intervention services.

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

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.2.10 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:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.2.11 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:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

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

Expected Outcome:

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

Baseline Findings:

WV DHHR reported that 833 children were served by Children's Mobile Crisis Response and Stabilization between July 2020 and June 2021. Additional data on child and family usage and experiences with Children's Mobile Crisis Response and Stabilization will be included in the July report.

6.3 Positive Behavior Support

6.3.1 How has the capacity to provide PBS services changed at the region and state levels? ‡

Expected Outcomes:

- Improved ability of WVU Center for Excellence in Disabilities to fulfill the requirements of their contract Ⓢ

- Reduced dependence on WVU Center for Excellence in Disabilities to assist in PBS service delivery by other providers and agencies in the state Ⓘ Ⓛ

- Improved performance by WVU Center for Excellence in Disabilities relative to identified performance metrics Ⓢ Ⓘ Ⓛ

- Sustained delivery of PBS services to meet needs statewide Ⓘ Ⓛ

- Expanded workforce and systemic capacity to provide PBS services statewide Ⓘ Ⓛ

Baseline Findings:

Providers who responded to the survey report statewide coverage for PBS, but organizations and facilities express capacity concerns. There were 21 providers who stated that they provided PBS in the last 12 months, which included behavior analysts, healthcare providers, psychiatrists, psychologists, residential mental health treatment facility social workers, and residential mental health treatment facility direct care staff (Appendix E, Services & Programs, Table 2). Coverage reported by providers varied by region. Region 4 had the most coverage, with well over half of the PBS providers (62%) offering services in that region, whereas Regions 3 and 5 have the fewest PBS providers (38% respectively; Appendix E, Skillset & Training, Table 3).

Trends in the provider survey data indicated that psychiatrists agreed that the WVU Center for Excellence in Disabilities training adequately prepared them to implement and deliver PBS, while behavior analysts and residential mental health treatment facility social workers somewhat agreed (Appendix E, Skillset & Training, Table 3); other providers neither agreed nor disagreed. In terms of workforce expansion, psychiatrists agreed that credentialing requirements might be making it too burdensome to get credentialed in PBS service delivery; other providers neither agreed nor disagreed (Appendix E, Skillset & Training, Table 3).

According to the Organization and Facility Survey, there are 35 organizations and facilities that offer PBS (Appendix D, Background, Table 2), and well over half of PBS organizations and facilities (63%) contract with outside providers (Appendix D, Workforce & Capacity, Table 1). When asked about workforce capacity and staffing, organizations and facilities reported the following:

- Only 23% of PBS organizations and facilities have adequate staff to serve youth. The percentage of organizations and facilities with adequate staff ranged from 8% in Region 2 to 30% in Region 3 (Appendix D, Workforce & Capacity, Table 1).

- Less than half of PBS organizations and facilities (43%) have the staff with the necessary training and skills. The percentage of organizations and facilities reporting staff with the necessary training and skills ranged from 17% in Region 4 to 50% in Region 1 (Appendix D, Workforce & Capacity, Table 1).

- Slightly less than half of PBS organizations and facilities (46%) have the capacity to serve the youth being referred to their facilities (Appendix D, Workforce & Capacity, Table 1). However, regional variation indicated differences in capacity across the state. More than half of organizations and

facilities in Regions 2 and 3 (54% and 60% respectively) had capacity, whereas only 33% of organizations and facilities in Region 1, 17% in Region 4, 11% in Region 5, and 13% in Region 6 reported capacity to serve youth (Appendix D, Workforce & Capacity, Table 1). Only 26% of organizations and facilities lacking capacity have a nearby provider to offer needed services, which also varied regionally. Region 1 reported the most organizations and facilities (50%) able to reach out to other nearby providers to support the children and youth needing services, and Region 6 reported the fewest (14%; Appendix D, Workforce & Capacity, Table 1).

Two-thirds of PBS organizations and facilities had difficulty recruiting and retaining social workers and therapists (Appendix D, Workforce & Capacity, Table 3). PBS organizations and facilities also stated that an array of providers across disciplines are needed, including healthcare providers, special education instructors, providers experienced in teaching and engaging families, and in-home support providers (Appendix D, Workforce & Capacity, Table 3). Most of the organizations and facilities offering PBS suggested that challenges hiring and retaining staff has much or a great deal to do with salary ranges in WV, and that lack of workforce has much to do with the lack of capacity to serve all of the youth being referred to PBS (Appendix D, Workforce & Capacity, Table 2). Organization and facility administrators reported that lack of services somewhat affected capacity, whereas administrative or legal processes such as MOUs or contracts had little impact on capacity.

Most providers expressed concerns about PBS resources and capacity, yet many of the providers, as well as organizations and facilities, continue to refer children and youth to PBS (Appendix D, Referrals, Table 3; Appendix E, Services & Programs, Table 4; Appendix E, Referrals, Table 1). PBS ranked third in terms of the number of referrals made by providers (24%) in the last 12 months; residential mental health treatment facilities and the Children with Serious Emotional Disorder Waiver are the first and second most referred to services, respectively (Appendix E, Services & Programs, Table 4; Appendix E, Referrals, Table 1). Many of the referrals to PBS were made by behavior analysts and psychiatrists (Appendix E, Referrals, Table 1). More than half of social workers (56-68%) and half of the probation officers also made referrals to PBS (Social Services & Probation, Table 2). Judges in Regions 2 and 5 also reported requiring participation in PBS as part of case disposition in the last 12 months (Appendix E, Judges & Attorney Guardian, Table 2).

According to organizations and facilities, referral rates varied by service. The greatest percentage of PBS organizations and facilities received referrals from Children with Serious Emotional Disorder Waiver Wraparound and West Virginia Children's Mental Health Wraparound (37% respectively; Appendix D, Referrals, Table 3). Few PBS organizations and facilities received referrals from ACT (9%), or Children's Mobile Crisis Response and Stabilization (14%). The greatest percentage of PBS organizations and facilities made referrals to other PBS organizations and facilities (34%), followed by 26% of organizations and facilities that made referrals to Children's Mobile Crisis Response and Stabilization and residential mental health treatment facilities, respectively. Very few PBS organizations and facilities made referrals to residential mental health treatment facilities (14%).

Workforce and capacity issues, in addition to the considerable number of referrals being sent to PBS, are reflected in the waitlist data reported by organizations and facilities. Forty percent of PBS providers in WV reported a waitlist for new clients. It is worth noting that the percentage of organizations and facilities with waitlists and length of waitlist time varied by region (Appendix D, Coordination, Table 2). The greatest percentage of organizations and facilities with waitlists resided in Regions 1 and 4 (67% respectively), but

the waitlist time was much shorter in Region 1. The median wait time reported in Region 1 is 12 days, with most children receiving services within 5-14 days. The median waitlist time reported in Region 4 is 37.5 days, with many children waiting for a little over 2 weeks (17.5 days) to several months (122.5 days) for PBS services. The fewest percentage of organizations and facilities with waitlists (30%) were in Region 3, with a median waitlist time of 3 days. Even though only 38% of organizations and facilities in Region 6 had waitlists for PBS, this region has the longest waitlist time with a median of 45 days, with many children waiting anywhere from a month to a year for services.

BBH is working to continue to build workforce and system capacity by increasing PBS offerings across the state, hiring a curriculum developer, and filling 2 additional behavior specialist positions.

WV DHHR reported that the number of children receiving PBS increased from 21 clients per month in 2020 to 41 clients per month in 2021, and as of January 2022 there were 10 children on the waitlist for PBS services. BBH is working with WVU's Center for Excellence in Disability to support and demonstrate its progress toward meeting performance expectations. In July 2022, some services offered by PBS will become Medicaid billable. Future reporting will be able to track subsequent changes in PBS capacity and usage.

6.3.2   How has the quality and timeliness of CANS assessments for PBS participants changed? §

Expected Outcomes:

- Routine use of standardized and approved *mental health* screenings Ⓘ Ⓛ
- Routine use of standardized and approved *mental health* assessments Ⓘ Ⓛ

Baseline Findings:

Many providers who responded to the survey reported that they were somewhat (34%) or very (18%) competent in conducting screenings and assessments, with behavioral analysts reporting the most competency (Appendix E, Skillset & Training, Table 1). More than half of providers (56%) would like more training, 14% of whom have received it (Appendix E, Skillset % Training, Table 1). This includes the 21 participants who identified themselves as PBS service providers.

BBH is in the process of collecting data on the timeliness of CANS for West Virginia Children's Mental Health Wraparound and PBS services provided in their BBH SOC. These data are being collected in a secure database management system that was launched in October 2021; therefore, BBH does not yet have sufficient baseline data to include in this report. These data will be included in next year's report. Together, the data from BBH and Marshall University should be able to describe whether CANS assessments were completed, and if so, when, and to what ends (i.e., were children referred to other community-based services as a result of their assessments).

WV DHHR's goal is to have a CANS assessment completed for any child receiving PBS who is also dual enrolled in West Virginia Children's Mental Health Wraparound and/or receives services from Children's Mobile Crisis Response and Stabilization. BBH is working with providers to ensure that timely CANS assessments are completed for all new clients receiving PBS from BBH SOC organizations and facilities and that CANS assessments are repeated every 6 months thereafter, for children needing long-term services. To achieve this outcome, PBS providers are receiving training and certification in the administration of CANS, which is part of Marshall University's quality initiative to be reported on later this year

6.3.3 How has the use of PBS services changed? §

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.3.4 How has quality of life changed for children and families following PBS intervention? †

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.3.5 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:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.3.6 How has the quality and timeliness of CANS assessments for PBS participants changed? ‡

Expected Outcome:

- Increased timely completion of CANS assessment on individuals receiving PBS Intensive Services Ⓢ Ⓘ

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.4 Assertive Community Treatment

6.4.1 How many ACT teams met all of the model fidelity factors? §

Expected Outcome:

- Statewide access to children's mental health prevention and treatment services Ⓢ Ⓘ

Baseline Findings:

BMS confirms the fidelity to ACT national standards before approving authorized providers. Kepro reassesses compliance every 18 months. Requisites include but are not limited to licensure, proof of certification and training, expectations for care planning based on services needed, and other administrative requirements associated with Medicaid-funded services.

6.4.2 How has involvement with the criminal justice system among ACT participants changed? †

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.4.3 How have referrals and orders to the criminal justice system changed for ACT eligible participants? †

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.4.4 How has the length of stay for inpatient hospitalizations due to a primary mental health condition changed among ACT participants? †

Expected Outcomes:

- Decreased inpatient hospitalizations among 18–21-year-olds enrolled in ACT services Ⓛ

- Shorter length of stay for inpatient hospitalizations among 18-21-year-olds Ⓘ

- Improved child functioning Ⓛ

- Increased medication compliance and self-management of psychiatric illness Ⓘ

- Increased engagement in the community, including the workforce, by 18-21-year-olds enrolled in ACT services Ⓛ

- Independent living Ⓘ Ⓛ

- Rate of noncompliance to treatment Ⓘ Ⓛ

- Decreased Juvenile Justice involvement Ⓘ Ⓛ

- Decreased Hospitalizations and RMHFT stays Ⓘ Ⓛ

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.4.5   How has the use of ACT services changed? ‡

Expected Outcome:

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

Baseline Findings:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

6.5   Workforce

6.5.1   How has awareness of mental health services for children changed among mental health providers and medical providers?? ‡ §

Expected Outcomes:

- Increased awareness of mental health services and support among child-serving mental health professionals Ⓘ

- Decreased use of Emergency Department usage for mental health needs Ⓘ Ⓛ

Baseline Findings:

Provider Survey respondents were asked to report on their own awareness of services of interest to the Evaluation. Overall, providers were least aware of ACT and most aware of residential mental health treatment facilities (Appendix E, Services and Programs, Table 4). However, awareness varied by provider and service type. For example, judges were aware of residential mental health treatment facilities, West Virginia Children's Mental Health Wraparound, PBS, and Children with Serious Emotional Disorder Waiver Wraparound, which they sometimes require as part of case disposition (Appendix E, Judges and Attorney, Table 2). Awareness of services among other providers was reported as follows (Appendix E, Services and Programs, Table 4):

- ***Assertive Community Treatment***: 17% of providers were aware; residential mental health treatment facility social workers were most aware (67%) and registered nurses and licensed practical nurses, nurse practitioners and physician assistants, and residential mental health treatment facility direct care staff were least aware (all 0%).

