Findings and Visualization Report

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

Baseline System and Community-Level
June 2022

West Virginia University
OFFICE OF HEALTH AFFAIRS

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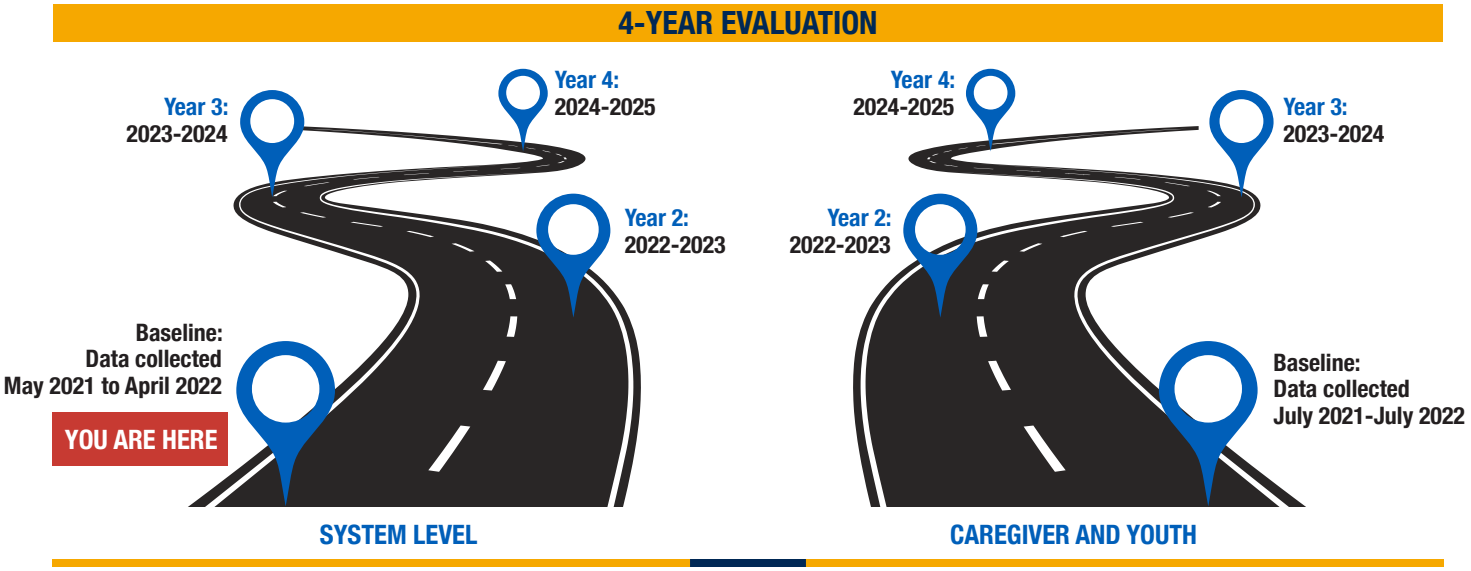
Introduction

Evaluation Overview

West Virginia University Office of Health Affairs (WVU OHA) is conducting a four-year evaluation of the West Virginia Department of Health and Human Resources (WV DHHR) Children's In-Home and Community-Based Services Improvement Project. The goal of the improvement project is to expand and improve access to children's mental and behavioral health services, so that more West Virginia children can receive care in their homes and communities. Information gathered from community partners, families and youth is being used to provide the WV DHHR information about the perspectives and experiences of people and partners serving or receiving care across children's mental health system continuum, such as organization and facility administrators; health providers; cross-sector partners; caregivers; and youth. This report represents the baseline, year-one, evaluation findings for organization and facility administrators, health providers and cross-sector partners data collection. The findings for the baseline, year-one, evaluation findings for caregivers and youth will be released to the WV DHHR in August 2022.

Data collection methods include:

WV DHHR and program partners are actively engaged in making changes to policies and practices that are not reflected in the presented data, as data collected during each year of the evaluation are intended to provide a snapshot of the experiences of people in the field, and youth and families who are at-risk and/or receiving residential mental health treatment. Future reporting will provide additional insight into WV DHHR's cumulative work over time throughout the project.



Report Overview

This report is a supplement to the **System and Community-Level Evaluation Report (March 2022)** and includes baseline data collected from May 2021 to April 2022. The Findings and Visualization report provides an overview of key findings from baseline data collection. For additional data and analysis, please refer to the full report; a topical index is provided in the Appendix to facilitate navigation.

Data presented in this report were collected through surveys from over 1,400 providers, staff, and partners; 49 one-on-one interviews among key informants; and 36 focus groups with a total of 103 participants. Responses provide perceptions about services including:

- Assertive Community Treatment (ACT)
- Children's Mobile Crisis Response and Stabilization (CMCRS)
- Wraparound Facilitation Services: West Virginia Children's Mental Health Wraparound and Children with Serious Emotional Disorders (CSED) Waiver Wraparound (Wraparound)
- Positive Behavior Support (PBS), which is now part of Behavioral Support Services
- Residential Mental Health Treatment Facilities (RMHTFs)

The Statewide Children's Crisis and Referral Line and key cross-sector partners are also included.

Findings in this report are presented in three ways: 1) at the state/systems level (page 4); 2) at the service level (page 12); and 3) by region (page 23). Readers are encouraged to access the section(s) that are most relevant to their interests and needs. Survey, interview, and focus group findings are highlighted to provide insight into organizational, provider, and partner perspectives, share suggestions from respondents for expanding on what's working, and to inform dialogue around opportunities for system improvements. Quotes are used to illustrate themes and/or to highlight unique perspectives.

In this report:

- "Providers" refer to healthcare and mental health providers such as behavioral analysts, social service providers, social workers, residential direct care staff, psychiatrists, psychologists, school counselors, and traditional healthcare professionals.
  - Unless otherwise specified, law enforcement officers, judges, attorneys, probation officers, DHHR workers, and school administrators were reported separately under the "Key Partners" section below. When findings are unique to a provider type, that is specified. Organizational leaders and administrators represent participants in the Organization and Facility Survey.
- "Youth" is used to refer to the continuum of children, youth, and young adults, ages 0-21, who receive or are eligible for the services outlined above.

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

Statewide Findings

Availability/Accessibility

Behavioral healthcare requires a systems approach to service delivery that includes a range of opportunities for treatment, support, and engagement. The continuum of services evaluated at baseline are focused primarily on community-based care for youth.

The services are making a difference, so people want more. Specifically, West Virginia has prioritized keeping youth in their homes. All evaluation participants echoed this priority of community-based services over residential treatment. To continue to prioritize community-based care, there is a need for more intensive outpatient treatment that provides a high-level of care and support.

Perceptions of service availability:

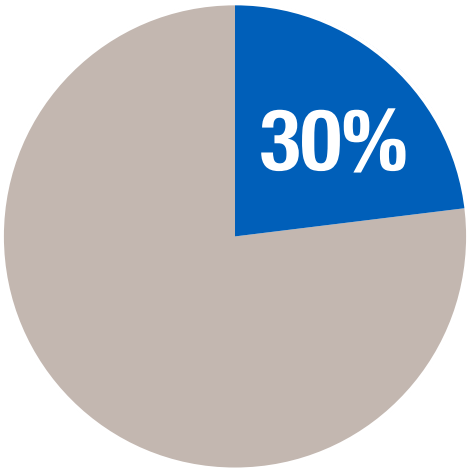
- Services being implemented are helping to keep youth in their homes and communities.
- Few of the services have sufficient resources to meet the demands.
- Cases are often "too severe" or "not severe enough" for the types of services that are available.

Service availability has been expanded to every region in West Virginia, although regional coverage may leave gaps at county or community levels.

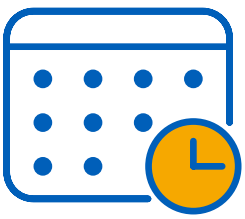
Waitlist

While services are available statewide, providers perceived that services are not always accessible in a timely manner. Organizational leaders and administration reported that approximately one-third of the locations they represent had waitlists for new clients to receive services.

