Identifying and Meeting Children's Behavioral Health Needs:

Current Policies, Perspectives, and Opportunities

A Report to the West Virginia Legislature

Published by:
Bureau of Business and Economic Research
College of Business and Economics
West Virginia University

150 Clay St.
Morgantown, WV 26501
(304) 293-7831
bebureau@mail.wvu.edu

Corey Colyer, Ph.D. — Associate Professor
Chair of the Department of Sociology and Anthropology
West Virginia University
Corey.Colyer@mail.wvu.edu
(304) 293-8174

Tracy Morris, Ph.D. — Eberly Distinguished Professor
Chair of the Department of Psychology
West Virginia University
Tracy.Morris@mail.wvu.edu
(304) 293-4098

Carrie Rishel, Ph.D. — Associate Professor
School of Social Work
West Virginia University
Carrie.Rishel@mail.wvu.edu
(304) 293-6377

December 2012

Table of Contents

Executive Summary

Every year, the state of West Virginia places between 40 and 60 young children under the age of 12 in residential care facilities in other states. The ultimate goal of policymakers and those involved in the welfare of these children is to best serve their needs and provide for the best future outcomes. This report provides an overview of the current policies and procedures in place for dealing with foster care and considers the benefits and challenges associated with serving some or all of these children in West Virginia.

There are advantages to serving children in-state, including the opportunity for better oversight by state officials, continuity of educational curriculum, and the potential for a smoother transition back to the child's home community at the conclusion of the residential stay. However, we also note some challenges associated with serving children in-state, including treatment availability and bureaucratic barriers.

Perhaps the most fundamental question in determining how much effort should go into establishing in-state residential care for young children is whether the children and state would be better served focusing these efforts on alternative care strategies. Residential care is expensive relative to community-based approaches and there is no convincing evidence that outcomes are better. However, there is a great need to address the behavioral health needs of children and lack of appropriate community-based services has been identified as a major issue in West Virginia. Our research efforts to interview state officials, pediatricians, and psychological, social work, and court professionals will highlight areas where the state might be able to focus efforts on early intervention and community support.

We interviewed a variety of key informants from different stakeholder groups including Child Protective Service (CPS) caseworkers, CPS administrators, state-wide administrators within DHHR, child service providers, and representatives from relevant

professional groups (including attorneys who provide Guardian ad Litem representation to children placed in out-of-state facilities). These informants were asked to identify the systemic issues affecting children's behavioral health from their professional point of view. In addition to these interviews, the research team also surveyed licensed psychologists practicing in the state of West Virginia (results are provided in the Appendix).

Key Points

- Prevention services are essential to reduce mental and behavioral health problems.
- Early intervention is a key to changing system outcomes—the longer (and earlier in life) a child is placed in group care, the less likely he or she is to be able to do without it. Early intervention, prevention, and holistic care approaches supported by local community investment are critical to achieving success.
- Strengthening the West Virginia professional workforce capacity to address specialized issues such as trauma experiences of young children may reduce the need for out-of-state placement.
- Treatment professionals, social workers, and Guardian ad Litems believe that reliance on out-of-state placement of children can only be reduced when we improve the system of care in West Virginia.
- Implementing models of service delivery that identify and effectively address both child and parent or guardian mental and behavioral health needs is critically needed in order to support families, therefore reducing the need for the residential placement of young children. In order to support the goal of keeping families together, integrated models of mental health and substance abuse treatment for parents are clearly needed, especially in rural areas.
- The state should continue to support the efforts of the Bureau of Behavioral Health and Health Facilities (BBHHF) to assess and build statewide behavioral health workforce

capacity. A particular focus on developing capacity to serve the behavioral health needs of West Virginia children and families should be emphasized as part of these efforts.

- Strategically using resources to strengthen the overall foster care system and implement an evidence-based treatment foster care model would likely reduce the number of young children placed in residential settings.