- ***Children's Mobile Crisis Response and Stabilization***: 51% of providers were aware; residential mental health treatment facility social workers were the most aware (100%); registered and licensed practical nurses (0%), attorneys (10%), and law enforcement officers (11%) were least aware. (Appendix E, Law Enforcement, Table 2).

- ***West Virginia Children's Mental Health Wraparound***: 67% of providers were aware; residential mental health treatment facility direct care staff and residential mental health treatment facility social workers were the most aware (100%) and registered and licensed professional nurses,

nurse practitioners and physician assistants as well as medical doctors and doctors of osteopathic medicine were the least aware (0%, 0% and 8%, respectively).

- ▪ **Children with Serious Emotional Disorder Waiver Wraparound**: Half of providers (51%) were aware of Children with Serious Emotional Disorder Waiver Wraparound. Behavioral analysts (88%) and social workers and case managers (71%) were the most aware, and registered and licensed practical nurses, and medical doctors and doctors of osteopathic medicine were least aware (0% and 17%, respectively).

- ▪ **Positive Behavioral Support**: 61% of providers were aware; residential mental health treatment facility direct care staff, residential mental health treatment facility social workers and behavioral analysts were the most aware (100%, respectively), and registered and licensed practical nurses (0%), medical doctors and doctors of osteopathic medicine (8%) as well as psychiatrists (11%) were the least aware.

- ▪ **Residential Mental Health Treatment Facilities**: 83% were aware; registered and licensed practical nurses, as well as residential mental health treatment facility social workers, were most aware (100%), followed by judges and attorneys (90% respectively). Awareness was lowest among nurse practitioners and physician assistants (20%).

- ▪ **Children's Crisis and Referral Line**: 66% were aware; residential mental health treatment facility social workers were most aware (100%) and registered nurses and licensed practical nurses, and residential mental health treatment facility direct care staff were least aware (0%).

Taken together, residential mental health treatment facility social workers and residential mental health treatment facility direct care staff reported the most awareness of most services, and healthcare providers such as nurses, physician assistants, and medical doctors tended to be the least aware.

Provider Survey respondents were also asked to report on other providers' awareness of available services that are included in this Evaluation. Judges from Regions 1 and 4 agreed that providers are aware of other services; judges from Regions 2 and 6, social service providers, and probation officers somewhat agreed (Appendix E, Judges and Attorney, Table 1; Appendix E, Social Services and Probation Officer, Table 1). Judges from Regions 3 and 5 and attorneys and guardians ad litem neither agreed nor disagreed (Appendix E, Judges and Attorney, Tables 1 & 3). Most of the remaining providers somewhat disagreed that other providers were aware of services of interest to the Evaluation (Appendix E, Referral Policies, Table 4).

Providers neither agreed nor disagreed that they are aware of nearby providers with the training needed to serve children and youth with mental health needs (Appendix E, Referral Policies, Table 4). Responses varied by provider type in that behavior analysts, psychiatrists, and residential mental health treatment facility social workers and residential mental health treatment facility direct care staff reported slightly higher levels of agreement (i.e., awareness) than other provider types. The main body of the report describes in greater detail the barriers and opportunities to expand awareness.

Provider awareness promotes service integration and has the potential to strengthen referral pathways across the children's mental health system. As a result, children and families should be able to access the level and type of services they need in their homes and communities, thereby reducing the reliance on residential mental health treatment facilities and hospitals. This includes decreased reliance on emergency medical services to provide mental and behavioral healthcare to children and youth who are

at-risk for placement in residential mental health treatment facilities. As reported in the main body of this report, the percentage of children and youth with a mental health diagnosis who accessed emergency services has changed in recent years, with decreased use observed after a peak in usage midway through 2021.

6.6 Reducing Reliance on 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:

The assessment findings for the Youth and caregiver-level of the Evaluation will be included in the July 2022 report.

7 Appendix B: Quantitative Data Collection Methods

7.1 Organization and Facility Survey Collection Methods

7.1.1 Overview

The Organization and Facility Survey collected data about all child serving organizations and facilities providing behavioral and mental health services in West Virginia (WV). The purpose of the Organization and Facility Survey was to identify the scope of service delivery, referral processes and pathways to community-based mental health services, and staffing challenges and successes for each organization or facility in WV that offers children's mental health services in WV.

Data was collected by web and phone between July 26, 2021, and December 30, 2021. Leaders of 86 behavioral and mental health organizations, agencies, and facilities across the state of WV responded to the survey. The survey was programmed and administered via West Virginia University's (WVU) HIPAA-compliant REDCap software. REDCap is a secure web application for building and managing online surveys and databases.

7.1.2 Organization and Facility Survey Sample

WVU OHA collaborated with WV DHHR to identify appropriate organizations and facilities for participation in the survey. The survey sample consisted of 151 combined organizations and facilities, with one of the organizations located outside of West Virginia that was excluded from the sample frame. Additionally, one organization had four facilities listed to contact, but after speaking with the facility administrator, it was determined that the four facilities shared resources and staff. For this reason, we considered these four facilities as one organization. After this review, the final Organization and Facility Survey sample consisted of 146 organizations and facilities that provide behavioral and mental health services to children, youth and young adults across WV. The organizations and facilities included in the survey were categorized into the following three provider systems: (1) residential mental health treatment facilities, (2) community-based mental health service providers and (3) hospital systems. The hospital systems sample was selected based on the availability of inpatient youth psychiatric services within the system.

Organization and facility administrators were identified through e-mail and telephone outreach with the leadership of the respective health system or reporting organization. The leadership of these health systems encompassed the roles of Chief Executive Officer, Executive Director, Director, President, and Vice President. Where possible, these leaders were identified through WV DHHR sources and when unavailable they were identified through an internet search of their associated webpage or making cold calls to the administrative office of the associated health system. Once leadership had been identified, they were contacted via e-mail introducing them to the evaluation and requesting the contact information of administrators at each of their facilities who would be most appropriate to complete the Organization and Facility Survey. When e-mail failed to produce a response, the organization leaders were contacted via telephone outreach.

Originally planned as a survey of organizations, it was determined that several of the BBH SOC grant recipient facilities within the organizations provide different services and a separate survey response for each of those facilities would be desirable. The SOC grant is funded to the WV DHHR BBH from the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand, align, and then

maintain a continuum of community-based services for children, youth, and young adults with serious mental illness and/or serious emotional disorders. The WV SOC grant program includes 12 programs that provide behavioral and mental health services to children, youth, and young adults who represent a large majority of the children in the evaluation who are at risk for placement in residential treatment facilities. Therefore, it was important to capture the BBH SOC programs in the Organization and Facility Survey.

For purposes of keeping communication materials and outreach strategies separate and consistent, facilities were labeled as either non-SOC (i.e. an organization providing children's mental and behavioral health services but not a BBH SOC grant recipient) or BBH SOC (i.e. an organization or facility providing children's mental and behavioral health services that were also a SOC grant recipient). Separate strategies had to be developed to accommodate for the circumstance that survey participation was a grant requirement for SOC organizations, as this survey data are being shared across both this evaluation and the BBH SOC grant program evaluation. However, some of the non-SOC and SOC organizations and facilities were not mutually exclusive. Some organizations operated facilities of interest that were a mix of non-SOC and SOC sponsored programs. In those cases, the communication and outreach to respondents followed the SOC protocols. The final sample consisted of both non-SOC facilities and SOC facilities. The unit of analysis varied across this and the SOC Evaluation due to slightly different definitions of a "facility," leading to slight variations in reported SOC samples sizes. For example, this evaluation used the exact number of organizations and facilities offering behavioral and mental health services as the unit of analysis, whereas many of the analyses for the SOC Evaluation are at the program level instead of facility level. Table 7-1 displays the number of organizations and facilities by SOC designation.

Contact information for the Organization and Facility Survey sample was robust, with all records containing a mailing address and nearly all also containing an email address and/or phone number.

Table 7--1: Number of Organizations and Facilities by SOC Designation

DESIGNATION	NUMBER OF ORGANIZATIONS		NUMBER OF FACILITIES	
Non-SOC*	68	61.3%	68	46.6%
SOC¥	43	38.7%	78	53.4%
SOC (standard)	33	76.7%	33	42.3%
SOC (custom)	10	23.3%	45	57.7%
Total Facilities	111	100.0%	146	100.0%
*Organization or facility providing children's mental and behavioral health services but not a BBH SOC grant recipient. ¥ WV BBH SOC grant recipient organization or facility.				

7.1.3 Organization and Facility Survey Content

The Organization and Facility Survey was developed by WVU OHA to specifically answer questions of this evaluation and the BBH SOC Evaluation using expert validity. This process relied on the expertise of WVU faculty subject matter experts in social services, psychology and psychiatry, as well as the expertise of the research consulting firm ICF. Survey drafts were then cognitively tested and reviewed by Abt Associates

for clarity of wording to ensure smooth administration. The survey instrument contained 75 items that captured services offered at that location, data use, staff/workforce demographics (including educational background, licensure, and tenure of staff), and information about referral processes. To ensure survey respondents met the inclusion criteria for the evaluation, the survey began with a screener question to confirm that the organizations and facilities offered at least one of the services of interest to the evaluation, the organization and facility was located in West Virginia, and that the organization or facility provided services to youth 21 years and younger. Following that process, participants were asked to indicate whether they received the BBH SOC SAMHSA grant, to help identify whether a provider was part of the BBH SOC sample. This designation triggered skip logic so that participants received program-specific items. Facilities that did not meet the criteria were determined to be ineligible for the survey. Additionally, any organization or facility for which 70% of questions were answered was considered a completed survey response

Communications for the Organization and Facility Survey differed by sample type (Non-SOC/SOC). SOC organizations were informed in their communications that participation was a requirement of SAMHSA's funded SOC grant. Additionally, facility administrators who managed multiple facilities received custom letters detailing the need to complete one survey for each facility.

7.1.4   Survey Administration

Field data collection for the Organization and Facility Survey was over a 13-week period. Participants received a survey invitation by both postal and electronic mail, three email reminders, and two postal mail reminders. The facilities identified for the sample were to receive two rounds of reminder phone calls; however, these were ongoing throughout the data collection period to allow for callbacks and several of the facilities received more than two call attempts. This was accomplished using computer assisted telephone interview. Table 7-2 details the organization and facility outreach schedule.

Table 7--2: Dates of Respondent Outreach in Organization and Facility Survey

TASK	SOFT LAUNCH	MAIN STUDY
Advance notification letter and email invitations	7/30/2021	8/16/2021
Reminder email #1	8/11/2021	9/2/2021
Phone Reminder #1	8/20/2021	9/24/2021
Reminder email #2	9/3/2021	9/17/2021
Reminder Letter #1	9/10/2021	10/1/2021
Reminder email #3	9/22/2021	10/20/2021
Phone reminder #2	Ongoing	Ongoing
Reminder email #4	10/20/2021	11/02/2021
Final email reminder (not part of original communication plan)	11/10/21	11/10/21

Non-responders to the Organization and Facility Surveys who had a telephone number in the sample file received at least one call from a telephone interviewer, reminding them to participate in the survey or, if preferred, to complete the survey on the phone.

7.1.5   Response Rates and Outreach Outcomes

The response rate represents the number of participants who received and accessed the survey compared to the number of people to whom the survey sent. There were 114 of 146 respondents who started the survey, for a response rate of 78%. Appendix C contains information about final analytic sample and methods to address potential nonresponse biases.

7.2   Provider Survey Collection Methods

7.2.1   Overview

The Provider Survey collected data about individual providers and professionals who serve a role in the coninuum children's mental health services in WV. These providers and profesionals included primary care health providers, mental health providers, social workers, and law enforcement officers, as well as other members of the legal and juvenile justice system. For ease of reference, all of the

Data were collected by web and phone between July 26, 2021, and December 30, 2021. There were 1,351 completed survey responses obtained from health service providers,persons involved in juvenile justice, and law enforcement. Surveys were programmed and administered via WVU's HIPAA-compliant REDCap software. REDCap is a secure web application for building and managing online surveys and databases.

7.2.2   Sample

The original Provider Survey sample included names of 7,313 doctors, nurses, counselors, social workers, probation officers, attorneys, judges, and other professionals involved with providing mental health services to youth. The sample includes professional roles across the system of children's mental health services. The Provider Survey sample was obtained in collaboration with WV DHHR.

In the final days of data collection, 19 additional providers were recruited via social media. Contact information for these providers contained only an email address, bringing the total records with an email to 2,585 providers and the total sample size to 7,332 providers (Table 7-3).