Facilities that said "yes" to having a waitlist



AVERAGE (MEDIAN) WAIT TIME
30 DAYS

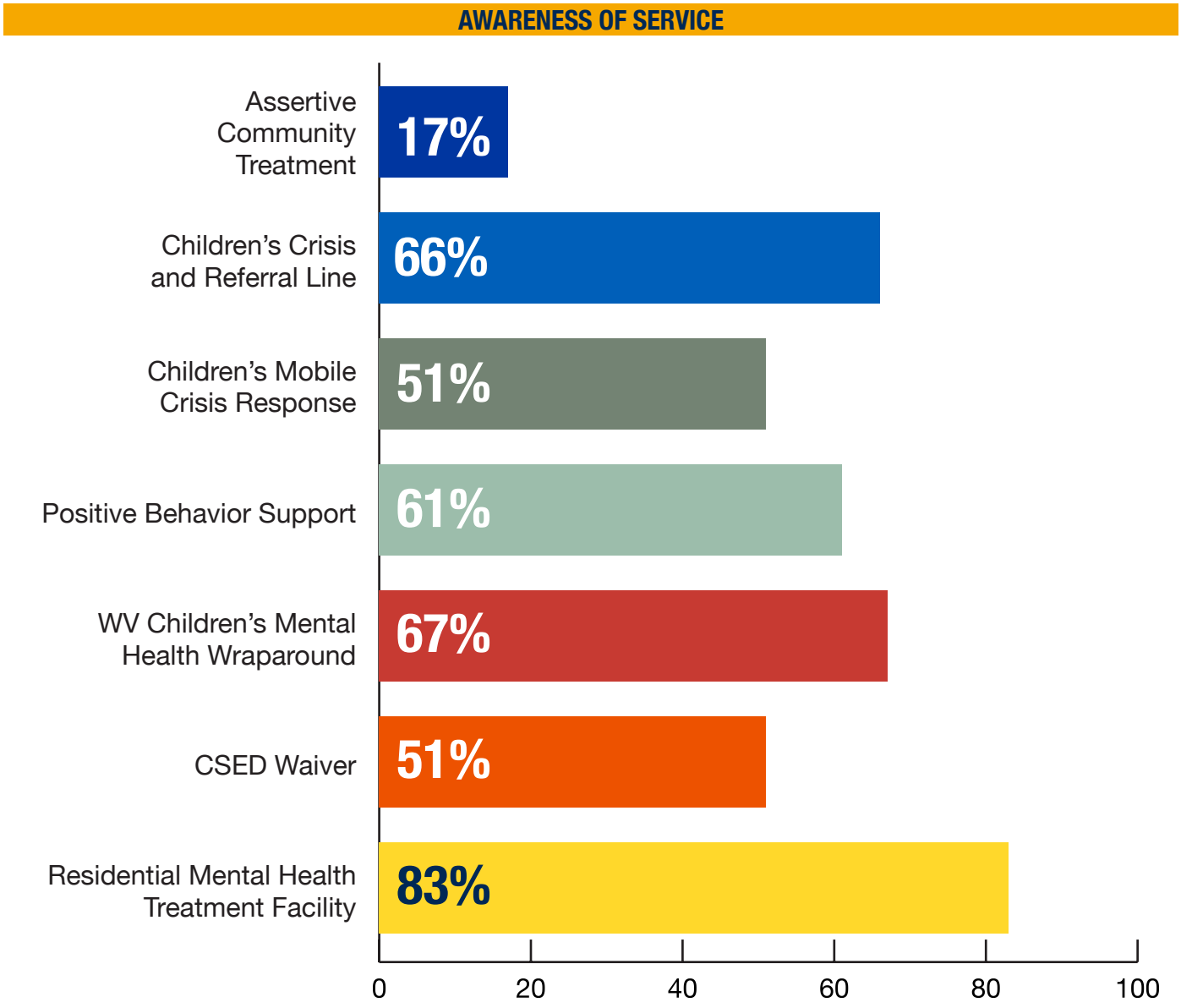


What they're saying

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.

Awareness

Survey data showed providers are more aware of some services than others. Providers were most aware of residential treatment (83% said that they were aware), and were least aware of Assertive Community Treatment (17%). Provider awareness of other services ranged from 51% to 67%.

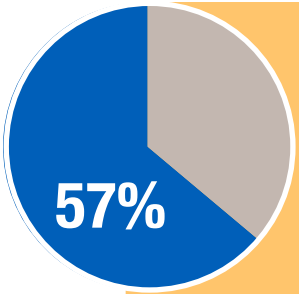


Providers perceived that families/caregivers could have misunderstanding of available services. Common themes around providers' perceptions on lack of family awareness and engagement included fear of legal impact, feeling worn down, and difficulty with access in remote areas of the state.

Consistently across interviews, there was 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 of providers on how to request waivers and continued conversation about policy requirements would be beneficial.

Workforce Capacity

Workforce capacity was a challenge across West Virginia. The need to expand staffing was consistent across survey, interview, and focus group data. Statewide, organizational leaders and administrators representing 57% of evaluated locations reported that they had the capacity they needed, and only 41% reported that they had adequate staffing to meet demand.



Facilities across the state that have the capacity to serve all youth referred to facility.

Of those that said no, **only 26%** said other providers in their region can meet youth needs.

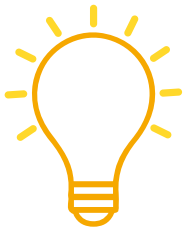
Perceptions of workforce capacity:

- Staffing shortages affect the quality and the quantity of services.
- There is a need for more staff to do assessments.
- Core staffing was a priority. Results also point to the importance of multidisciplinary staff to work across systems, such as the judicial system.

Workforce Recruitment

Recruitment and retention efforts directly impacted workforce capacity. Finding staff with specific skills and training was identified as particularly challenging. The most common recruitment and retention issues cited by participants were low salaries, COVID-19, and burnout due to the demands of the work.

75% of survey respondents said that there were mental or behavioral health positions with particular capabilities, skillsets, or credentials that were hard to retain or fill. The most difficult to hire for were: licensed therapists, psychologists, licensed social workers, and Master-level staff as well as direct care staff.



Findings suggest several ideas for addressing recruitment and retention challenges:

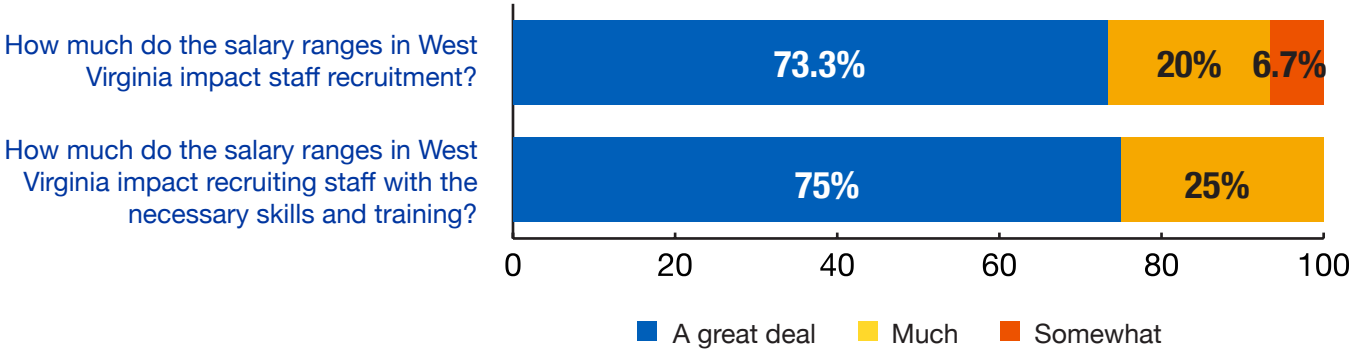
- Simplify the state licensing process, which is reported as confusing and lengthy.
- Consider waiving certain employment requirements for individuals with lived experience to be able to work in the system.
- As many Bachelor-level staff do not qualify for licensure, consider allowing for “years of experience” to qualify for licensure instead of only formal educational attainment.

Workforce Salary

Many organizational leaders and administrators encountering challenges with workforce capacity and staffing attributed it to salary ranges in West Virginia. Over 90% of the Organization and Facility Survey respondents identified salary as an issue in recruitment; 100% of respondents identified salary as a barrier to recruiting staff with the specific skills and training needed. Salary is particularly an issue in counties along state lines; those that border Maryland and Pennsylvania, for example, report “staff leav[ing] WV for more money.”

Perceptions of salary issues:

- While salary is important and should be addressed, benefits and helping to meet needs like child care are potential ways to balance wage issues.
- Staff across the WV children’s mental health system are dedicated to the work and feel that they can take on more if their experience would be factored into credentialing.
- Existing staff report that they have the skills that they need but are open to more training.