- The Legislature may wish to commission a thorough investigation of the Administrative Services Organization (ASO) that coordinates socially necessary services. ASO is not within the scope of this report, but plays a large part in the out-of-state placement of children.

- While there is a shortage of residential "beds" for children under age 12, increasing capacity is not necessarily an ideal solution.

- Many more children could remain in family-based care if appropriate and accessible community-based clinical and support services were available to families.

- Developing and implementing a statewide strategic plan to meet the behavioral health needs of West Virginia children and their families would likely facilitate more efficient use of resources, reduce the number of out-of-state placements, and promote improved child and family outcomes.

- Fully implementing the Expanded School Mental Health (ESMH) model throughout West Virginia is an important step to identifying and meeting the behavioral health needs of the state's children.

- West Virginia should closely investigate the new Medicaid regulations under the ACA, including potential use of waivers, in order to craft a statewide Medicaid package that includes the full range of supports and services that optimizes children's outcomes and reduces the need for residential care.

- As the state works to strengthen community-based services for children and families and reduce barriers to access, the Service Array Assessment process will provide valuable information and direction regarding what types of services are most needed in each community.

- West Virginia should consider adopting an evidence-based treatment foster care model as part of a strategic plan to meet the behavioral health needs of the state's children and families.

- Current residential providers should be allowed greater flexibility in Service Provision. Respite care is known to provide a key support for families and may assist in preventing failed placements for foster and adoptive families struggling with difficult child behavioral issues. Current state efforts to creatively utilize available residential facilities should be supported.

- Children should be kept in their homes whenever possible, and should be kept close to home when external placement is necessary.

- The state's DHHR caseworkers do a reasonably good job trying to keep children in their home communities despite impossible caseloads.

- The state severely lacks community-based resources to support clients in the community.

- The state's child welfare bureaucracy at times works against the best interest of their clients.

- Some children require the structure and resources that are only available in residential treatment centers.

- More children could be served locally in West Virginia communities with improvement to the state's system of care.

- The state's social service delivery mechanisms can get bogged down in bureaucratic red tape, for which appealing to a judge's authority is the best remedy.
- The four Guardian ad Litems interviewed for this project believe that the state's case management capacity is a limiting factor in maximizing the number of children who are served locally rather than in out of state placements.
- The formation of Multi-systemic Therapy (MST) Teams within the major catchment areas/population centers in the state will enhance the system of care for families in West Virginia. While the training and licensing of MST teams will require initial financial investment from the state government, the cost savings would prove substantial over the long term.

Child Placement Policy & Procedures

This section of the report outlines the policy framework that shapes placement practices both within and outside of West Virginia. Child placement is influenced by three levels of policy (federal law, state law, and agency policy). Federal law provides the overarching framework to which state law and agency policy conform. State law orients the courts and their officers, as well as state agencies. Agency policy provides state workers with a blueprint for action.

Federal Law

Federal policy has long shaped child welfare practice on the state level. With the Social Security Act of 1935 (see Title IV-B), the federal government began providing funds to the state for foster care provision and preventative services. This was expanded in 1961 with the Aid to Dependent Children program, which included foster care maintenance payments. This legislative structure places responsibility for delivering care on the state, while reserving oversight responsibility for the federal government.

Over the past forty years, Congress has passed laws that further shape child welfare practices. The Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (P.L. 93-247) and amended and reauthorized by the Child Abuse Prevention and Treatment Act Amendments of 1996 (P.L. 104-235), provided federal funding to the states in support of prevention, assessment, investigation, prosecution, and treatment activities, and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) set the tone and precedent for child welfare practice over the next thirty years. It mandated that states take a child's ongoing needs for stability and nurturance into account in the case planning process. Using the financial lever of federal foster care matching funds, the law required

states to demonstrate that they had made "reasonable efforts" to minimize out of home placements. Additionally, states were required to establish reunification programs for children in foster care and to develop prevention programs to intervene before out-of-home placement was necessary.