There was no sampling performed as this evaluation was conducted as a census. From the frame, 2,566 records (33%) included at least an email address as part of their contact information, 5,033 (69%) included a mailing address, and 5,927 (81%) included a phone number. There were also 11 records that had no contact information and were excluded from the study. Internet searches were conducted to locate a new phone number for any provider with a non-working or bad phone number. On October 29th, 2021, there were 540 such cases. Of these, new phone numbers were found for 397 providers (73.5%).

Law enforcement officers were a subset of the provider sample. However, as officers were recruited at the agency-level, this survey was treated separately from the remaining provider sample.

Table 7--3: Provider Type by Sample Group

PROVIDER TYPE	TOTAL SAMPLE	
Uncategorized Provider*	2,385	32.5%
Nurse Practitioner or Physician's Assistant	1,283	17.5%
Pediatrician or Primary Care Provider	2,494	34.0%
Counselor	225	3.1%
Psychiatrist	61	0.8%
Licensed Social Worker	258	3.5%
Registered Nurse or Licensed Practical Nurse	1	0.0%
Case Manager or Case Worker	42	0.6%
Probation Officer	315	4.3%
Attorney	195	2.7%
Judge	73	1.0%
Total	**7,332**	**100.0%**
*Uncategorized providers did not have a provider type classification associated with the contact information but were later classified via survey response.		

7.2.3 Characteristics of Sample Frame Provider vs Responding Sample

The sample frame consisted of 7,332 providers[4], of which 1,564 (21%) had missing or invalid contact information, such as an email bounce-back, undeliverable mailing address notification from the United States Postal Service, or non-working phone number call disposition. Law Enforcement Officers were not included in this analysis due to the lack of sample frame information. We saw that Pediatricians and Primary Care Providers comprised the largest provider type group in the sample frame (34%) but made up only 4% of survey respondents. Nurse Practitioners and Physician's Assistants were also under-represented in the responding sample (1%) compared to the sample frame (18%). In contrast, providers affiliated with WV DHHR made up only 12% of the sample frame population, but account for almost one-third (32%) of survey respondents.

The provider's location was unknown for the 19% of providers on the sample frame who did not have a mailing address available. Of the 1,396 providers known to be located outside of WV (mostly in Ohio and

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[4] Law Enforcement Officers were excluded from this analysis due to the lack of information on the sample frame. Firstly, the inability to confirm the number of officers per department across West Virginia. Additionally, the lack of confirmation of survey distribution to all law enforcement officers in the state.

Virginia), only 6 completed the survey. When we look at the survey data, we see that about 3% of providers reported serving counties outside of the state of WV. Taken together, it seems likely that providers located outside of WV are under-represented in the survey results.

7.2.4   Survey Content and Structure

This process relied on the expertise of WVU faculty subject matter experts as well as consultation with the research firm ICF. Drafts were then reviewed by Abt Associates for clarity of wording to ensure smooth administration.

The survey used a screening question to confirm the respondent had interacted with a youth who was experiencing a mental health crisis or had mental health difficulties in the last 12 months. Providers who responded "no" were screened-out as ineligible and no further questions were asked. The remainder of the survey contained over 250 items divided into modules that were specific to different provider types (as reported by the respondent). Respondents who refused to provide their provider type (n = 3) skipped directly to the demographics and were later classified as minimally completed because they did not receive any substantive questions. Table 7-4 shows the modules and which provider types were asked each module. Any provider who answered 70% or more of their question items was classified as a completed survey response, if fewer than 70% of survey items were answered, the provider was coded as a partially completed survey.

Submodules in the Provider Survey were asked of certain providers depending on services offered, such as HealthCheck, social services, PBS, ACT, residential mental health treatment, or wraparound services.

Demographic questions, such as age, gender, race/ethnicity, education, and WV service area (county) were collected of all respondents at the end of the questionnaire.

Table 7--4: Populations Surveyed in Each Module of the Provider Survey

MODULE NAME	POPULATION
Health Provider	▪ Behavioral Analysts ▪ Registered Nurses (RN) or Licensed Practical Nurses (LPN) ▪ Nurse Practitioners (NP) or Physician Assistant (PA) ▪ Pediatricians or Primary Care Physicians (MD or DO) ▪ Psychiatrists ▪ Psychologists ▪ Residential Direct Care Staff ▪ Residential Facility Workers
Judges	▪ Judges
Attorney, Guardian ad litem	▪ Attorney
Law Enforcement Officers	▪ Law Enforcement Officers
Social Services	▪ Case Manager or Case Workers ▪ Counselor ▪ Licensed Social Worker ▪ School Counselor

Probation Officer	▪ Probation Officers

7.2.5 Health Provider, Social Service Provider, Attorney and Probation Officer Contact Protocol

The Provider Survey was fielded for 14 weeks. Invitation letters were sent to any health provider, social service provider, attorney, and probation officer with a mailing address, and an invitation email was sent to any with an email address. Those with a postal and electronic mailing address received both invitations. Three reminder emails and two reminder letters were sent during the data collection period (Table 7-5).

Reminder phone calls were also made with an option to complete the interview via phone to those with a telephone number in the sample file. This was accomplished using computer assisted telephone interview. This software distributed calls across days of the week. Up to five 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, with the information to access each method. Requests for callbacks were honored and some respondents received multiple phone calls as a result. Non-responders with a telephone number in the sample file received at least one call from a telephone interviewer reminding them to participate in the survey or, if preferred, to complete the survey on the phone via a live computer assisted telephone interviewer.

Approximately halfway through the data collection period, 15% of the letters sent by mail were returned as undeliverable. With such a high number of returns, internet searches were performed on a test sample of 20 providers and new mailing addresses were found for 17 undeliverable (85%). With these promising results, the search was expanded to all 774 letters that were returned as undeliverable. With this approach, new addresses were obtained for 416 providers (53.8%) and new letters were mailed to these addresses. Similar to the locating efforts for the undeliverable postal mail, internet searchers were conducted to assist with phone number locating effort.

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

TASK	SOFT LAUNCH	MAIN STUDY
Advance notification letter and email invitations	7/26/2021	8/16/2021
Reminder Letter #1 and reminder email #1	8/11/2021	9/13/2021
Reminder Letter #2 and reminder email #2	9/2/2021	10/1/2021
Phone reminder #1	10/18/2021	10/18/2021
Reminder email #3	10/22/2021	11/2/2021
Final email reminder	11/10/21	11/10/21

7.2.6 Judge Contact Protocol

Seventy-three Judges were identified to be included in the survey. Judge outreach was directed to the Judge's Administrative staff via email with telephone follow-up. The survey was administered by WVU OHA staff via a one-on-one Zoom interview, with the interviewer reading the survey items and making selections for the Judge.

The Judge contact protocol was informed by advice from the Director of the Division of Children & Juvenile Services and Supreme Court of Appeals of WV.

7.2.7 Law Enforcement Office Contact Protocol

Outreach to law enforcement officers was conducted by a retired WV State Police Officer. Law enforcement agencies were contacted directly and asked to share the survey link with their officers. In lieu of an ID number, a question indicating department or agency was added to the beginning of the law enforcement survey instrument to help track completion rates by department/agency.

7.2.8 Response Rates and Outreach Outcomes

There were 1,063 survey responses collected from health providers, social service providers, attorneys, judges, and probation officers combined and 288 law enforcement officers.

7.2.9 Health Provider, Social Service Provider, Attorney, Judge and Probation Officer Outcomes

There were 1,450 of the 7,332 sampled providers who logged into and started the Provider Survey, which represents a 20% response rate. This excludes law enforcement officers, whose response rate is reported below. The final analytic sample is described in greater detail in Appendix C.

7.2.10 Law Enforcement Officer Survey Outcomes

According to the Bureau for Labor Statistics, there are 3,110 officers in West Virginia. A total of 468 law enforcement officers logged into the survey, for a response rate of 15%.

8 Appendix C: Quantitative Data Analytic Methods

8.1 Analytic Methods

This section describes the analytic approaches used for the Organization and Facility Survey, the Provider Survey, and the WV National Syndromic Surveillance Program (NSSP) data. Data from this Evaluation were primarily reported as frequencies (i.e., counts), valid percentages, and measures of central tendency such as means, medians, and ranges. When applicable, write-in responses were compiled, reviewed, summarized, and incorporated into the findings. Analyses were conducted with SAS[5] and R[6] data analytic software. Sections below describe how final samples were derived, and how certain stratification variables were constructed.

8.2 Organization and Facility Survey

The Organizations and Facility Survey was sent to the leaders and administrators of the census of organizations and facilities that provide the continuum of children's mental health services throughout West Virginia. This section describes the application of exclusion criteria that lead to the final sample included in analyses (i.e., the analytic sample).

Of the 146 leaders and administrators who received the Organization and Facility Survey, 114 logged into and started the web-based survey, for a response rate of 78%. After the Organization and Facility Survey closed for data collection, the data for service offerings and counties served were validated through brief telephone interviews of all respondents who completed a survey. Table 8-1 describes the number and percentage of participants who were screened out because they did not meet the inclusion criteria of:

1. Providing mental or behavioral health services to children or youth aged 21 years and younger (6 respondents excluded).

2. The organization or facility offers direct care services (1 respondent excluded with the survey screening question; 2 additional respondents were removed as a result of the data validation process).

3. The organization or facility offers services of interest to the evaluation (11 respondents excluded with the survey screening question; an additional 5 respondents were excluded as a result of the data validation process).

4. The organization or facility administrator responding to the survey completed at least 70% of survey questions (10 respondents excluded).

A total of 79 organizational leaders and administrators were included in the final analysis, representing a final completion rate of 54%.

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

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

Table 8--1: Organization and Facility Respondent Screening and Exclusion

Screening and Exclusion	Number and Percentage of Organizations and Facilities
Total Sample	146 (100%)
Total response rate	114 (78%)
Excluded by screen out questions:	
Does not offer services to individuals 21 years of age and younger	6 (4%)
Does not offer direct care services	1 (1%)
Does not offer the mental health services of interest to the evaluation	11 (8%)
Completed less than 70% of the survey	10 (7%)
Excluded during data validation process due to not offering direct care services	2 (1%)
Excluded during data validation process due to not offering services of interest to the evaluation	5 (3%)
Final organization and facility respondents	**79 (54%)**

A variable was created to categorize organizations and facilities into 6 regions. Regions were defined by the Department of Health and Human Resources (WV DHHR) Bureau for Behavioral Health (BBH). The description of West Virginia counties included in each BBH region can be found in Table 8-2.

Table 8--2: West Virginia Counties by Bureau for Behavioral Health Region

Region	Counties
Region 1	Hancock, Brooke, Ohio, Marshall, Wetzel
Region 2	Jefferson, Berkeley, Morgan, Hampshire, Mineral, Hardy, Grant, Pendleton
Region 3	Tyler, Ritchie, Calhoun, Roane, Jackson, Wirt, Wood, Pleasants
Region 4	Monongalia, Preston, Tucker, Randolph, Upshur, Lewis, Braxton, Gilmer, Doddridge, Harrison, Barbour, Taylor, Marion
Region 5	Mingo, Boone, Kanawha, Clay, Wayne, Lincoln, Putnam, Cabell, Mason, Logan
Region 6	McDowell, Wyoming, Raleigh, Fayette, Nicholas, Webster, Greenbrier, Monroe, Summers, Mercer, Pocahontas

The region variable was populated with the validated data reflecting service provision by county. In some cases, organizations and facilities provided services in multiple counties that spanned multiple regions.

For example, an organization might reside in Pendleton County (Region 2), but also provide services to Tucker County (Region 4). For analytic purposes the data from that organization would be reported for both Region 2 and Region 4; therefore, the region variable is not mutually exclusive but allowed for a clearer picture of what services are provided where and by which organizations and facilities.

There were several survey items that allowed respondents to select an "other" response. For example, one of the survey items asked respondents to select the category that best described their facility. Response options included a range of facility types such as community-based health centers, DHHR government agencies, school districts, private adoption agency, as well as "other." If "other" was selected, respondents were asked to write in an alternative response, qualitatively. Respondents selected "other" and wrote qualitative responses for 6 survey items. The qualitative analysis team reclassified the write-in responses so that the data could be included in quantitative analyses. In many cases the write-in responses fit within one of the response options already provided in the survey. Tables 8-3 through 8-8 include the raw data and reclassifications of the write-in responses.

Table 8-3 describes the reclassification of write-in responses to the survey item that asked respondents to select a category that best describes their facility.

Table 8--3: Reclassified "other" responses from survey item "What category best describes your facility?" included in Appendix D, Organization and Facility Tables, Background, Tables 2a & 2b.