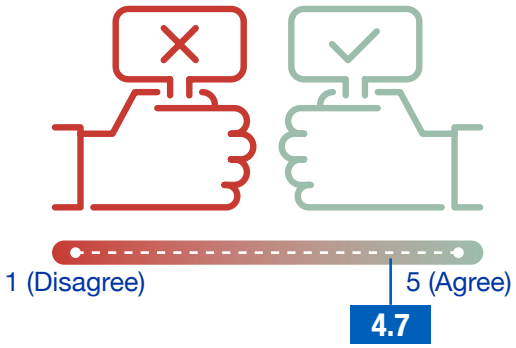
Training and Education

Training is a bright spot of the children’s mental health system. Consensus across all data collected was that trainings offered are working and helpful. Most providers feel that they have the necessary training to function in their current role. Generally, there was agreement that staff have the training and skills needed to deliver evidence-based practices which is key to enhance effectiveness of interventions.

Respondents want more training across all provider types and professional roles. There is a specific need for de-escalation training for providers and families.

The need for more training for new hires and workforce with less professional experience was a theme of interviews and focus groups.

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



Please indicate where you want to receive additional training?

Top 5 areas:

1. Crisis Response/Stabilization (66%)
2. Trauma Informed Care (62%)
3. Mental Health Assessment (54%)
4. Mental Health Screening (53%)
5. Treatment Engagement and Retention (53%)

Key Partners

This section describes findings related to several key partners that operate within and across systems and sectors to support children's mental health in West Virginia.

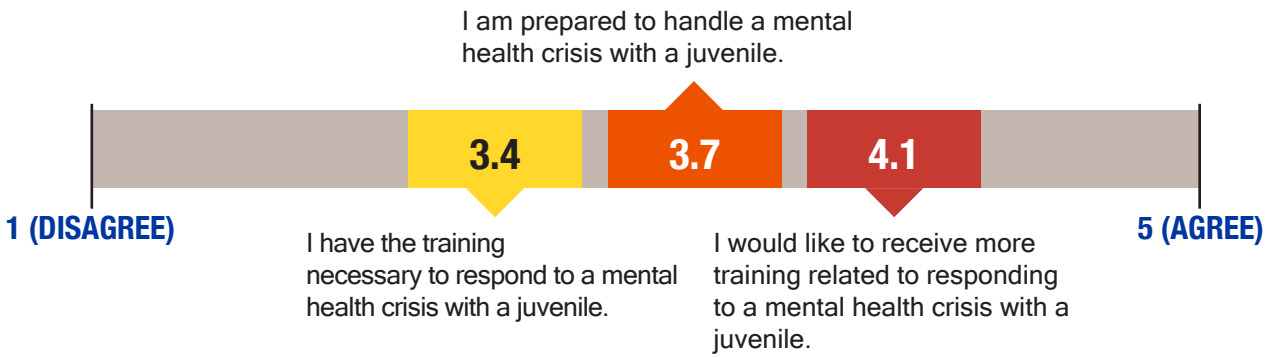
Law Enforcement Officers

Law enforcement officers are sometimes called to situations involving a mental or behavioral health crisis. However, law enforcement officers (89%) are generally not aware of the Children's Mobile Crisis Response and Stabilization (CMCRS) team in their area or network.

Of the law enforcement officers who did know about CMCRS services:

- 79% were aware of how to access the team in their area or network;
- 67% said that they need training on working with CMCRS teams;
- 18% had worked with or responded with a CMCRS team in the past year.

Do you agree or disagree with the following:



Juvenile Justice Partners

Judges work with attorneys and guardians ad litem to represent the best interest of youth in the juvenile justice system. When asked about their perspectives on community-based mental health services:

- Judges 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 districts
- Judges, attorneys, and guardians ad litem neither agreed nor disagreed that service provider agencies in their jurisdictions are accessible to the juveniles and caregivers they serve;
- Judges disagreed that there are services that can meet the diverse mental health needs of juveniles in their circuit. Attorneys and guardians ad litem somewhat disagreed and expressed concerns about service availability and the quality and effectiveness of mental health services in their jurisdictions.
- Judges agree that they prioritize in-home and community-based treatments over residential when it is safe to do so.
  - Attorneys and guardians ad litem somewhat agree that judges prioritize in-home and community-based treatments.
- Judges neither agree nor disagree that caregivers and families are aware of community-based services, whereas attorneys and guardians ad litem somewhat disagree.

Judges discussed the need for more services, including family therapy. They would like the ability to order these services to support counseling for parents and family members and maintain youth in their homes, recognizing that family issues often contribute to removal.

Attorneys and guardians at litem felt that there were not clear protocols in place for representing youth with mental health needs involved in the juvenile justice system, and neither agreed nor disagreed that they have the information they need to make appropriate recommendations to the court. Judges, on the other hand, reported the ability to request the information needed to make a case disposition if it was not already provided to them.

Education system and schools

All data collected suggested increasing mental health care in WV school settings. Interview and focus group participants agreed that having school-based social workers made mental health services more accessible to youth, but insufficient workforce and high turnover among social workers remains a challenge to service delivery. Health providers identified schools as safe and accessible places to offer and receive services. Some even suggested each school have its own social worker and counselor.

Providers in school-based settings were limited in the types of screenings and assessments they can perform. They conduct safety or risk assessments, such as for suicide or self-injurious behaviors, with students showing signs of anxiety or mental health issues. Beyond safety and risk assessment, school-based providers must refer for further evaluation elsewhere.

Focus group participants also noted that different treatment plans in different settings (such as school versus home) that do not "meld" together can create challenges for youth. Providers shared examples of multiple, disjointed behavioral plans for individual youth across settings (i.e., the plans do not 'talk to each other'). Consistency for plans across in-home, school, and community-based settings is recommended.

What they're saying

One superintendent reported going "way over our budget" to hire employees to address the mental health issues in their school system. They also worried that subsequent leaders may not place the same value in mental health services and **emphasized it is critical to have as many state supported services in schools as possible.**

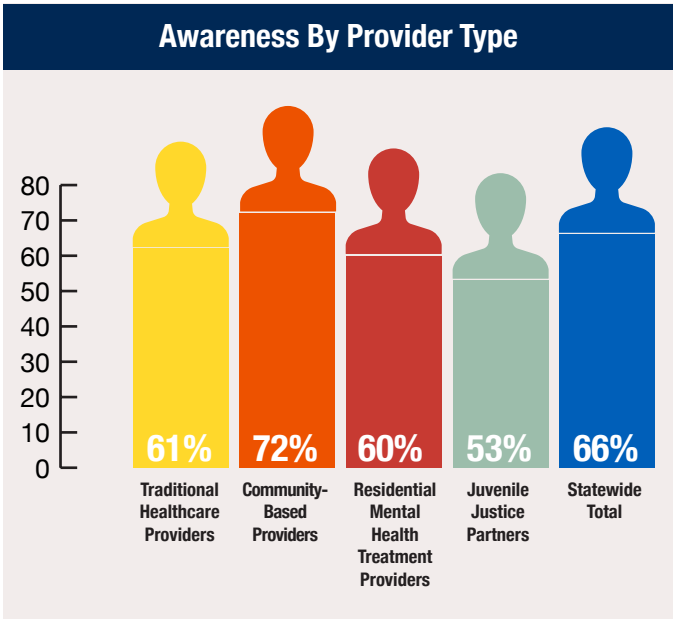
Traditional Healthcare/Hospitals

Overall, healthcare providers think there is a lack of awareness across other service providers and report system-wide misunderstandings of the needs of youth. A lack of services and staff impede collaboration and referral processes for traditional healthcare providers; however, they report sending referrals to community-based programs on a regular basis.

Organizational leaders and administrators reported strong communication, coordination, and referral networks with hospitals and other primary care settings such as pediatric offices and private practices. Statewide, more than 50% of services give referrals to and receive referrals from hospitals and other healthcare facilities.

Statewide Children's Crisis and Referral Line

The Statewide Children's Crisis and Referral Line (844HELP4WV) is a statewide, 24/7 service provided by the Bureau of Behavioral Health for youth ages 0-25 (although this evaluation is focused on 0-21). The hotline is a key access point to behavioral health services across the state. Two-thirds (66%) of providers said that they were aware of the Statewide Children's Crisis and Referral Line. WV DHHR started outreach to primary care providers in November 2021 that reached 214 (of 659) during the reporting period. Outreach efforts are intended to increase referrals via the Statewide Children's Crisis and Referral Line. Press releases and media campaigns are also planned to promote awareness of Statewide Children's Crisis and Referral Line.