Under the law, when out-of-home placement is necessary, children should be placed in the least restrictive setting as close to a parent's home as is practical. A court or its designated agency was required to review the child's status every six months to determine what was in his or her best interest, with an emphasis placed on returning the child home as soon as possible.

The federal government expanded on these principles in the Family Preservation and Support Services Program Act of 1993 (P.L. 103-66). This law encouraged the states to build and coordinate a robust set of family-focused services for troubled children and their families. Emphasis was placed on activities that would prevent out-of-home placement and the states were encouraged to work collaboratively with community based organizations. This legislation encouraged broad community stakeholder cooperation to deliver child welfare services.

Five years later in the Adoption and Safe Families act of 1997 (P.L. 105-89) federal policy shifted to make children's safety the paramount concern for all child welfare decision making. The family preservation and reunification priorities had to be balanced with a child's need for safety and permanency. States were required to initiate court proceedings to "free a child for adoption" after he or she had been in foster care for at least 15 of the most recent 22 months. This legislation also increased accountability measures, requiring states to document child-specific measures to move children into adoptive homes.

This body of federal legislation shapes West Virginia law and policy. Specifically, each law modified Title IV-B and IV-E of the Social Security Act, which spell out the criteria

for receiving federal reimbursement for prevention and foster care services. "These regulations are incorporated into the policies and procedures of the Department," (Department of Health and Human Resources 2012a).

West Virginia Law

West Virginia law has been crafted to be consistent with federal mandates. Relevant sections of the code are summarized below.

West Virginia law calls for a coordinated system of child welfare and juvenile justice that is family focused, attuned to the mental and physical welfare of children, and that recognizes the fundamental rights of children and their parents (see §49-1-1 of the West Virginia Code). The state intends to "provide services that are community-based, in the least restrictive settings that are consonant with the needs and potentials of the child and his or her family," [§49-1-1. (a)(7)]. Under the Code, removal of children from the custody of their parents should only occur when doing so is consistent with the child's best interest.

Consistent with the federal language in the Adoption Assistance and Child Welfare Act of 1980, West Virginia defines "community-based" as facilities, programs, or services "located near the juvenile's home or family" and involves "community participation in planning, operation and evaluation," [see §49-1-4.(3)].

The law calls for coordination of services under the guiding framework of strategic treatment planning. These treatment plans may call for the placement of a child outside the home of his or her parents. The circuit court has the authority to order compliance with these treatment plans or an alternative that places juveniles in community-based facilities, which are "the least restrictive alternatives appropriate to the needs of the juvenile and the community," (§49-5-11a. et seq.). In cases where the court orders a juvenile to be placed in an out-of-state facility, the reasons the placement was not made in an in-state facility should be set forth in the order (§49-5-13.(c).).

West Virginia Code further establishes a requirement for counties to make use of multidisciplinary teams (MDTs) to coordinate and oversee treatment service delivery. West Virginia's MDT system is characterized by two types of teams: investigatory and treatment oriented teams. This is a system where MDTs were imposed by legislative action rather than being homegrown, which is how they are created in most jurisdictions.

State law requires that each county establish multidisciplinary teams (MDTs) to assist the courts and the Department of Health and Human Resources (DHHR) in child abuse and neglect proceedings, as well as in youth services proceedings (see §49-5D et seq.). A treatment MDT advises the court on treatment and placement recommendations and monitors ongoing treatment delivery. State code specifies that MDTs in West Virginia are to be convened and directed by the family's caseworker from the DHHR and consist of (a) the child, when deemed appropriate ; (b) the child's custodial parent or parents, guardian or guardians, and/or other immediate family members; (c) legal counsel for the child (e.g., a Guardian ad Litem) and for the parents (counsel to the adult respondent); the prosecuting attorney (or a designated representative of the same), who functions as legal counsel for the DHHR; (d) when appropriate and available, a court appointed special advocate (CASA); a member of the local child advocacy center; appropriate school officials; and "any other person or an agency representative who may assist in providing recommendations for the particular needs of the child and family."