Submitted response	Reclassification
Mobile crisis response and stabilization team office	Community mental health center
Licensed Behavior and Health Center (LBHC) (n = 3)	Community mental health center
Non-Profit	Other
Intellectual development disabilities waiver provider (n = 4)	Community mental health center
Private Child Placing Agency (Emergency Shelter Care, Foster Care, Adoption, Transitional Living) (n =2)	Private adoption agency
Youth Emergency Shelter and Private Non-Profit Community Based Services	Community mental health center
Day Program/Transitional Learning	Community mental health center
Community Rehabilitation Professional - Employment Specialists	Other
Home and Community-Based Services (HCBS) (n = 2)	Community mental health center
Both Residential Mental Health Treatment and Outpatient/in home Behavioral Health services	Residential mental health treatment facility

Respondents were asked to indicate their professional role within their facility. Response options included Administrator/Director, Clinical Supervisor/Chief Clinical Officer, and Program Coordinator. Reclassification of the write-in responses for those who selected "other" are described in Table 8-4.

Table 8--4: Reclassified "other" responses from survey item "What category best describes your professional role at your facility?" included in Appendix D, Organization and Facility Tables, Background, Table 3

Submitted response	Reclassification
School Counselor	Other
Social Worker	Other
Assistant Director of Operations/case manager supervisor	Administrator/Director
Director of Shelter Care Services - Admin Staff	Administrator/Director
Executive Director	Administrator/Director

Participants were asked to indicate the mental health service offerings at their facilities. Options included the use of HealthCheck and other screening and assessment tools that would be used by healthcare providers, as well as mental health services such as family therapy. The reclassification of the one write-in response is displayed in Table 8-5.

Table 8--5: Reclassified "other" responses from survey item "We would like to understand the type of services offered by your facility" included in Appendix D, Organization and Facility Tables, Background, Table 4

Submitted response	Reclassification
Prevocational, Day Program, and Transitional Learning	Supportive education

Respondents were asked to indicate the kinds of facilities from which they received referrals in the last 12 months. Response options included community-based health centers, juvenile justice facilities, and pediatric care centers. Table 8-6 describes how the write-in responses were reclassified for analytic purposes.

Table 8--6: Reclassified "other" responses from survey item "Please indicate the kinds of facilities from which you received referrals for mental and behavioral health services during the last 12 months", included in Appendix D, Organization and Facility Tables, Referrals, Table 2

Submitted response	Reclassification
Police departments (n = 2)	Community mental health center
Help4WV	Other
Parents/Caregivers (n = 2)	Other
WVDHHR	State
Department of Rehabilitation Services	State
Aetna for CSED	Other
Referrals come by DHHR however PR receives referral for youth at high risk, out-of-state youth, youth at risk for placement outside of the home, etc.	Other

Respondents were also asked about the kinds of facilities to which referrals were made. The write-ins for "other" responses were reclassified as described in Table 8-7.

Table 8--7: Reclassified "other" responses from survey item "Please indicate the kinds of facilities to which you made referrals for mental and behavioral health services during the last 12 months," included in Appendix D, Organization and Facility Tables, Referrals, Table 2

Submitted response	Reclassification
Food banks, restore	Community mental health center
Any referral is based on youth/family individualized needs	Other
Outpatient Services	Other

Respondents were asked to indicate the types of non-mental health organizations that their facilities coordinate with while providing mental health services. The write-in responses by those who selected "other" were reclassified as described in Table 8-8.

Table 8--8: Reclassified "other" responses from survey item "What non-mental health organizations does your facility typically coordinate with while providing mental health services for youth?," included in Appendix D, Organization and Facility Tables, Coordination, Table 3

Submitted response	Reclassification
Foster Care	Child Protective Services
Churches, DHHR youth services	Community-based youth services
Boy scouts, equine therapy, loc	Community-based youth services
PR partners with any community	Community-based youth services
CAC	Juvenile justice

Once the region variable was created and the qualitative write-in responses were reclassified, the data were analyzed, and the data tables were generated. Some of the Evaluation questions were best addressed using aggregate data by service across regions (e.g., Appendix D, Coordination, Table 1). Data were also stratified by BBH region, services offered, and/or counties served (e.g., Appendix D, Coordination, Table 2). Stratification allowed for more nuanced comparisons to be made, for example workforce capacity for ACT across regions (Appendix D, Workforce & Capacity, Table 1). Most of the data were described with frequencies, percentages, means, and in the case of waitlist times medians and interquartile ranges that were best suited for the distribution of responses. Medians are preferred over means when the data are skewed with outliers (e.g., some organizations and facilities had very short wait times and others very long wait times, making it difficult to interpret "mean" wait time). Interquartile ranges describe how spread out the data are by providing the range of values within which the middle 50% of data resides (i.e., that fall between the 25th and 75th percentile). The data tables include notes that contain information about denominators used for means and percentages, missingness, and other details that might assist with interpretation of the data.

8.3   Provider Survey

The Provider Survey was sent to 7,332 providers who represent the continuum of services in the children's mental health system in WV. This section describes the exclusion criteria that was used to derive the final analytic sample.

There were 1,450 providers who logged into and started the web-based survey, for a response rate of 20%. Table 8-9 describes the number and percentage of participants who were screened out because they did not meet the following inclusion criteria:

1. Interacted with a child or youth in mental health crisis or experiencing mental health difficulties in the last 12 months (189 respondents excluded).

2. The healthcare or mental health provider offers health screenings, assessments, or other mental health services (e.g., family therapy, supported education; 16 respondents excluded).

3. Completed at least 70% of survey questions.

4. Identified their professional role.

Table 8-9 excludes law enforcement officers, who are reported below in Table 8-10 below.

Table 8--9: Provider Survey Screening and Exclusion

Screening and Exclusion	Number and Percentage of Providers
Total sample	7,332 (100%)
Total response rate	1,450 (20%)
Excluded by screen out questions	
Did not interact with youth in mental health crisis or experiencing mental health difficulties in the past 12 months	189 (3%)
Does not offer health screenings, assessments, or other mental health services	16 (<1%)
Completed less than 70% of the survey	179 (2%)
Did not identify their professional role	2 (<1%)
Was moved to the law enforcement officer provider group	1 (<1%)
Final provider analytic sample	**1,063 (15%)**

The response rate for law enforcement officers was 15%. The inclusion criteria used for law enforcement officers was:

1. Interacted with a child or youth in mental health crisis or experiencing mental health difficulties in the last 12 months (138 respondents excluded).

2. Completed less than 70% of the survey (43 respondents excluded).

Table 8-10 describes the application of the inclusion criteria and the final law enforcement officer analytic sample of 288.

Table 8--10: Law Enforcement Officer Screening and Exclusion

Screening and Exclusion	Number of Law Enforcement Officers
Total sample	3,110 (100%)
Logged into survey	469 (15%)
Excluded by screen out questions	
Did not interact with youth in mental health crisis or experiencing mental health difficulties in the past 12 months	138 (4%)
Completed less than 70% of the survey	43 (1%)
Final law enforcement officer analytic sample	**288 (9%)**

The response rates varied by provider. Most other provider types met or exceeded response rates reported in studies with similar samples.[7] Judges and case managers or case workers had the highest completion rates at 41% and 38% respectively. The lowest response rates were among registered nurses (<1%) and medical doctors and doctors of osteopathic medicine (1.5%). The low response rates among health providers could be attributed to the survey being administered during the third surge of the COVID-19 pandemic.

A region variable was created for the Provider Survey using the BBH's county distribution grouped in 6 regions as described above in Table 8-2. Providers were asked to indicate the counties in which they provide services; responses to this question were then used to populate the region variable for analyses.

The Provider Survey included modules that were specifically designed for different provider types. The provider role that was self-selected by respondents was used to identify which providers received the different modules. Table 8-11 details the number of providers who received each module.

Table 8--11: Providers Receiving Provider Survey Modules

Module Name	Professional Role	Total Surveys Completed
Health Provider	- Behavioral Analysts - Registered Nurses (RN) or Licensed Practical Nurses (LPN) - Nurse Practitioners (NP) or Physician Assistant (PA) - Pediatricians or Primary Care Physicians (MD or DO) - Psychiatrists - Psychologists - Residential Direct Care Staff - Residential Facility Workers	90
Judges	Judges	30
Attorney, Guardian ad litem	Attorney	42
Law Enforcement Officers	Law Enforcement Officers	288
Social Services	- Case Manager or Case Workers - Counselor - Licensed Social Worker - School Counselor	826
Probation Officer	Probation Officers	75

There were several survey items that allowed participants to mark "other" and write in qualitative responses. The "other" category was used by respondents for 3 survey items. The qualitative analysis team reclassified the write-in responses so that the data could be included in quantitative analyses. The raw data and reclassifications for each survey item with reclassified "other" responses are included in

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[7] Baruch Y, Holtom BC. Survey response rate levels and trends in organizational research. Human relations. 2008 Aug;61(8):1139-60.

tables below. The first item with qualitative write-in responses asked about the type of organization or agency for which the provider works. These data are displayed across three tables for readability (Table 8-12).

Table 8--12: Reclassified "other" responses from survey item, "What category best describes the organization or agency where you are employed?," included in Appendix E, Provider table, Background, Table 2a & 2b

Submitted response	Reclassification
Acute psych hospital	Private or public hospital (including inpatient psychiatric unit)
Community practice (n = 3)	Community-based health center [including Federally Qualified Health Centers]
Emergency department	Private or public hospital (including inpatient psychiatric unit)
Juvenile Detention & Corrections (n = 5)	Juvenile justice agency
Primary care	Community-based health center [including Federally Qualified Health Centers]
Private Practice (n = 14)	Group private health practice
Rural Health Clinic	Community-based health center [including Federally Qualified Health Centers]
WVU Medicine - private group and academic training of physicians and other health professions strident/trainees	Community-based health center [including Federally Qualified Health Centers]

Table 8--13: Reclassified "other" responses from survey item, "What category best describes the organization or agency where you are employed?," included in Appendix E, Provider Tables, Background, Tables 2a & 2b, continued

Submitted response	Reclassification
Academic health center	Community-based health center [including Federally Qualified Health Centers]
Nonprofit/community based	Community-based health center [including Federally Qualified Health Centers]
ABA Therapy	Group private health practice
ASO/CSED provider	Community mental health center
Adolescent Health grant	Community mental health center
Behavioral Health/Foster Care Agency (n = 5)	Private adoption agency
Behavioral Health & Social Service Agency	Community mental health center
Community based wraparound (n = 2)	Community mental health center
Communities In Schools	Local school district
Community/Residential Human Resources Agency	Residential mental health treatment facility
DHHR	DHHR government agency, State
Homebase	Other
In Home Mental Health Counseling	Community mental health center
In home service provider	Community-based health center [including Federally Qualified Health Centers]
Independent Nonprofit	Community mental health center
JDRC, but I have worked at Group/home within the past 12 months.	Group home/Group residential facility
Mental and behavioral health provider also SNS (n = 2)	Community mental health center
Mobile Crisis	Other

Table 8--14: Reclassified "other" responses from survey item, "What category best describes the organization or agency where you are employed?," included in Appendix E, Provider table, Background, Table 2a & 2b, continued

Submitted response	Reclassification
School (n = 14)	Local school district
Self employed	Other
Social Services Agency, which provides Case Management for various programs, therapy, and also manages in-home care	Community mental health center
University Hospital	Private or public hospital (including inpatient psychiatric unit)
WVU CED PBS	Community mental health center
Solo counselor	Community mental health center
Applied Behavior Analysis	Counseling or therapy
Assistant Director	Counseling or therapy
Behavior Intervention Specialist	Counseling or therapy
Consultant/Training for special education	Education
Emergency medicine provider	General medical practice
I do both family medicine and psychiatry	Psychiatry
Psychology/Counseling/Addictions	Psychology
behavioral health	Education
geriatric psychiatry	Psychiatry
positive behavior support specialist	Counseling or therapy
Primarily residential, with 1 community program of which I am a part	Residential mental health treatment facility
Probation	Social service representation in law enforcement offices
Psychiatrist's office as a counselor	Group private health practice

Respondents were asked about the data sources they use when recommending residential treatment. Write-in responses were reclassified as described in Table 8-15.