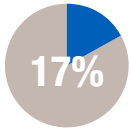


Service Profiles

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) operates out of local agencies that are reimbursed by Bureau of Medical Services (BMS) for the service. ACT provides an array of inclusive community-based mental health services for individuals ages 18 years and older with serious and persistent mental illness. This evaluation focused on young adults receiving ACT who are between the ages of 18 and 21. DHHR is working to provide statewide coverage by September 2022.

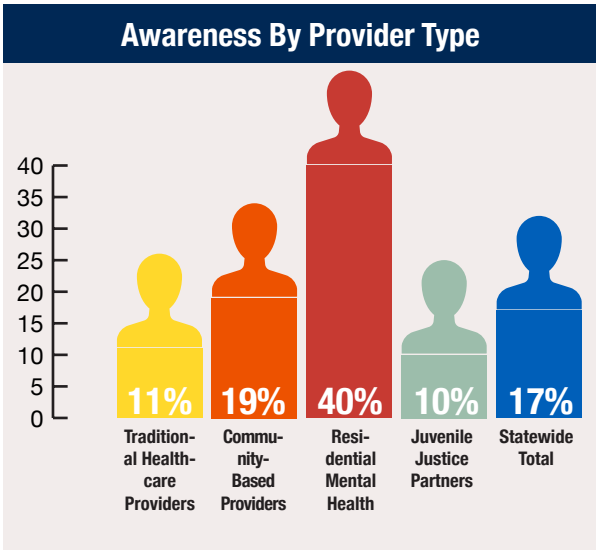
Awareness of Assertive Community Treatment

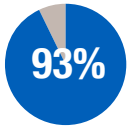


Less than 17% of providers statewide said they were aware of Assertive Community Treatment. The majority of providers who were aware of ACT (83%) reported that the service does not have sufficient resources.

More education about ACT and awareness of the services will increase provider knowledge.

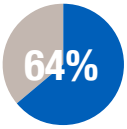
Judges and lawyers find ACT to be a beneficial service.



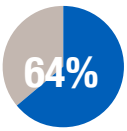


Organizational leaders and administrators reported that for their locations offering ACT, hospitals (93%) and schools (93%) refer to ACT services the most and CMHC refer to ACT the least (13%).

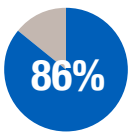
Workforce Skills and Recruitment



ACT organizational leaders and administrators reported that 64% of their locations had adequate staffing to serve all youth who need service.

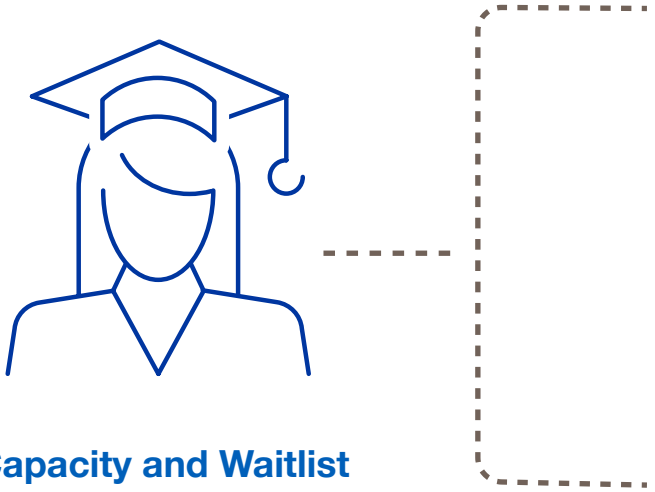


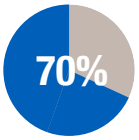
ACT organizational leaders and administrators reported that 64% of their locations had staff with necessary training and skills to serve youth; this is higher than any other service included in this evaluation.



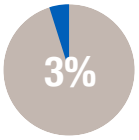
ACT organizational leaders and administrators reported that 86% of their locations experienced challenges recruiting staff with particular capabilities, skillsets, or credentials, compared to 75% statewide. ACT organizational leaders and administrators reported challenges with hiring and retention of all licensed positions. Unique to ACT was specific needs for licensed psychologists and licensed practical nurses.

Training and Education

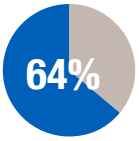




70% of all providers who responded to the survey said that ACT is applicable to their jobs.



Very few (3%) of all providers surveyed reported that they had recieved training on ACT.

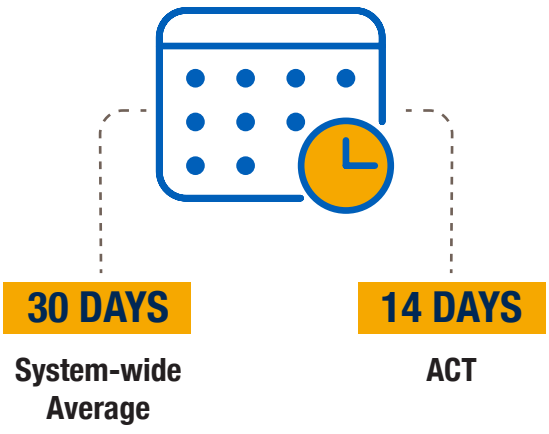


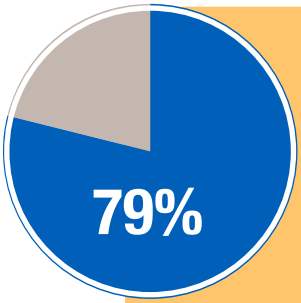
Almost 2/3 (64%) of providers across all services want more training on ACT.

Capacity and Waitlist

ACT organizational leaders and administrators reported that salary was an issue in recruiting and retaining staff, particularly those with the necessary skills and training. However, salary was less of an issue for ACT than it was across the system.

ACT organizational leaders and administrators reported that 7% of their locations have waitlists for new clients to receive services, compared to 30% across the system. Organizational leaders and administrators perceived that for locations with waitlists, half of youth seeking new ACT services would be seen within 14 days, shorter than the system-wide average (median) of 30 days.





ACT facilities that have the capacity to serve all youth referred to facility.

Of those that said no, 0% said other providers in their region can meet youth needs.

An organizational leader said about ACT:

"We're really in touch with them [youth]. We really know them well, and that way we can really understand what services they need."

Wraparound Facilitation Services

Children's Mental Health Wraparound is a suite of services based on the National Wraparound Initiative, and in this report includes Wraparound services offered by BBH (Children's Mental Health Wraparound) and through the Bureau of Medical Services' Children with Serious Emotional Disorder Waiver (CSEDW). Wraparound is a comprehensive team-based approach to developing creative and individualized strengths-based care plans that enable families to identify their own needs and work together with care providers and natural supports to meet them. Wraparound is available in all BBH regions.

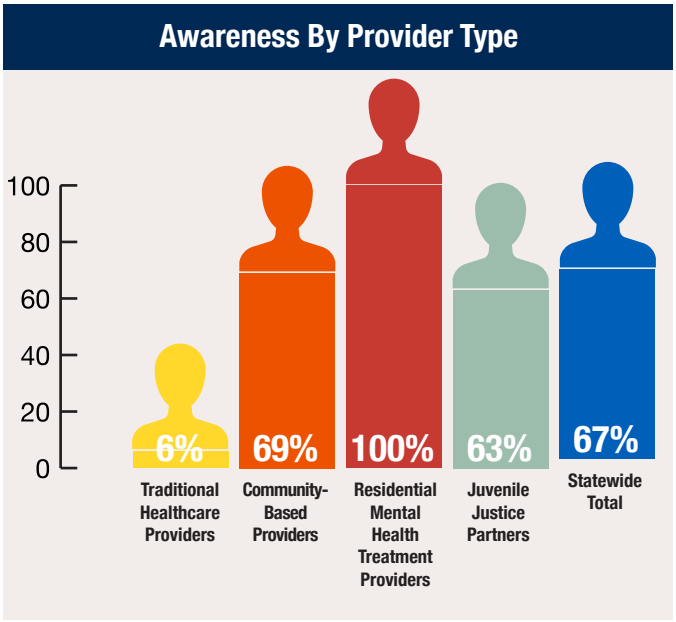
Awareness of WV Children's Mental Health Wraparound

2/3

Statewide, two-thirds of providers were aware of WV Children's Mental Health Wraparound, the highest of all community-based services in the evaluation.

For wraparound, referrals were most often by word of mouth. Lack of awareness across communities about wraparound services limits access for youth who need services.

In addition to the lack of resources, more parent education and training were cited as needs.