The MDT process is the state's cornerstone strategy for ensuring that each child has an appropriate treatment and permanency plan (United States Children's Bureau, 2009). By code, the MDT convenes at least once every 90 days. This creates an opportunity to bring all the stakeholders together to discuss progress and/or make adjustments. Note that a recent study of West Virginia MDTs found that the implementation of this policy varies considerably across the state (Colyer & Plein, 2008).

DHHR Policy

West Virginia's Child Welfare services are administered by the Bureau of Children and Families under the Department of Health and Human Resources (DHHR) [see §49-1-1(c)]. Under the code, the DHHR must comply with federal regulations and "receive and expend federal funds for these services" [see §49-1-1(d)]. Children placed into secure detention for acts of delinquency are under the administrative jurisdiction of the State's Division of Juvenile Services (DJS), which is a sub-entity of the Department of Military Affairs and Public Safety. Under §49-1-1(e) the DHHR and DJS are required to present a joint plan for a coordinated system of child welfare and juvenile justice. The DHHR has published several policy documents on its website.[1] Most relevant to this inquiry are the Foster Care (Department of Health and Human Resources 2012a) and Youth Services Policies (Department of Health and Human Resources 2012b).

Foster Care Policy

West Virginia's child welfare system coordinates service delivery to nurture the healthy development of children and their families. Out-of-home placements are guided by the state's foster care policy, last revised on June 14, 2012 (Department of Health and Human Resources 2012a). The term "foster care" refers to "a comprehensive, complex array of services for children who, for any number of reasons, cannot live with their families" (Department of Health and Human Resources 2012a, p. 4). Accordingly, children placed in out-of-state residential placements fall under the purview of this policy. The policy establishes an underlying philosophy for state practice that ensures compliance with federal law.

[1] http://www.wvdhhr.org/bcf/policy/

According to the policy foster care placements should be temporary and targeted. "The time the child is in out-of-home care must be productive in terms of services provided to address the identified needs of the child in order for him to grow, develop, and achieve his [sic] permanency plan" (Department of Health and Human Resources 2012a). Children placed into facilities—in-state or out-of-state—should be placed for specific reasons. These reasons should reflect child-centered and family-focused principles. Indeed, the family should play a featured role in decision-making about the child's future.

Elements of Foster Care Placement

The placement process involves six elements—Intake, Assessment, Case Planning, Case Management, Case Review, and Case Closure—that together constitute a continuum of care providing for children. State personnel assess the child's needs at the intake stage to determine which services are appropriate. This includes compiling information in the presenting problem, a summary of prior and current services, current educational and medical information, and the child's physical, emotional, behavioral, and developmental characteristics. This information is vital to determining which placement options are appropriate.

Following intake, caseworkers conduct several assessments on the child and his or her situation, which the multidisciplinary team uses to construct a treatment plan. In compliance with §49-5D-3 of the West Virginia Code, the Bureau for Children and Families established a Comprehensive Assessment and Planning Process (CAPS) for children and families receiving child welfare services from the DHHR. This process is required for juveniles involved in court proceedings and recommended for youth and families receiving services from the Bureau for Children and Families. CAPS includes psychosocial, physical adaptive functioning, and needs assessments for the child and family, followed by more specific assessments calibrated to the child's situation. The details of these assessments are processed into a Comprehensive Assessment Report (CAR) which is provided to the Multidisciplinary Team.

The case plan is prepared through the collaboration of a multidisciplinary team. The policy dictates that the formal case plan should be developed and documented in the management information system within 60 days of a child entering care. This plan must include permanency provisions to ensure that foster children do not drift and languish in administrative limbo. To comply with the dictates of the Federal Adoption and Safe Families Act, West Virginia uses a concurrent planning model that articulates a primary permanency target (such as reunification in the family home) as well as an alternative permanency target (such as adoption) (See Section 4.5).