Table 8--15: Reclassified "other" responses from survey item, "When making a decision regarding residential placement, which of the following sources of information do you use?," included in Appendix E, Provider table, Referral Policies, Table 1

Submitted response	Reclassification
Send to the emergency room to be evaluated	Mental health clinician
N/A at this time	Don't know/no experience with this process
Neighbors who are familiar with the family.	Families/Caregivers
Hospital inpatient info and clinic info	Mental health clinician

Respondents were also asked about barriers to maximizing referral networks for children or youth referred to residential treatment programs. The reclassification of write-ins is described in Table 8-16.

Table 8--16: Reclassified "other" responses from survey item, "Which of the following do you consider barriers to maximizing the potential efforts of your referral network for youth referred to residential treatment programs?," included in Appendix E, Provider table, Referrals, Table 5

Submitted response	Reclassification
N/A	N/A- we do not experience these barriers
HIPAA is a barrier to referrals and getting data	Lack of protocols and policies
Lack of DHHR staff	Lack of resources (funding, staff, materials, space)

Once the regional variable was created and the qualitative write-in responses were reclassified, the data were analyzed, and the data tables were generated. Provider data was included in each county or region that they offered services, meaning that when the data were stratified providers in Regions 2 and 4 were include in analyses for Region 2 and for the analyses in Region 4 in order to provide a clear picture of what services are being offered where and by whom.

8.4   National Syndromic Surveillance Program Data

The NSSP data were used to describe trends in emergency department (ED) utilization. The NSSP data were restricted to persons 21 years of age and younger who had an ED visit during the evaluation period (2019-2021). ICD-10 codes were used to identify mental health related ED visits. Subject matter experts helped identify the 42 ICD-10 codes used for these analyses (see Table 8-17).

Table 8--17: ICD Codes Used in the Evaluation

ICD-10 Codes	
F06 - Other mental disorders due to brain damage and dysfunction and to physical disease	F50 - Eating disorders
F20 - Schizophrenia	F54 - Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F21 - Schizotypal disorder	F60 - Specific personality disorders
F22 - Persistent delusional disorders	F63 - Habit and impulse disorders
F23 - Acute and transient psychotic disorders	F64 - Gender identity disorders
F24 - Induced delusional disorder	F65 - Disorders of sexual preference
F25 - Schizoaffective disorders	F70 - Mild mental retardation
F30 - Manic episode	F71 - Moderate mental retardation
F31 - Bipolar affective disorder	F72 - Severe mental retardation
F32 - Depressive episode	F73 - Profound mental retardation
F33 - Recurrent depressive disorder	F78 - Other mental retardation
F34 - Persistent mood [affective] disorders	F79 - Unspecified mental retardation
F38 - Other mood [affective] disorders	F81 - Specific developmental disorders of scholastic skills
F39 - Unspecified mood [affective] disorder	F84 - Pervasive developmental disorders
F40 - Phobic anxiety disorders	F90 - Hyperkinetic disorders
F41 - Other anxiety disorders	F91 - Conduct disorders
F42 - Obsessive-compulsive disorder	F92 - Mixed disorders of conduct and emotions
F43 - Reaction to severe stress, and adjustment disorders	F93 - Emotional disorders with onset specific to childhood
F44 - Dissociative [conversion] disorders	F94 - Disorders of social functioning with onset specific to childhood and adolescence
F45 - Somatoform disorders	F95 - Tic disorders
F48 - Other neurotic disorders	F98 - Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

The percentage of WV children and youth 21 years of age and younger with a documented mental health diagnosis who visited the ED for mental health services was calculated in 6-month intervals. These data were displayed in Figure 1 in the main body of the report. The volume and quality of the data included in the NSSP dataset might vary over time, especially given the COVID-19 pandemic and subsequent changes in health care-seeking behavioral that could not be accounted for in these data at this time. Thus, caution should be taken when comparing statistics during the surge of the pandemic to other periods of time.

8.5 Limitations

There are several limitations to the methods and analytics that are worth noting. Each limitation is described below, as well as measures taken to mitigate said limitations when possible.

The completion rate for the Provider Survey was low overall, but also varied by provider type. Additionally, variations in service perspectives could be influenced by provider type and region of service provision. Therefore, the survey data were often stratified by provider type and region, as can be seen in the data tables. Different providers have different training, take on different roles and responsibilities for providing care, and therefore will have different perspectives on the children's mental health system. Stratifying the data by provider role helps account for these expected differences. In a similar sense, region is related to the ways in which resources are distributed across the state, thereby affecting important indicators of interest such as capacity and availability of services. When possible, data were stratified by provider type and region to account for these underlying differences, account for variations in completion rates, and to facilitate comparisons.

The limitations of stratifying the data was that it sometimes resulted in only a few data points in a given category. For example, 8 Wraparound providers were captured in the Provider Survey. Trends in these survey responses are included in the report but must be interpreted with some caution. The small number of survey responses makes it difficult to generalize from a statistical standpoint. However, these data have the potential to be representative in that there are currently 14 Wraparound providers funded by BBH. The exact number of Children with Serious Emotional Disorder Waiver and Safe and Home agencies' Wraparound facilitators are still being determined but DHHR reports that funding streams overlap for many of these providers. The quantitative findings were also compared to qualitative data to gain greater insights into Wraparound providers' perspectives and experiences. The qualitative data were integrated into the quantitative findings to triangulate the data, meaning that multiple data sources and multiple data collection methods were used to enhance the validity and credibility of the findings.[8]

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 Provider Survey was sent to the census of providers across the children's mental health system, and the Organization and Facility Survey was sent to a census of leaders and administrators who represent all the organizations and facilities offering services included in the Evaluation. In fact, the response rates for the Organization and Facility Survey exceeded those typically observed in other studies of this size and nature. Rates for the Provider Survey varied by provider type.

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[8] Schoonenboom, J. Johson, B. *How to Construct a Mixed Methods Research Design.* Köln Z Soziol (2017).

Unfortunately, response rates were particularly low among health providers. One concern is that non-respondents might systematically differ from those who did respond. Capturing a diverse array of providers and organizations in the surveys and qualitatively validating the findings helps address this limitation and ensure good representation of stakeholders in the children's mental health system.

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, West Virginia University, 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 Provider Survey respondents to follow up and gain greater insights into their perspectives, thereby reducing the likelihood of recall bias by allowing comparisons of provider responses across data collection methods. By using multiple methods and triangulating the data, and stratifying by provider type and region, 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.

Finally, data were collected and included for TFC, although the service is no longer being included as part of the evaluation, due to the conflation of the tiers of offered services. The STAT Home Model has been selected and is expected to be implemented in fall 2022.

9 Appendix D: Organization and Facility Table Index

Organization and Facility Survey data tables display detailed survey results. These tables are included as a separate attachment in an Excel document with the file name: W*VUevaluation_OrgFacSurvey_DataTables*. The Organization and Facility Survey data tables are grouped into 5 tabs in the Excel document, which are described in the index below.

9.1 Background Tab

Table 1: Organization and facility administrator responses to frequency of evaluation service offerings statewide and by BBH region.

Table 2: Types of organizations & facilities responding to survey by evaluation service.

Table 3: Survey respondents' professional role in organizations & facilities responding to survey by evaluation service.

Table 4: Service offerings by evaluation service and BBH region.

9.2 Supervision Staffing Tab

Table 1: Joint supervision and staffing by evaluation service and BBH region.

9.3 Workforce & Capacity Tab

Table 1: Capacity of staff to serve youth with needs by service.

Table 2: Organization and facility barriers to staff recruitment and capacity to serve all youth referred by evaluation service.

Table 3: Organization and facility staff capabilities, skillsets, or credentials that are hard to retain or fill by evaluation service.

9.4 Referrals Tab

Table 1: Evaluation services offered by organizations and facilities by WV county.

Table 2: Organization and facilities making and receiving referrals by evaluation service type.

Table 3: Evaluation services making and receiving referrals by organization type.

9.5 Coordination Tab

Table 1: Frequency of organizations and facilities with waitlists for new clients to receive services by evaluation service.

Table 2: Organization and facility waitlist for new clients to receive services by services and BBH region.

Table 3: Organization and facility coordination by evaluation service, statewide.

Table 4: Organization and facility coordination by evaluation service by region.

10 Appendix E: Provider Survey Table Index

Provider Survey data tables have been created by WVU OHA to display the survey results. These tables have been included as a separate, standalone attachment, in an Excel document with the file name: *WVUevaluation_ProviderSurvey_DataTables*. The Provider Survey data tables are grouped into 13 tabs in the Excel document. The tables included in each specific Excel tab are described in the index below.

10.1 Module Tab

Table 1: Summary of survey responses by provider type and survey module.

10.2 Background Tab

Table 1: Demographic profile of providers surveyed by provider type.

Table 2a: Organization or facility type employing providers by region.

Table 2b: Organization and facility type employing providers by professional role.

Table 3: Health provider years practicing in West Virginia and in current role by provider type.

Table 4: Health Provider Module respondents by provider type and services offered.

Table 5: Total number of providers for screening services, by their professional role.

10.3 Services & Programs Tab

Table 1: Screening services offered by provider types, statewide.

Table 2: Evaluation service offerings by provider type, statewide.

Table 3: Provider service offerings by evaluation service and provider type, regionally.

Table 4: Provider awareness, resource sufficiency and belief of service benefit by provider type.

10.4 Skillset & Training Tab

Table 1: Provider service delivery competency assessment, training history and training needs by provider type.

Table 2: Health provider beliefs on training and service delivery by provider type, statewide.

Table 3: Level of agreement on PBS training quality and sufficiency by health provider type and region.

10.5 Capacity & Resources Tab

Table 1: Service provision and capacity by provider type, statewide.

Table 2: Service provision and capacity by provider type and BBH region.

Table 3: Health providers' weekly caseload and hours worked by provider type and BBH region.

10.6 Plans Tab

Table 1: Health providers' current career plans by provider type, statewide.

Table 2: Health providers' current career plans by provider type and region.

10.7 Referrals Tab

Table 1: Health providers frequency of making or receiving referrals to evaluation services by provider type, region, and length of practice.

Table 2: Health provider referral frequency to Children's Mobile Crisis Response.

Table 3: Follow-up frequency after initial referral has been made to a residential treatment program.

Table 4: Health provider sources of information for making decisions regarding residential replacement by provider type and region.

Table 5: Barriers to maximizing referral network to residential treatment programs.

Table 6: Experience of making referrals as a result of health check.

10.8 Referral Policies Tab

Table 1: Health provider awareness and efficacy of WV DHHR policies by provider type and demographics, statewide summary.

Table 2: Health provider awareness and efficacy of WV DHHR policies by provider type and demographics per BBH region.

Table 3: Health provider reported frequency of their organization's referral processes and policies by provider type and region.

Table 4: Health provider collaboration, communication, and awareness of other service providers and organizations by provider type and region.

Table 5: Health provider methods follow-up after a referral has been made to a community-based program by provider type and region.

Table 6: Health provider level of agreement on referrals made to residential treatment programs by provider type, region and length of service.

Table 7: Frequency of follow-up after referral.

10.9 Out-of-Home Placements Tab

Table 1: Health provider reported contributors to youth being sent to out-of-home placement by provider type and region.

Table 2: Health provider reported "other" reasons for placing a youth out-of-home for care by provider type.

Table 3: Health provider management and involvement with family/caregivers during service delivery by provider type and region.

Table 4: Residential mental health treatment provider coordination with community-based services by provider type and region.

10.10 Wraparound & ACT Tab

Table 1: Health provider knowledge and skills related to the National Wraparound Initiative model by provider type and region.

Table 2: Health provider knowledge and skills related to Assertive Community Treatment by provider type and region.

10.11 Judges & Attorney Guardian Tab

Table 1: Judges' level of agreement on interacting with youth needing mental health services by region.

Table 2: Judges' required participation in evaluation services via case disposition by region.

Table 3: Attorney agreement about children's mental health processes and protocols in WV by region.

10.12 Law Enforcement Tab

Table 1: Law enforcement officers' preparedness to work with youth in mental health crisis by region.

Table 2: Law enforcement officers' awareness of Children's Mobile Crisis Response by region.

Table 3: Law enforcement officer training needs by jurisdiction and region.

10.13 Social Services & Probation Tab

Table 1: Social service workers and probation officers' level of agreement for working with youth mental health needs.

Table 2: Social service worker and probation officer service awareness, service referrals, and capacity of follow up by provider type and region.

11 Appendix F: Qualitative Data Collection Methods

11.1 Overview of Qualitative Data Collection Methods

WVU OHA used focus groups and semi-structured interviews to collect qualitative data at the system and community/provider levels. Focus groups are useful for obtaining a wide range of perspectives from participants, while 1:1 interviews allow for an in-depth exploration of an individual's unique experiences.