Workforce Skills and Recruitment

38%

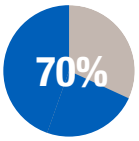
Organizational leaders and administrators reported that 38% of their locations offering wraparound had the adequate staffing to serve all youth who need service, lower than the 41% reported across the system statewide.

50%

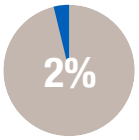
Organizational leaders and administrators reported that half of their wraparound locations have staff with the necessary training and skills to serve youth.

Organizational leaders and administrators reported that 88% of their locations experienced challenges recruiting staff with particular capabilities, skillsets, or credentials, compared to 75% statewide. Wraparound organizational leaders and administrators reported challenges with hiring and retention of all licensed positions.

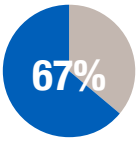
Training and Education



70% of all providers who responded to the survey said that wraparound is applicable to their jobs.



Very few (2%) of all providers surveyed reported that they had recieved training on wraparound.

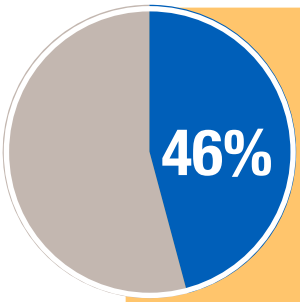


More than 2/3 (67%) of providers across all services reported that they were interested in training on wraparound.

Capacity and Waitlist

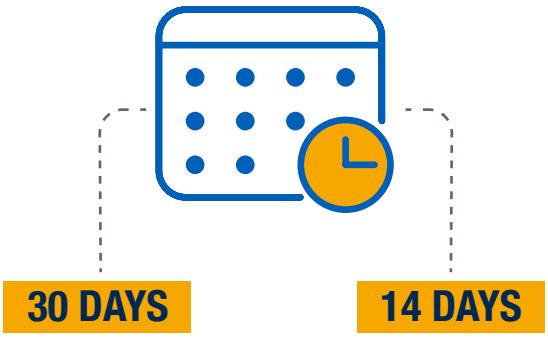
Wraparound organizational leaders and administrators reported that salary was an issue in recruiting and retaining staff, particularly those with the necessary skills and training. Findings around the importance of salary in recruitment and retention were consistent with statewide percentages.

According to wraparound organizational leaders and administrators, less than a third (29%) of their locations had waitlists for new clients to receive services, compared to 30% across the system. Organizational leaders and administrators perceived that for the locations with waitlists, half of youth seeking new services would be seen within 14 days, shorter than the system wide average (median) of 30 days.



Wraparound facilities have the capacity to serve all youth referred to the facility

Of those that said no, only 23% said other providers in their region can meet youth needs.



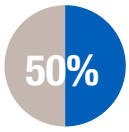
An organizational leader provider said about CSED:

"So, do I think [Wraparound] is a good program that will keep kids in their home? Yes, if we can get the providers."

Children's Mobile Crisis Response and Stabilization

Children's Mobile Crisis Response and Stabilization (CMCRS) teams provide on-site support for families with children ages 0-21 experiencing an emotional or behavioral crisis. Children's Mobile Crisis Response and Stabilization teams can be deployed through the Bureau for Behavioral Health's Statewide Children's Crisis and Referral Line to disrupt and de-escalate crises. CMCRS is available statewide.

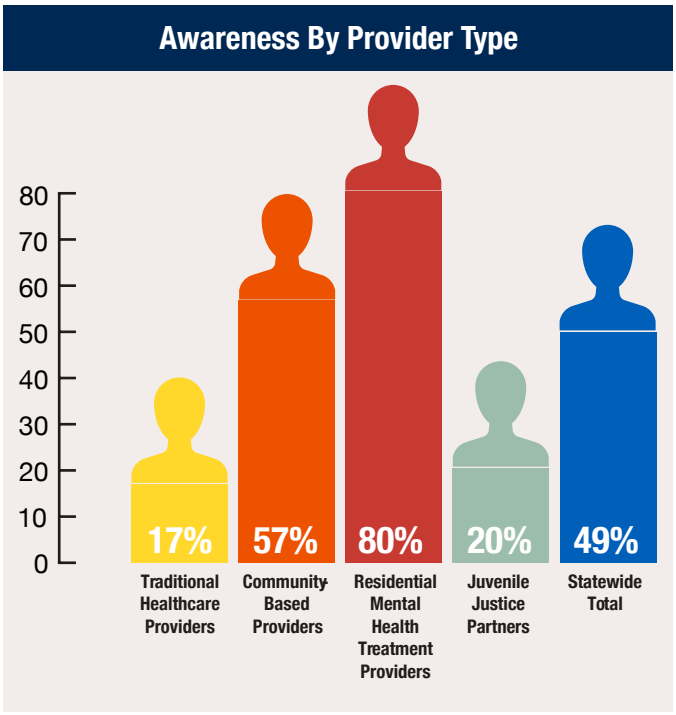
Awareness of Children's Mobile Crisis Response and Stabilization



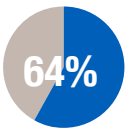
Statewide, nearly 50% of providers said that they were aware of Children's Mobile Crisis Response.

A lack of awareness and knowledge of existing services was mentioned as a significant barrier to referrals to treatment.

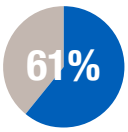
Relationship building and networking have helped to increase awareness of and expand Children's Mobile Crisis Response and Stabilization services.



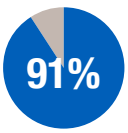
Workforce Skills and Recruitment



Organizational leaders and administrators reported that 64% of their CMCRS locations have the **adequate staffing** to serve all youth who need service.

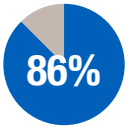


Although there is a lack of staff, organizational leaders and administrators reported that 61% of their locations offering CMCRS have staff **with necessary training and skills** to serve youth.

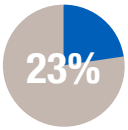


Organizational leaders and administrators reported that 91% of their CMCRS locations experienced challenges in recruiting staff with particular capabilities, skillsets, or credentials, compared to the 75% reported statewide across the system. Specifically, CMCRS administrators stated the additional need for licensed psychologists and traditional healthcare providers.

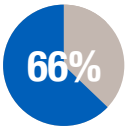
Training and Education



86% of providers said that CMCRS is applicable to their jobs.



Almost a quarter (23%) of all providers surveyed reported that they had received training on CMCRS.

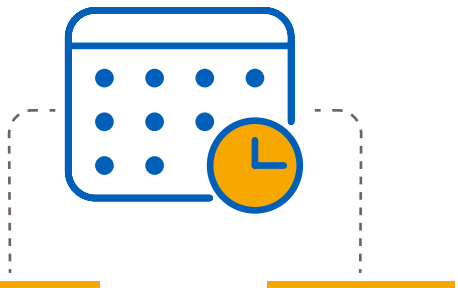


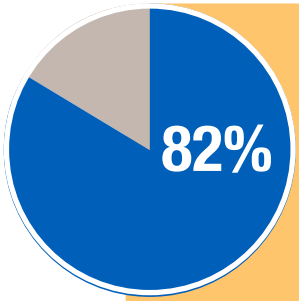
Two-thirds (66%) of providers across all services want more training on CMCRS.

Capacity and Waitlist

Many organizational leaders and administrators for Children's Mobile Crisis Response and Stabilization that encountered challenges with workforce capacity and staffing attributed it to salary ranges in West Virginia. Findings around the importance of salary in recruitment and retention were consistent with statewide percentages.

Organizational leaders and administrators reported that less than 10% of their CMCRS locations had waitlists for new clients to receive services, compared to 30% across the system. Organizational leaders and administrators perceived that among locations with waitlists, youth seeking new CMCRS services would receive them within 14 days, shorter than the system-wide average (median) of 30 days.





CMCRS facilities have the capacity to serve all youth referred to facility.

Of those that said no, only 17% said other providers in their region can meet youth needs.

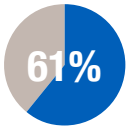
A social service provider said about CMCRS:

"[CMCRS is] very responsive. They go to the home to help parents deescalate and not just provide youth with community resources, but they stick with them. It's short term but it linked them up with other services that are able to last longer."

Positive Behavior Support (PBS)

Positive Behavior Support (PBS) is a series of services that therapists can offer to support families with children and youth (ages 0-21) who are demonstrating challenging behaviors and are at risk of out-of-home placement or involuntary commitment. PBS services, which are a part of Behavioral Support Services, include mental health and behavioral assessments; development and implementation of person-centered treatment plans; modeling for the family and other caregivers on how to implement behavioral support plans; and skill-building services. Home-based services are available for youth with more intensive needs. PBS became available statewide effective October 2020.