Table 11--1 Qualitative Data Collection Methods and Participants by Data Source

Data Source	Data Collection Method	Participant Type	Baseline Data Collection	Number of Focus Groups/ Interviews
System-Level				
System-Level Focus Groups	Focus Groups	▪ School administrators and leadership ▪ WV DHHR local county level staff ▪ CPS staff ▪ Juvenile Justice administrative staff ▪ Sheriffs	Summer 2021	12
Community-Level				

Provider Focus Groups	Focus Groups	▪ Regional focus groups:
		  ▪ Attorneys
		  ▪ General medical providers
		  ▪ Law enforcement officers (Interviews)
		  ▪ Mental health service providers
		  ▪ Social service providers
		  ▪ Probation officers
		▪ Statewide focus groups:
		  ▪ Children's Mobile Crisis Response and Crisis Hotline staff
		  ▪ Residential mental health treatment facility staff
		  ▪ Wraparound facilitators
			Winter 2021	27

Organization Interviews	Interviews	▪ Residential mental health treatment facility leadership ▪ Community-based mental health organization leadership	Fall 2021	14
Judge Interviews	Interviews	▪ Judges who rule on juvenile cases in West Virginia	Summer 2021	32

WVU OHA collected data from four sources: 1) system-level focus groups, 2) provider focus groups, 3) organizational key informant interviews, and 4) judge interviews (see Table 11-1). Separate interview guides[9] were developed for each data source based on the corresponding evaluation questions identified in the WV Children's In-Home and Community-Based Services Improvement Project Evaluation Plan (April 8, 2021). Semi-structured interview guides were drafted by the Principal Investigators and included four to six core questions with probes. Feedback was solicited and incorporated from WVU Subject Matter Experts. 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 and focus group facilitation. Data collection began in June 2021 and ended in February 2022. WVU OHA used purposive sampling throughout to identify participants that are particularly knowledgeable about the phenomenon of interest.[10] Recruitment strategies included direct outreach to participants and survey recruitment. Specifically, at the end of the provider survey, respondents were asked to indicate their interest in participating in a follow up focus group. All interviews and focus groups 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. Informed consent was obtained by presenting each participant with information about the Evaluation, including the main objectives, data collection procedures, risks and benefits, voluntary participation, and confidentiality at the beginning of each session. All sessions were recorded using Zoom with participants' consent to be recorded. To show appreciation for their participation, participants in the focus groups and interviews received a thank you note and were offered a $25 Visa gift card. Judges received a thank you note, but did not receive the $25 gift card incentive offer.

In total, the WVU OHA team conducted 27 focus groups with providers (this includes three 1:1 interviews with law enforcement officers), 14 key informant organizational interviews, 32 judge interviews, and 12 system-level focus groups with WV DHHR and partner agency staff.

11.2 System-Level: WV DHHR and Partner Agency Focus Groups

System-level focus groups with WV DHHR and partner agency staff were conducted to obtain a rich understanding of the collaborative processes, policies, and relationships among various child-serving systems (i.e., human services, education, law enforcement, and/or juvenile justice). Focus group questions focused on WV DHHR and partner agencies' intersections with other behavioral health systems, including 1) current communication and coordination, 2) alignment of standards and data sharing, 3) awareness of available services, 4) barriers to effective coordination (as well as steps to overcome barriers), and 5) philosophies toward community-based models of care. In Year 1 of the Evaluation, data collection centered on current collaborative processes between systems. Follow-up focus groups conducted in Year 3 will include questions to assess system-level changes over time within the state.

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[9] See Phase 2a, Deliverable 4 Focus Group Guides (June 30, 2021), Deliverable 2 Provider Focus Group Guides (June 30, 2021), and Deliverable 3 Organization Key Informant Interview Guide (Sept 28, 2021) for focus group and interview guides.

[10] Creswell J, Plano Clark V. Designing and Conducting Mixed Methods Research. Thousand Oaks, CA, 2017

A maximum-variation sampling strategy was used to purposefully select counties identified by their rate of children placed into residential mental health treatment facilities in the prior year. Counties chosen had the highest and lowest rate of children placed in residential mental health treatment facilities per BBH region. Invitations were sent out to potential participants via email. Participants were offered up to three dates and times to participate in a focus group; the date and time preferred by the most participants were selected, and the focus group was scheduled. Twelve system-level focus groups were conducted (two per BBH region). Participants included school staff, principals and superintendents, WV DHHR Community Services Managers, CPS supervisors, juvenile justice facility administrators, and sheriffs (see Table 11-2). The length of each focus group ranged from 45 to 60 minutes.

Table 11--2: WV DHHR and Partner Agency (System-Level) Focus Group Participants by BBH Region

BBH Region	Participant Type	Number of Focus Groups	Number of Participants per Focus Group
1	▪ CPS Supervisor ▪ Youth Service Supervisor ▪ Superintendent of Schools ▪ Special Education Director	2	2,2
2	▪ School Board Service Option Specialist ▪ WV DHHR Community Service Manager ▪ Assistant Prosecuting Attorney ▪ Case Manager Youth Reporting Center	2	1,5
3	▪ WV DHHR Community Services Manager ▪ Assistant Prosecutor ▪ Director of Special Programs ▪ Social Service Attendant and Child Nutrition Director ▪ Sheriff ▪ Special Education Director and Attendance Director ▪ Student Success Coach	2	1,5
4	▪ Special Education Coordinator ▪ WV DHHR Community Service Manager ▪ Assistant Prosecuting Attorney ▪ WV DHHR Social Services/Youth Supervisor ▪ Assistant Principal ▪ Captain with Sheriff's Department ▪ Chief Probation Officer	2	1,6
5	▪ Middle School Principal ▪ CPS and Youth Service Supervisor ▪ Youth Reporting Center Case Manager	2	1,2
6	▪ WV DHHR Community Service Manager ▪ Community Resource Coordinator Juvenile Services ▪ Youth Reporting Center Director ▪ CPS Supervisor ▪ High School Principal ▪ Sheriff ▪ Superintendent ▪ Director of Attendance ▪ Truancy Diversion Specialist	2	2,8
TOTAL		12	36

11.3 Community/Provider Level: Focus Groups with Providers

Focus groups with health providers and other professionals that support or interact with the continuum of children's mental health care in WV were conducted to further explore key issues identified in the survey administered to the providers and professionals, and to gain a greater understanding of providers' experiences and perspectives that might vary by region. Focus group questions were tailored for each provider or professional type but focused primarily on perspectives of statewide implementation of the Initiative, mechanisms for improving workforce capacity, and determinants of service delivery, referrals, and collaboration.

Of the 24 focus groups conducted between December 2021 and Jan 2022, 21 were carried out with providers or professionals at the regional level and three included providers or professionals delivering services throughout the state (i.e., statewide). Regional focus groups included seven types of providers or professionals: attorneys, general medical providers, law enforcement officers, mental health service providers, social service providers, probation officers, and wraparound facilitators. Participants were recruited from the Provider Survey; at the end of the survey respondents were asked about their willingness to participate in a follow-up focus group to share their perspectives. Individuals who expressed interest in participating received an email invitation and were asked to select their preferred focus group time. Participants were grouped based on BBH region. Due to challenges with the recruitment of law enforcement officers for focus groups, a decision was made to utilize individual interviews instead of focus groups. WVU OHA worked to identify and conduct direct outreach to officers in specific BBH regions and invite them to participate in an interview. Similarly, WVU OHA conducted interviews with court judges, instead of focus groups. Statewide focus groups included two types of providers: 1) Children's Mobile Crisis Response and Crisis Hotline staff and 2) residential mental health treatment facility administrators. Crisis Hotline staff and Children's Mobile Crisis Response were paired together in the same focus group because the Crisis Hotline is a referral source for mobile crisis teams. WVU OHA contacted the organizations contracted to provide Children's Mobile Crisis Response and Crisis Hotline to recruit appropriate participants to invite. A list of active residential mental health treatment facility administrators was obtained from WV DHHR and used to recruit the administrators. Table 11-3 includes the breakdown of regional and statewide focus groups and interviews by participant/provider type. All participants were invited to participate via email. Focus groups ranged from 45 to 60 minutes.

Table 11--3: Regional and Statewide Provider-Level Qualitative Data Collection

Data Collections Type	Participant Type	Number of Focus Groups/ Interviews	Number of Participants per Focus Group/ Interview	Total Participants
Focus Groups				
Statewide	Children's Mobile Crisis Response and Children's Crisis and Referral Line Staff	1	11	11
Statewide	Residential mental health treatment facility Staff	1	11	11
Statewide	Wraparound Facilitators	1	3	3
Regional	Attorneys	2	1, 1	2
Regional	General Medical Providers	1	2	2
Regional	Mental Health Service Providers	2	1, 1	2
Regional	Social Service Providers	13	1 - 7*	32
Regional	Probation Officers	3	1, 1, 2	4
Focus Group Totals		24		67
Interviews				
Regional	Law Enforcement Officers	3	1, 1, 1	3
Statewide	Court Judges	32	1	32
Interview Totals		35		35
Overall Total		59		102
*A total of 32 Social Service Providers participated in the 13 focus groups, with a range of 1- 7 participants per group. *Some focus groups only had 1 participant in attendance. For these, the data collection process functioned like a 1:1 interview, but they are categorized as focus groups as they were originally intended to include multiple participants.				

11.4 Community/Provider Level: Organizational Interviews

Interviews were conducted with administrators holding leadership positions in residential mental health treatment facilities and community-based behavioral organizations to identify specific barriers to organizational capacity-building and alignment with statewide changes related to improvements in workforce capacity. The interview questions focused on workforce successes and challenges, service

delivery, collaborations and referral processes with community-mental health services, and the impacts of COVID-19 on service delivery. Each individual interview guide was tailored using the participants' or agency's responses gathered from the Organization and Facility Survey. In Year 1 of the Evaluation, interviews focused on examining current organizational capacity. Follow-up interviews to be conducted in Year 3 of the Evaluation will include questions to assess changes in workforce capacity and service delivery over time.

A preliminary analysis of the Organization and Facility Survey data informed the purposive sampling of interview participants. Data from organizations in the same BBH defined region were compared based on number of community-based services offered, number of referral types received and made, and workforce capacity. Selections were made to achieve representation in organizational characteristics including organization size, geographic location, and services offered. Participants were recruited by phone with email follow up. In total, 14 leaders from residential mental health treatment facilities and community-based organizations participated in the Organizational Interviews (see Table 11-4). Each of the six BBH regions were represented by at least two participants. Interviews ranged from 40 to 60 minutes.

Table 11--4: Services Offered by Organizations Represented in Interviews by Region

Region	Services Offered by Organizations Sampled	Number of Interviews
1	- PBS - Wraparound - Residential mental health treatment facilities	2
2	- Children's Mobile Crisis Response - PBS - Wraparound - Children with Serious Emotional Disorder Waiver	2
3	- PBS - Wraparound - Children with Serious Emotional Disorder Waiver	2
4	- Children's Mobile Crisis Response - Wraparound - Children with Serious Emotional Disorder Waiver - Residential mental health treatment facilities	2
5	- Wraparound - Children with Serious Emotional Disorder Waiver - Residential mental health treatment facilities	3
6	- ACT - Children's Mobile Crisis Response - PBS - Wraparound - Children with Serious Emotional Disorder Waiver	3
TOTAL		14

11.5 Community/Provider Level: Judge Interviews

Judges who handle juvenile cases in West Virginia participated in a 1:1 interview, answering structured, multiple-choice survey questions in addition to four open-ended questions. The open-ended qualitative questions focused on the judges' experiences placing children in residential treatment facilities and their opinions on community-based programs as an alternative.

WVU OHA confirmed the list of judges who take juvenile cases with the director of the Division of Children & Juvenile Services, Supreme Court of Appeals of West Virginia. Next, they reached out to judge assistants via phone and email to recruit judges and schedule each interview. A total of 32 judges participated in the interviews. Two judges interviewed did not complete the Provider Survey. Each interview lasted between 30 and 40 minutes.

12 Appendix G: Qualitative Data Analytic Methods

12.1 Analytic Methods

Audio recordings from interviews and focus groups were downloaded from Zoom and sent to Rev.com, a speech-to-text transcription service, for transcribing. Each transcript was reviewed and compared with the original audio recording to ensure accuracy. Identifying information (i.e. participants' full names) was removed to ensure confidentiality. Transcripts were grouped based on region and data source for analysis.