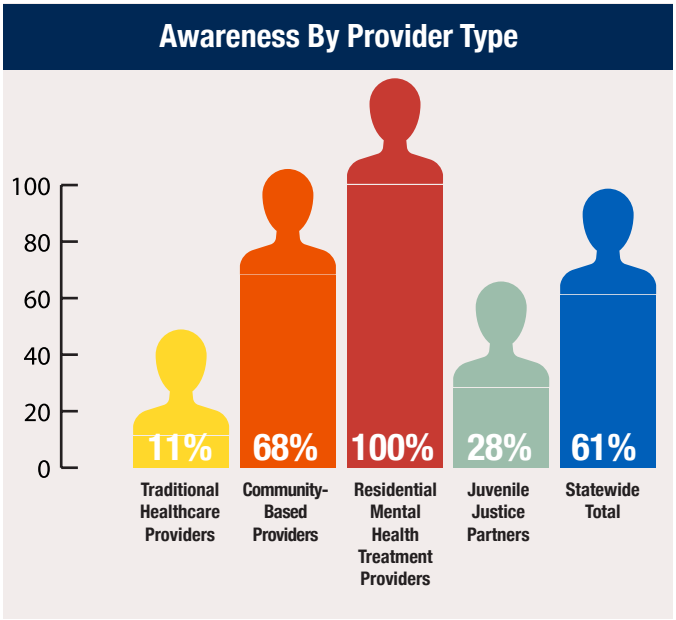
Awareness of Positive Behavior Support



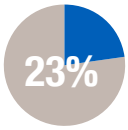
Statewide, six in ten (61%) providers are aware of PBS, trailing only Wraparound and CMCRS.

Multi-disciplinary case presentations were identified 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.

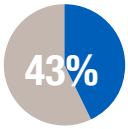
Awareness of PBS within organizations is as important as awareness outside the organization.



Workforce Skills and Recruitment



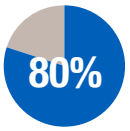
Organizational leaders and administrators reported that 23% of their locations offering PBS had adequate staffing to serve all youth who need services, lower than the 41% reported statewide across the system.



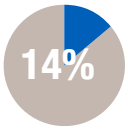
Organizational leaders and administrators reported that less than half (43%) of their locations offering PBS had staff with the necessary training and skills to serve youth.

Organizational leaders and administrators reported that 66% of their locations offering PBS encountered challenges in recruiting staff with particular capabilities, skillsets, or credentials, compared to 75% statewide. PBS organizational leaders and administrators also reported specific challenges with hiring and retention of therapists and direct care staff.

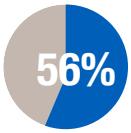
Training and Education



80% of all providers who responded to the survey said that PBS is applicable to their jobs.



14% of all providers surveyed reported that they had received training on PBS.

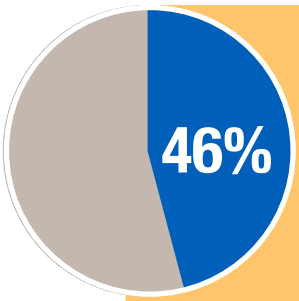


Over half (56%) of providers across all services are interested in training on PBS.

Capacity and Waitlist

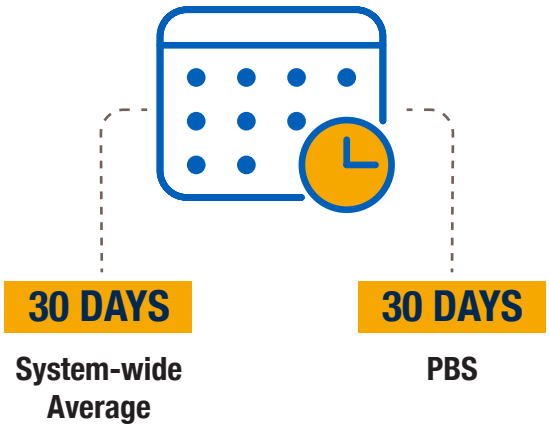
PBS organizational leaders and administrators whose locations faced challenges with workforce capacity and staffing attributed the problem to salary ranges in West Virginia. Findings around the importance of salary in recruitment and retention were consistent with statewide percentages.

Organizational leaders and administrators reported that 40% of their locations offering PBS had waitlists for new clients to receive services, higher than the 30% reported across the system and state. For PBS organizations that had waitlists, organizational leaders and administrators perceived that half of youth seeking new services would be seen within 30 days, equal to the system-wide average (median) of 30 days.



PBS facilities have the capacity to serve all youth referred to facility.

Of those that said no, only 26% said other providers in their region can meet youth needs.



An organizational leader said about PBS:

"[PBS] is a valuable tool in working with youth…with behavior issues."

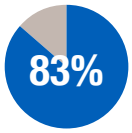
Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities are designed for clients to reside at the treatment center in order to obtain structured 24-hour care amongst their peers. RMHTFs are located in every BBH region across the state.

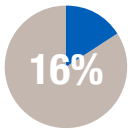
- Intensive home- or community-based services are often not available, leading to placements in RMHTFs because of a lack of alternatives that can offer outpatient services.
  - Providers consistently reported that mental health problems faced by children and youth are often "too severe" or "not severe enough" for community-based services in WV.
- A shift away from residential services toward community-based services is supported and accepted by providers, judges, attorneys and guardians ad litem, who state that the greater availability of community-based services can reduce reliance on RMHTFs.

Quality screening processes and availability of home- and community-based services can prevent children from being unnecessarily placed in residential care.

Awareness of Residential Mental Health Treatment Facilities

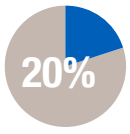


Eighty three percent (83%) of providers are aware of Residential Mental Health Treatment Facilities, the highest awareness of any service in the system.

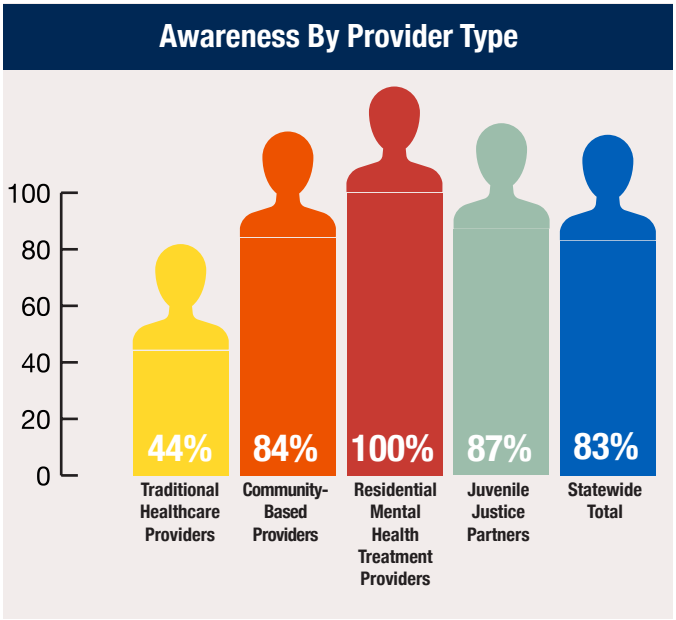


In the last 12 months, the greatest percentage of healthcare providers (16%) sent referrals to RMHTFs.

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).

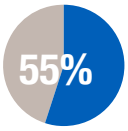


Awareness was lowest among nurse practitioners and physician assistants (20%).

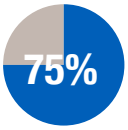


Workforce Skills and Recruitment

Half (50%) of RMHTFs had the adequate staffing to serve all youth who need service, slightly higher than for other services reviewed at an average of 41%.



Just over half (55%) of facility leaders and administrators reported having staff with necessary training and skills to serve youth.



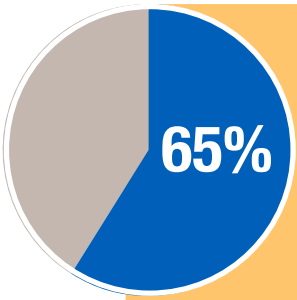
Three-quarters of RMHTFs reported challenges in recruiting staff with particular capabilities, skillsets, or credentials, matching the state-wide percentage (75%). Organizational leaders and administrators of RMHTFs reported specific challenges with hiring and retention of all staff, particularly Master's-level (licensed) staff.