The WVU OHA team used conventional content analysis to analyze all interview and focus group data. Content analysis involves a subjective interpretation of the content of text data through a systematic classification process of coding and then identifying themes and patterns.[11] ATLAS.ti qualitative data analysis software was used to facilitate all aspects of data management, classification, coding, and synthesis. In the first coding round, two independent coders read each transcript and sorted data into a set of pre-determined codes based on the evaluation questions and interview guides. After in-depth debriefing and discussion, coders collaboratively developed and agreed upon a final hierarchical coding structure. In the second coding round, coders independently re-coded each transcript using the revised categories and subcodes. Data reports (i.e., quotes) contained with each code were run by BBH region. The WVU OHA team synthesized and interpreted the findings by examining each code, cleaning and synthesizing quotes to transfer to a data analysis template. Coders populated the templates with representative quotes and accompanying narrative descriptions for each code by BBH region. Data from each source and region were combined and synthesized to develop BBH regional profiles. Qualitative data from each template and regional profile (e.g., categories, themes, quotes, and code descriptions) were integrated with quantitative data where appropriate. 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[12] (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 the phenomenon of interest has been obtained. Data credibility was ensured via rigorous training for each staff member involved in data collection and analysis. Further, a variety of techniques, such as data triangulation, reflective memoing and debriefing, and review of all interview guides by Subject Matter Experts promotes 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 has 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

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

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

intercoder agreement and reliability. In addition, an audit trail was established to document the changes made during evaluation, lessons learned, and limitations.

12.2 Limitations

There are several limitations related to the qualitative findings in this report. While the overall sample size was robust, especially for a qualitative study, some populations of interest were underrepresented in the data (i.e., law enforcement officers, attorneys, and medical professionals). The WVU OHA team experienced difficulties recruiting these groups for focus groups and interviews. Recruitment challenges occurred due to COVID-19 impacting participant availability and competing job responsibilities. Specifically, providers, judges, and key informants have work schedules that were not always conducive to scheduling interviews and focus groups far in advance and during traditional work hours. An original goal was to obtain a census of judges for surveys and interviews (n=73), but only 32 judges participated. Finding times to meet the needs of professionals for scheduling system-level focus groups was also challenging. Additionally, some potential participants worked from home and were not readily available in their offices. This created challenges with contacting and recruiting, because oftentimes voicemail capabilities were not set up on work telephones. Further, some potential participants experienced issues with unstable or unreliable computer or cellphone equipment and internet access, limiting their recruitment and participation. Provider focus groups were scheduled around the Thanksgiving holiday in November, which may have impacted participation. When trying to recruit law enforcement officials, many officers the WVU OHA team attempted to contact were sick with COVID-19 or had passed away from the virus. Finally, because participants for key informant interviews and provider focus groups were sampled from survey responses, results of the quantitative data collection efforts had the potential to impact qualitative recruitment. For example, the inclusion of certain groups was predicated on their delivery of certain services. In some instances, participants revealed during interviews and focus groups that those services were not offered. While this helped lend credibility and validity to the quantitative data in this report, those participants may not have been the best source of information on those programs.

Many participants sometimes did not show up for interviews and focus groups that they were scheduled to attend. Although confidentiality was assured, some participants expressed concerns about openly sharing their perspectives and some opted not to have their interviews recorded. In the future, some participants may feel more comfortable attending individual interviews versus focus groups. Across this large-scale evaluation, there were multiple facilitators/moderators. Their varying knowledge and skill levels related to both facilitation and topics discussed may have impacted the quality and quantity of data collected.

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 debriefing sessions between coders across all analysis teams were carried out to 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 data analysis templates to record key findings. Data analysis templates can provide structure and consistency across large coding teams, but can also create restrictions on how the data are analyzed. Care needs to be taken to ensure that important pieces of data do not become de-contextualized with software and template use, leading researchers to miss the essence of meanings in data.

While data were saturated for key findings across evaluation questions, some BBH regions had more participant representation than others. Therefore, caution is advised when making comparisons across regions using qualitative data alone, as experiences and perspectives in this report might not represent a holistic picture of what is happening within a given region. Thus, the viewpoints included should not be taken to be generalizable or representative across regions or WV. However, the mixed methods approach of this evaluation provides the ability to triangulate these findings to the quantitative data to provide more depth and reliability for the qualitative findings.

13 Appendix H: Qualitative Findings

13.1 Regional Profiles Overview

Profiles for BBH Regions 1 – 6 were created using data collected from interviews and focus groups. Each profile describes findings related to workforce capacity and staffing, collaboration between agencies and referral systems, specific community-based services of interest to the evaluation that are offered, and barriers and facilitators to providing mental and/or behavioral health services for youth. It should be noted that some participants represented multiple regions.

13.2 Region 1 Profile

In Region 1, two organizational leaders participated in organizational and facility key informant interviews and five service providers participated in provider focus groups. Four WV DHHR and partner agency staff participated in system-level focus groups, and one judge participated in an interview.

Region 1 has experienced successes and barriers to delivering services for youth with mental and behavioral health needs. Primarily, there is a need for more staff to deliver mental health services. The pandemic has increased recruitment difficulties and further magnified the low-wage problem in the mental health profession in WV. Staffing challenges have contributed to a cycle where the lack of services, especially shelter beds, pulls staff away from daily service provision to supervise children in transition, in turn creating burnout and exacerbating capacity issues. As an example, two mental health service supervisors in the region reported taking 12-hour shifts staying in hotels with up to five youth on separate occasions in 2021. These types of situations cause staff to get behind on work and experience burnout, and they eventually leave the workforce. A second barrier to delivering services for youth with mental and/or behavioral health needs is the age of employees. The current average age of direct care employees is early 20s. Consequently, these employees require more vigilance and training to provide adequate care to children with mental and behavioral health needs. Finally, licensing requirements for mental health professionals create a barrier to staff recruitment. Specifically, the requirements prevent applicants who grew up in the system (e.g., had CPS reports, drug offenses, etc.) from some employment opportunities in the mental health profession. Organizations used strategies like wage adjustment, applying for extra funding and grants, and contract employment to attract and retain employees. However, even with these strategies, facility administrators report not being able to compete with new businesses such as Lowe's, The Home Depot, Inc., and fast-food restaurants re-opening in the area.

Organizations in Region 1 offer a variety of mental health services and resources, including education pathways, work skill development, and mentoring. Community outreach, good relationships with other service providers, and streamlined collaborative processes contribute to successful collaboration with other community-based mental health providers and, in turn, increase the likelihood of program success. However, high staff turnover within and across service organizations has decreased the consistency of programming and contributed to long wait times for services. Agencies' different procedures and system-level priorities sometimes complicate the referral process, and the COVID-19 pandemic has exacerbated service delivery barriers, including referrals. A few providers have acknowledged a shift in the prioritization of service delivery from residential to community-based treatment.

Participants from Region 1 reported that Children's Mobile Crisis Response is responsive to families' needs and can help parents deescalate youth metal health crisis situations and provide them with short-term support and access to resources in the community. However, it was noted that Children's Mobile Crisis Response lacks enough staff for the program to function as planned.

Several providers in Region 1 report Children with Serious Emotional Disorder Waiver Wraparound and WV Children's Mental Health Wraparound services are helpful, and they would like to see them expanded to more youth in need. Providers mentioned that they collaborate with counselors at the Youth Service Center and Alternative Learning Center for Wraparound services. Some participants in interviews and focus groups had not heard of or used PBS, which could be a barrier to referrals. Others shared positive collaborative experiences and strong engagement with PBS program providers. However, even those participants that had interacted with PBS noted they sometimes do not get a response when they contact organizations offering PBS.

The closure of a short-term stabilization unit in Wheeling has created major challenges for linking youth with residential treatment in Region 1, as there is nothing closer than Morgantown and many parents are not able or willing to travel. The lack of short-term services and psychiatrists for youth with severe behavioral issues who need residential treatment is a barrier for residential mental health treatment facility programs. Additionally, some facilities are specialized and may restrict access to youth with certain types of mental or behavioral issues, resulting in some children being unable to access treatment. For example, facilities that serve autistic youth may not accept youth with violent tendencies. In turn, facilities that accept youth with a history of violence may not be equipped with the resources to also support autistic youth, and thus they will not be accepted at certain facilities. A judge from Region 1 noted services for families that are currently lacking, such as family therapy, parenting classes, or therapy for parents, would be most impactful for youth. This judge identified issues with understaffing at the DHHR and described how that can influence the accessibility of services for youth and their families. He gave the example of not having enough staff to allow for regular visitation for abuse and neglect cases.

13.3 Region 2 Profile

In Region 2, two organizational leaders participated in organizational and facility key informant interviews and five service providers participated in provider focus groups. Also, six DHHR and partner agency staff participated in system-level focus groups, and five judges participated in interviews.

Staffing issues complicate the delivery of mental and behavioral health services for youth in Region 2. The challenging nature of youth mental health work and low salary contribute to hiring difficulties. A key informant shared that their organization can only employ part-time mental health professionals. Efforts such as sign-on bonuses have been utilized to hire additional nursing staff. Positions with special credential requirements are especially difficult to fill. Professionals have opted to become licensed and practice in Virginia and Maryland due to complicated licensing procedures in West Virginia. As a result, staffing vacancies and high turnover in different agencies decrease the consistency of services and sometimes discourage family engagement in the treatment process. Specifically, participants discussed that families sometimes choose to discontinue seeking and participating in services because youth are continually retraumatized from constantly changing clinicians and case managers.

Region 2 offers several mental health services including Children's Mobile Crisis Response, school-based therapy, and comprehensive behavioral health service centers. However, all participants agreed that

there were major barriers to accessing these services, including long waitlists and a lack of services in their immediate community. There was a consensus among participants that child-serving systems prioritized serving children in their communities and their homes (if it was safe to do so) as opposed to treating them in residential facilities away from their support systems. Participants stressed the importance of having adequate resources to address big picture issues, such as community stigma surrounding mental health, de-escalation training among staff, and stabilization services for youth. Participants emphasized the importance of relationship building and communication with other organizations and agencies. Organizations in Region 2 work with juvenile drug courts, CPS, and local residential facilities and receive referrals from probation officers, school systems, and foster agencies. Organizations in Region 2 work with juvenile drug courts, CPS, and local residential facilities and receive referrals from probation officers, school systems, and foster agencies. However, organizations are not sharing information in a way that can accelerate the referral process. Participants report that the DHHR and CPS are not responsive to referrals. The pandemic has also affected staffing and thus many organizations' abilities to process referrals. Even though the Family Resource Network in this region provides information to the community, community members typically cannot receive services or need additional support (e.g., due to health literacy) to understand services.

Despite being registered and contracted with WV DHHR to provide Children's Mobile Crisis Response, services are unavailable in some areas of Region 2 due to the lack of licensed providers to supervise the team. Community engagement and community awareness promote Children's Mobile Crisis Response usage, but WV's rural geography poses challenges with service access. Providers in emergency departments often connect youth with mental and/or behavioral health issues to Children's Mobile Crisis Response or other care providers before discharge.

Region 2 only has one provider for Children with Serious Emotional Disorder Waiver Wraparound who is providing behavioral health wraparound services. They manage all the youth services cases, and they serve a large area. To be eligible for Wraparound services in Region 2, children cannot have any involvement with DHHR. Additionally, a provider shared that foster children involved with juvenile justice were ineligible for help or crisis intervention from either DHHR or foster agencies.

PBS in Region 2 falls under the supportive counseling offered by some organizations, so communication with counselors, therapists, and social workers occurs. A key informant would like PBS training to include de-escalation strategies for youth and noted a PBS training for parents has been developed. All schools in Pleasants County are Positive Behavior Interventions and Supports schools, meaning they participate in the Positive Behavior Intervention and Supports program and have received training and program offerings to PBS skills. Qualitative data reveal that PBS service training is of high quality, and many mental health professionals and staff throughout WV have received PBS training.

13.4 Region 3 Profile

In Region 3, two organizational leaders participated in organizational and facility key informant interviews. Six service providers participated in provider focus groups, while seven DHHR and partner agency staff participated in system-level focus groups, and five judges participated in interviews.

Participants in Region 3 describe a dedicated mental health workforce, despite experiencing major challenges to recruiting staff. They reported feeling fortunate to be as staffed as they are but note the rural and remote locations of Region 3 create significant barriers to hiring. More therapists, facilitators,

direct support workers, and youth care workers in shelters are needed. Judges note that workers are overworked, understaffed, and underpaid. Judges report that due to understaffing, they sometimes have trouble getting reports from DHHR workers promptly. However, a probation officer from Region 3 discussed having a highly active and successful MDT program in their county. The probation officer coordinates the MDT meetings for the judge and summarizes the findings during court proceedings.

Participants shared that their organizations have built collaborative relationships with various mental health organizations and agencies, but rural counties lack providers for collaboration. Strong relationships with other organizations and outreach to the community have supported referral pathways. Barriers in the referral pathway include a lack of services, lack of communication between organizations about what is available, and long wait times. Rurality was mentioned as associated with longer wait times in Region 3. Participants mentioned that most services have a wait time of "weeks or months." One key informant mentioned there is about a 45-day approval period for youth in acute care to receive a bed in a residential setting. Additional barriers in the referral pathway include difficulties collaborating with overburdened organizations and a need for additional training among CPS workers. In addition, a participant in the organizational key informant interview reports that many families are exhausted from working with DHHR, not being able to access information and services in a timely manner, and feeling burnout related to seeking help within their local communities

The organizations participating in interviews and focus groups in Region 3 offer Children with Serious Emotional Disorder Waiver Wraparound, West Virginia Children's Mental Health Wraparound, PBS, and limited Children's Mobile Crisis Response. Despite the impact of the pandemic, agencies continue to provide services, either through telehealth or safe, in-person meetings. Participants shared that while Children with Serious Emotional Disorder Waiver is a good program, in theory, it does not always deliver the services it promises. Issues include not enough agencies providing adequate services resulting in long approval times. There is only one agency providing case management and other agencies are responsible for in-home services. If the services that families are currently receiving do not qualify for the Children with Serious Emotional Disorder Waiver, they need to find new providers and start the therapeutic process all over again, and approval for the Children with Serious Emotional Disorder Waiver can take three to four months. Children with Serious Emotional Disorder Waiver requirements limit services and referrals as children in kinship care cannot also qualify for Wraparound. Additionally, since Children with Serious Emotional Disorder Waiver is a Medicaid-funded program, the funds for programming are limited.

Feedback about Wraparound services included a need to adequately prepare staff with de-escalation and intervention strategies. Representatives from Region 3 stated Wraparound referrals are made by word of mouth and thus lack of awareness about services limits referrals and the ability to reach youth in need.

In Region 3, PBS is a virtual program that is cited as useful for creating a roadmap and action plan for families. Participants believe it does successfully help kids stay out of residential treatment. Of note, in Region 3, PBS training includes de-escalation strategies for first responders and mobile crisis staff. Region 3 providers mentioned using PBS within the school systems. For Children's Mobile Crisis Response and Stabilization, a participant in the system-level focus group for Region 3 revealed that families and youth must have an open case to use the Children's Mobile Crisis Response and Stabilization units and that it was not a service offered to the general public or youth in crisis who are not already receiving services.

13.5 Region 4 Profile

In Region 4, two organizational leaders participated in organizational and facility key informant interviews and twelve service providers participated in provider focus groups. Additionally, seven DHHR and partner agency staff participated in system-level focus groups, and seven court judges participated in interviews.

Overall, participants in Region 4 agreed that their communities lacked the appropriate services to address the needs of children with severe emotional and behavioral problems (e.g., services for children with autism spectrum disorder, effective therapeutic foster homes, and acute inpatient treatment clinics). Service delivery was impeded by staffing and workforce capacity issues, family dynamics, the stigma of mental health treatment, and transportation/waitlist issues.

Regarding staffing, organizations have retained higher-level staff, but struggle to hire lower-level staff, leaving workers with a high caseload resulting in turnover and burnout, particularly among recent college graduates. Judges noted that DHHR workers are overworked and understaffed, which can foster a lack of trust among families and youth.

Family-level barriers impacting service delivery noted by key informants include strong stigma related to mental health and fear of CPS removing children from homes when seeking community-based services. Judges in Region 4 discussed sometimes sending children to residential treatment if they perceived youth would be unsafe in their homes or with certain family members. Parental mental and/or behavioral issues, as well as substance use, can sometimes contribute to an unwillingness to seek services for youth, especially in-home services. For those families who do seek services, participants reported having an open line of communication for referrals and were eager to help families find the appropriate services. However, wait times can limit this process, as it can take up to weeks or months to get proper services. Other barriers to accessing treatment include long waitlists and a dearth of local providers, which often require families to seek services outside of their county or state. Participants discussed that more in-home services could alleviate transportation and waitlist issues and that supportive services for parents are needed. Participants from one county in Region 4 reported having more resources (e.g., inpatient unit, outpatient clinics, juvenile drug court, school-based probation officers) than their neighboring counties, whereas participants from the rural county in this region reported limited programs and facilities. Participants in the rural areas reported challenges with transportation, internet connectivity issues making telehealth access difficult, and an overall lack of medical, school-based, and community-based providers to address the mental health needs of children and families.

In Region 4, Children with Serious Emotional Disorder Waiver Wraparound, WV Children's Mental Health Wraparound, and Children's Mobile Crisis Response are offered. According to participants, Children with Serious Emotional Disorder Waiver Wraparound and WV Children's Mental Health Wraparound programs have contributed to helping keep youth in their communities rather than residential treatment. However, it can be difficult to enroll youth in the Children with Serious Emotional Disorder Waiver program because it takes parents a long time to fill out and return the proper paperwork to an agency.

Region 4 participants discussed that collaborations with mental health wraparound services exist, specifically counseling centers in the area, but that they have extremely long waitlists. Qualifying youth can get counseling through juvenile drug court and DHHR involvement qualifies them for Safe at Home Wraparound. Some participants were not aware of any wraparound services in their areas and others were not fully aware of how wraparound is being utilized in their communities. The difference between

statewide Children's Mobile Crisis Response and Children with Serious Emotional Disorder Wavier crisis services are confusing to providers. In Region 4, Children's Mobile Crisis Response serves as a liaison between a family currently receiving Children with Serious Emotional Disorder Waiver services and their therapists instead of providing de-escalation and crisis stabilization services. One participant discussed how Children's Mobile Crisis Response is only for Children with Serious Emotional Disorder Waiver clients, and this is not a service for the general public to use for any mental health crisis situation. Another representative for Children's Mobile Crisis Response in this region described more comprehensive program coverage for youth throughout the region, specifically via the statewide crisis hotline (844-HELP-4WV) and Appalachia Community Health. System-level focus group participants were aware of Children's Mobile Crisis Response services but had yet to use them nor heard of others using them. Finally, a Children's Mobile Crisis Response provider from Region 4 has their staff take PBS training for de-escalation techniques for first responders and mentioned this provider has referred families to PBS services and training offered by the WVU Center for Excellence in Disabilities.

Finally, Region 4 has seen an increase in telehealth services due to COVID-19 as a replacement for group therapy or in-home visits. Reportedly telehealth has not been as successful as in-person services, as many families struggle with faulty internet connections and prefer in-person communication over virtual interactions.

13.6 Region 5 Profile

In Region 5, three organizational leaders participated in organizational and facility key informant interviews and twelve service providers participated in provider focus groups. Also, four DHHR and partner agency staff participated in system-level focus groups, and 14 judges participated in interviews.

Mental health professionals in Region 5 are dedicated and driven by their desire to help youth and families in the community. Although staffing has seen some successes in salary adjustment and having enough workers to cover services (specifically in residential mental health treatment facilities), high caseloads combined with lower WV salaries compared to surrounding states contribute to higher turnover in the field. Key informant administrators reported having positions open in their organizations, but they receive few applications and state there are limited eligible applicants to interview and hire. This issue results in youth not receiving services when they need them. Although resources (such as empty beds) are available, a lack of staff prevents service delivery.

Key informants reported some success with referrals in Region 5, but knowledge gaps exist related to which providers and programs are available for youth and families. Providers did note a recent shift wherein more community resources are being offered after residential placement and information referral pathways prioritize community-based options. Key informants explicitly described trying to reduce the reliance on residential services through their programs, and believe they are taking steps in the right direction. Still, there is a tremendous need for more services and providers for referrals to community-based services to be successfully utilized. COVID-19 has impacted referral systems by stifling providers' abilities to keep an updated list of available programs. However, efforts to establish and maintain relationships with providers, including local psychiatrists, to facilitate referrals, are ongoing.

In terms of specific programs offered, providers were well connected with Children's Mobile Crisis Response services and stated the agency was "fabulous" with referring to outpatient, in-home, wraparound, and Safe at Home programs.

Implementation of Children with Serious Emotional Disorder Waiver services is challenging in Region 5, primarily due to understaffing resource constraints due to low wages. Organizations are not currently providing any new Children with Serious Emotional Disorder Waiver services. Wraparound providers in Region 5 described holding weekly meetings to improve services and the referral process. Wraparound was noted as an excellent service that should be expanded throughout the state. Judges described Safe at Home as a service that was especially useful but often not available due to lack of staff.

Key informants noted successful collaborations with DHHR and relationship building across programs and agencies are strong assets in Region 5. However, participants noted the multidisciplinary team process in this region is challenging; some counties' multidisciplinary teams operate more smoothly than others. In some areas, multidisciplinary teams operate on short notice and there is limited participation from relevant team members.

COVID-19 related impacts on Region 5 include increased stress on the workforce, significant loss of staff due to COVID and burnout, and high turnover. Training for staff and foster families has also been challenging to implement virtually. Telehealth has been utilized, but key informants believe in-person training raises the quality of teaching and overall communication. Family's ability to communicate and visit youth in residential treatment has also been interrupted, as some families lack access to technology. Judges also noted that not all families were comfortable with providers coming into their homes and stressed the importance of families receiving treatment as well as youth.

13.7 Region 6 Profile

In Region 6, three organizational leaders participated in organizational and facility key informant interviews and 15 service providers participated in provider focus groups. Also, ten DHHR and partner agency staff participated in system-level focus groups, and nine judges participated in interviews.

Staff shortages and high turnover limit the services organizations can offer in Region 6. The challenging nature of mental health work with children, coupled with low pay, are the major barriers to staff recruitment in Region 6. Several key informants from Region 6 mentioned that the inability to offer competitive salaries is the greatest barrier to staffing, with potential hires going to other states or even fast-food establishments to make higher wages. Those who are hired are often inexperienced and require significant training before they can begin working and it is common for facilities to have high rates of staff turnover in all positions. A judge mentioned a lack of psychiatrists in their region, stating that there was only one and that he was part-time. Judges perceived lack of services and understaffing are due to low salaries as well. A key informant has received grants to staff positions which have resulted in more hiring and retention of staff due to their ability to offer a higher salary. In a discussion about the dearth of mental health services available within schools, a superintendent in Region 6 discussed valuing youth mental health to the point where they reported going "way over our budget" to hire school-based mental health professionals.

Participants from Region 6 discussed experiences with Children's Mobile Crisis Response, West Virginia Children's Mental Health Wraparound, Children with Serious Emotional Disorder Waiver Wraparound, PBS, and ACT and believe these programs have contributed to keeping youth in their homes rather than residential treatment. However, wait times for receiving services ranged from several weeks to months after youth are in crisis; thus, short-term placement is a significant issue, especially given the wait time for beds in residential mental health treatment facilities. Further, programs and providers often do not

'speak the same language' regarding program offerings and availabilities, which limits collaboration and streamlined referral processes. On the other hand, strong collaboration between DHHR and CPS was reported in Region 6. A solid working relationship facilitates communication and follow-ups to better serve the youth in the area.

In terms of mobile crisis, Children's Mobile Crisis Response is provided in Region 6 despite the lack of staffing and shortage of therapists. Providers work with a licensed therapist at the Youth Reporting Center and a wraparound coordinator to process referrals to West Virginia Children's Mental Health Wraparound. One provider noted that although Children with Serious Emotional Disorder Waiver Wraparound is now available, they have not formally started offering those services but hope to offer in-home services soon. PBS is offered to children in the IDD waiver program in Region 6, and organizations are trying to integrate PBS principles and skills into other services, especially ACT and children's mental health programs. More specialized staff with adequate training are needed to fully implement PBS. Region 6 was the only region in WV that reported offering ACT services in interviews and focus groups. Due to the intensive nature of ACT, including frequent touchpoints with clients, the staff know and understand the youth well and are informed about the services they need. The teamwork approach ACT utilizes includes daily staff meetings which contribute to the success of the program. However, COVID-19 created significant challenges to delivering ACT services in Region 6; most notably, transportation services, which are an integral part of the program, were significantly limited. Participants reported that telehealth is helpful in some capacity for older youth who are familiar with technology, but young children and grandparents may have significant issues accessing and using virtual services.