Capacity and Waitlist

Organizational leaders and administrators reported that 65% of their RMHTFs have the staff capacity that they need to serve all youth currently being referred, higher than the 57% reported statewide across the system.

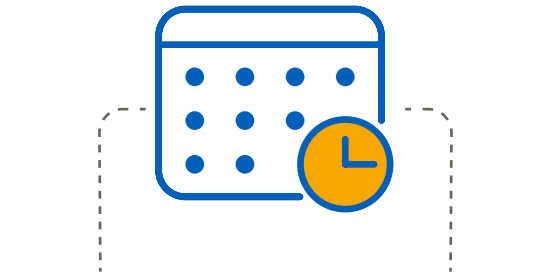
Many Residential Mental Health Treatment Facility organizational leaders and administrators that encountered challenges with workforce capacity and staffing attributed it to salary ranges in West Virginia. Findings around the importance of salary in recruitment and retention were consistent with statewide percentages.

Forty five percent (45%) of Residential Mental Health Treatment Facilities had waitlists for new clients to receive services, higher than the 30% reported across the state and system. RMHTF organizational leaders and administrators perceived that for facilities with waitlists, half of youth seeking new services would be seen within 30 days, equivalent to the system-wide average (median) of 30 days.



RMHTF have the capacity to serve all youth referred to facility.

Of those that said no, only 29% said other providers in their region can meet youth needs.

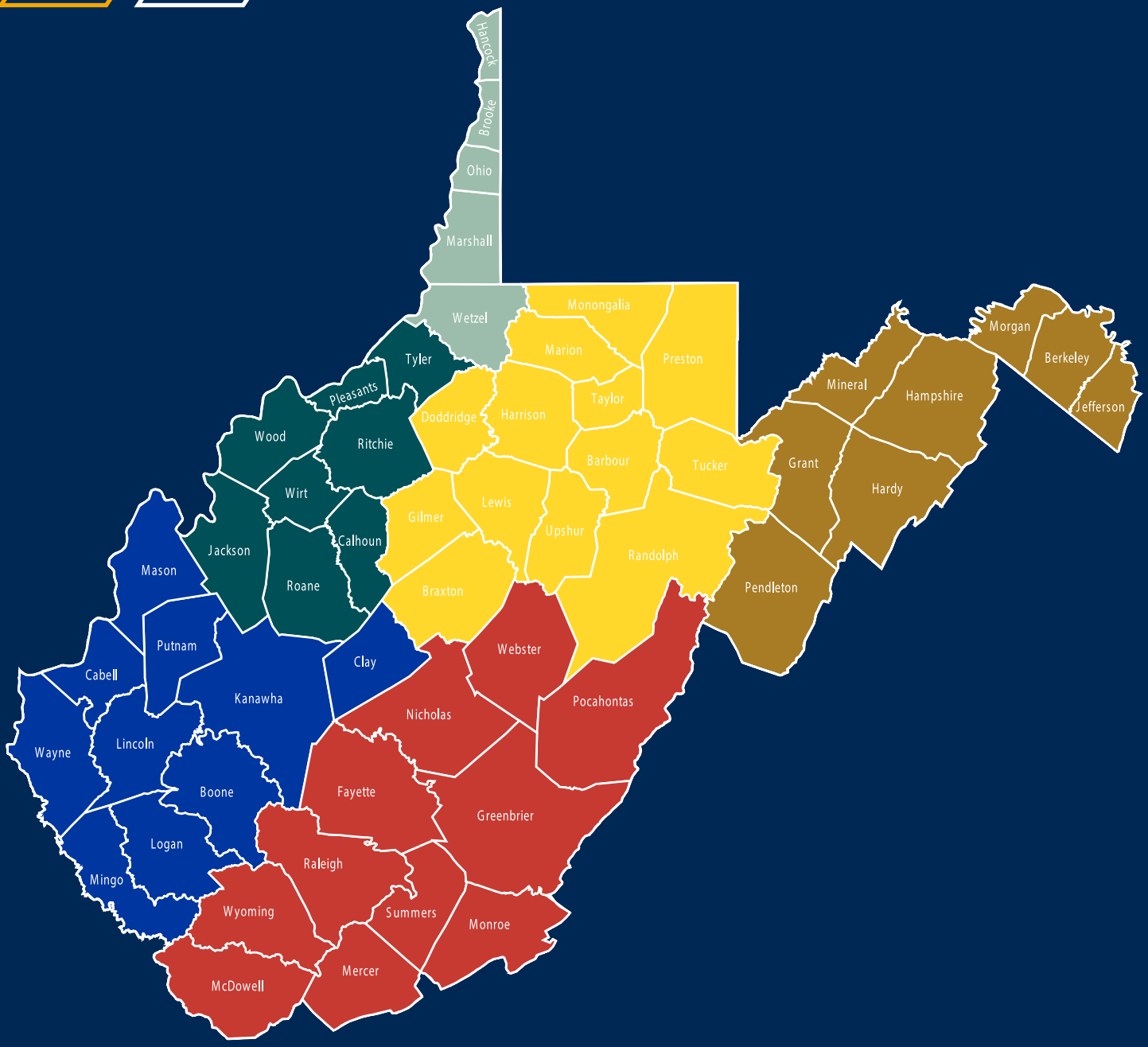


System-wide Average **RMHTF**

An organizational leader said about RMHTF:

"We see frequently with the kids that are in DHHR custody not appropriate to be discharged to a foster home or shelter, something like that. But they need a residential placement."

BBH Region Profiles



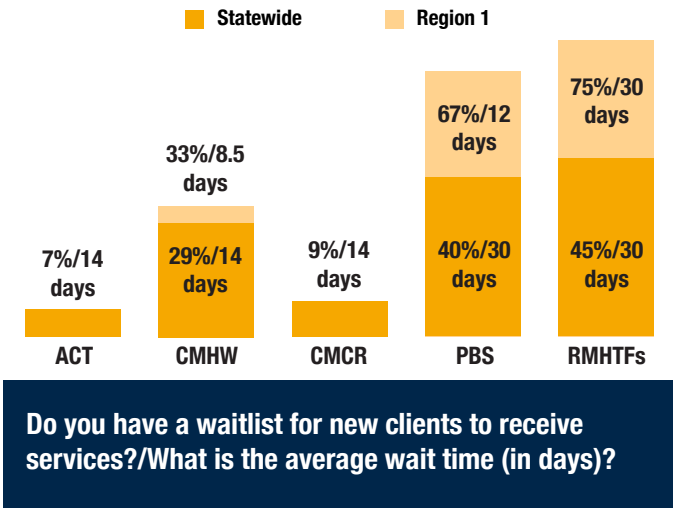
Region 1

Availability of Service

- Several providers have acknowledged a shift in the prioritization of service delivery from residential to community-based treatment.
- Several providers in Region 1 report that Wraparound services (CSEDW and WV Children's Mental Health Wraparound) are helpful, and they would like to see them expanded to more youth in need.
- In Region 1, a judge pointed out that services for families that are lacking, including family therapy, parenting classes, or therapy for parents, would be most beneficial to youth.

Workforce Capacity and Recruitment

- Region 1 providers tended to be earlier in their career and require additional training and support.
- Licensing requirements for mental health professionals create a barrier to staff recruitment.
- Organizational leaders and administrators in Region 1 used strategies like wage adjustment, applying for extra funding and grants, and contract employment to attract and retain employees.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

Waitlists for Services

- High staff turnover within and across service organizations has decreased the consistency of programming and contributed to long wait times for services.
- The closure of a short-term stabilization unit in Wheeling has created major challenges for linking youth with residential treatment in Region 1. The next closest service is in Morgantown and many parents are not able or willing to travel.

What they're saying

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.

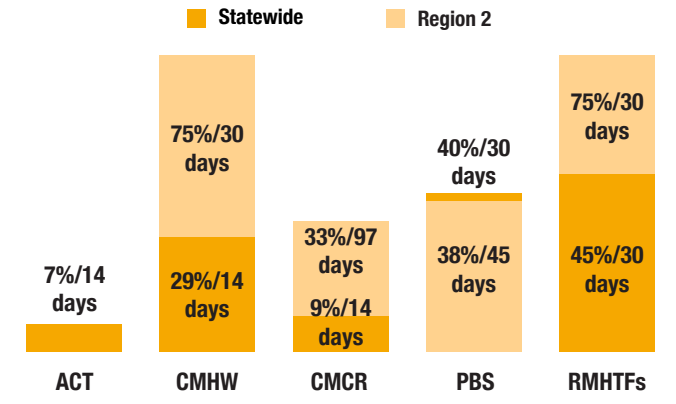
Region 2

Availability of Service

- 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.
- Community engagement and community awareness promote CMCRS usage, but WV's rural geography poses challenges with service access.
- Key informants report 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.
- ACT is not currently offered in Region 2 but was recently expanded to cover the entire state.

Workforce Capacity and Recruitment

- The participants explained that youth are continually retraumatized by changing clinicians and case managers, which sometimes leads families to stop seeking services. Efforts such as sign-on bonuses have been utilized to hire additional nursing staff.
- Key informants indicated that complicated licensing procedures in WV are driving professionals to practice in neighboring states like MD and VA
- A key informant would like PBS training to include de-escalation strategies for youth and noted a PBS training for parents has been developed.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

Waitlists for Services

- Participants agreed that there were major barriers to accessing these services, including long waitlists and a lack of services in their immediate community.

What they're saying

There was a consensus among Region 2 participants that child-serving systems prioritized serving children in their communities and their homes.

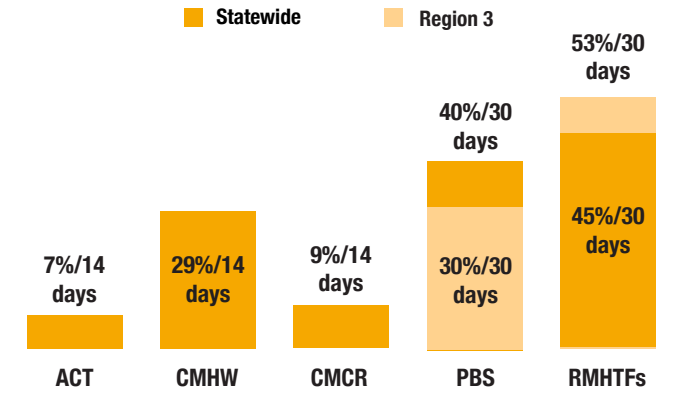
Region 3

Availability of Service

- All services are available in Region 3.
- Despite the impact of the pandemic, agencies continue to provide services, either through telehealth or safe, in-person meetings.
- The participants mentioned that their organizations have developed collaborative relationships with a variety of mental health organizations and agencies, but rural counties lack the providers they need.

Workforce Capacity and Recruitment

- Region 3 has a dedicated mental health workforce, despite experiencing major challenges to recruiting staff.
- 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 and underpaid. Judges report that due to understaffing, they sometimes have trouble getting reports from DHHR workers promptly.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

Waitlists for Services

- Referral pathways have been supported by strong relationships with other organizations and outreach to the community. 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.

What they're saying

Region 3's multidisciplinary team programs, including attorneys, the probation office, school personnel, mental health providers, and family members, are active and successful. They review juvenile cases every 90 days and report to the judge in advance of court proceedings.

Region 4

Availability of Service

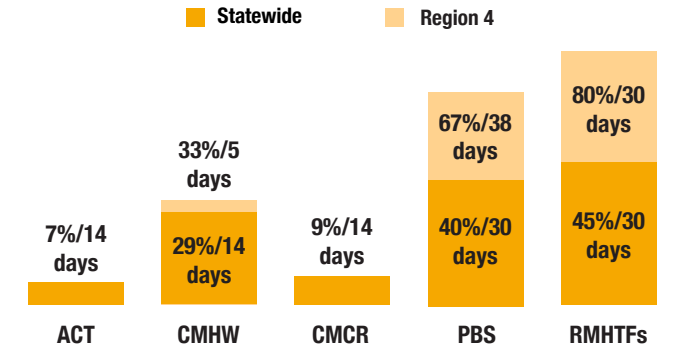
- Focus group participants in Region 4 agreed that their communities lacked the appropriate services to address the needs of children with severe emotional and behavioral problems.
- Participants in the rural areas reported challenges with transportation and an overall lack of medical, school-based, and community-based providers to address the mental health needs of children and families.
- Region 4 has seen an increase in telehealth services due to COVID-19 as a replacement for group therapy or in-home visits. Reports suggest that telehealth is not as successful as in-person services, as many families struggle with faulty internet connections and prefer in-person over virtual interactions.
- ACT is not currently offered in Region 4 but was recently expanded to cover the entire state.

Workforce Capacity and Recruitment

- 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.

Waitlists for Services

- Long waitlists and a lack of local providers often force families to seek treatment outside their county or state. It can take up to weeks or months to get proper services.
- Participants discussed that more in-home services could alleviate transportation and waitlist issues and that supportive services for parents are needed.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

What they're saying

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.

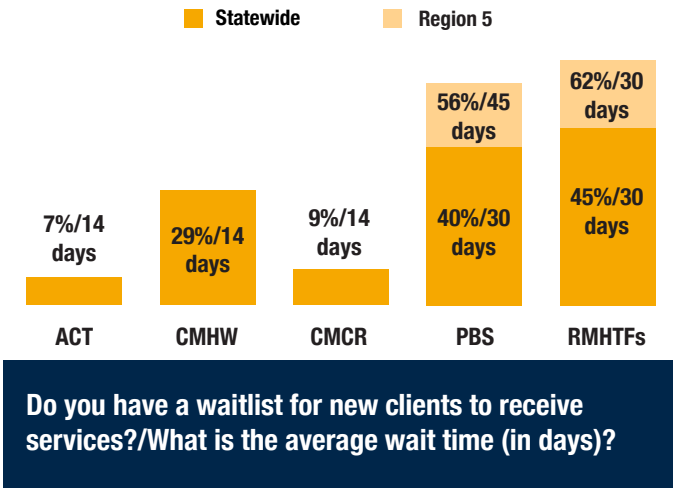
Region 5

Availability of Service

- Providers in Region 5 noted a shift in treatment, where more community resources are being offered after residential placement and information referral pathways prioritize community-based options.
- Key informants explicitly described reducing the need for residential services, and believe they are working toward that goal. Providers were well connected with CMCRS services and stated the agency was "fabulous" with referring to outpatient, in-home, wraparound, and Safe at Home programs.
- Although key informants reported success with referrals, there are gaps in knowledge about who offers services and programs.

Workforce Capacity and Recruitment

- Although staffing has seen some successes in salary adjustment and having enough workers to cover services (specifically in RMHTFs), high caseloads combined with lower WV salaries compared to surrounding states contribute to higher turnover in the field.
- 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.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

Waitlists for Services

- During qualitative interviews, there were no mentions of waitlists being an issue in Region 5.
- Survey data from organizational leaders and administrators aligns: no perceived waitlists were reported in ACT, CMHW, or CMCRS services.
- Waitlists for PBS and RMHTFs in the region, however, are above the wait times reported statewide.

What they're saying

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.

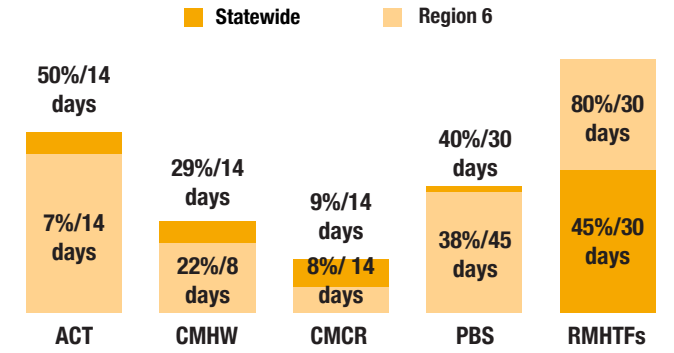
Region 6

Availability of Service

- In terms of mobile crisis, CMCRS is provided in Region 6 despite the lack of staffing and shortage of therapists.
- One provider noted that although CSEDW is now available, they have not formally started offering those services but hope to offer in-home services soon.
- Focus group 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.

Workforce Capacity and Recruitment

- Staff shortages and high turnover limit the services organizations can offer in Region 6.
- 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.
- Those who are hired are often inexperienced and require significant training before they can begin working and organizational leaders and administrators reported that high turnover rates were commonplace in their locations for all positions.



Do you have a waitlist for new clients to receive services?/What is the average wait time (in days)?

Waitlists for Services

- 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 RMHTFs.

What they're saying

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.

Appendix: Topical Index

Topical Index

The topics covered in the Findings and Visualization Report are reported in more detail on the following sections and pages in the System and Community-Level Evaluation Report, revised in June 2022.

Topical Index Continued

Topical Index Continued

Topical Index Continued