Once a child has been placed under the guiding logic of a case plan developed by a multidisciplinary team and informed by assessments, his or her case is actively managed by the DHHR. The child's caseworker is required to maintain regular contact with the child while he or she is in placement. The Child and Family Services Improvement Act of 2006 (P.L. 109-288) now requires states to demonstrate that a caseworker has face to face contact with children in care at least once every thirty days. Case management implies that the child is receiving appropriate medical care and educational services.

The case is then reviewed multiple times at different junctures by different bodies to monitor progress and to ensure that the DHHR has met its goals. Each child in foster care will be reviewed quarterly by the court until the child achieves his or her permanency plan. For children who remain in care 12 months or longer, there is a yearly permanency hearing and review to ensure that the concurrent plan is appropriate to the child's needs. These case reviews can lead the circuit court to file a modification of dispositional order to effect appropriate change.

Finally, in the case closure phase the child is discharged and treated according to the terms of the treatment plan. Children discharged from a Psychiatric Residential Treatment Facility may require additional placements or advanced preparatory work to ensure a smooth transition.

Referral Policy

The State's foster care policy differentiates family foster care from residential placement. There are three levels of non-family foster care. Placement in a group home setting is justified in situations where family dynamics would undermine the therapeutic efficacy of placement in a surrogate family environment, or in situations where the child's behavior is sufficiently challenging to require greater structure, routine, and expertise that a group home provides. Group home placement does not involve specific on-site therapeutic interventions (counseling services, school, etc).

In contrast, residential treatment facilities do provide on-site therapeutic interventions. By policy, the state pursues residential treatment placement to meet the child's learning, social, or motor skill needs. Section 2.4.7 of the policy specifies specific characteristics for residential placement (Department of Health and Human Resources 2012a):

a) The child's emotional disturbance is so severe as to require comprehensive, intensive treatment and services (i.e., individual and/or group psychotherapy, special educational needs, vocational training, social and cultural enhancement, after-care services) and on-site supervision.

b) The child has serious behavior deviations (i.e., severe aggression, chronic runaway, fire setting, sexual acting out, chronic truancy, drug usage, suicidal gestures, extreme temper tantrums, severe relationship problems, etc.)

c) The child is depressed, has low frustration tolerance, personality disorders, psychosomatic illnesses, emotional development [sic], mild or severe forms of eating disorders, impaired thought or affect disorders, or exhibits other symptoms of serious emotional and/or thought dysfunction.

d) The child is a danger to himself or others, or is severely withdrawn.

e) The child cannot function in a public school setting because of his [sic] acting-out behavior and/or severe learning deficits.

f) The child needs extensive professional help in areas of social skills, learning skills, and/or motor skills.

g) The child exhibits pre-psychotic or psychotic symptoms that require a closed setting.

Lastly, Psychiatric Residential Treatment is the most restrictive type of care used with West Virginia foster children. This placement type is reserved for children who have been diagnosed with a psychiatric, emotional, or behavioral disorder so severe that it constitutes a danger to the child or others. Such placements are a matter of expediency not convenience.

This report provides a summary of the state's Foster Care Policy to convey the seriousness of a residential placement. If the state's policies are followed, children should only be placed into group, residential, or psychiatric facilities when there is a clear and compelling therapeutic reason. If there are no suitable placement alternatives in-state, then the multidisciplinary team must consider out-of-state options.

Children are only to be placed in those facilities that meet the DHHR's Home-Finding Policy, Child Placement policy, or Group Residential Licensing regulations. Care in residential treatment centers must be provided by specially licensed facilities in situations dictated by the child's physical health, mental health, and safety needs.

Placement in residential treatment facilities must be considered in consultation with a DHHR supervisor and the child's Multidisciplinary Team. First consideration is to be given to facilities that have a current contract with the Bureau for Children and Families and/or are approved as West Virginia Medicaid providers. Placements may be made at non contract facilities and non-Medicaid providers, but a formal contract must be prepared and executed before the placement is made.

Title IV-E Eligibility/Reimbursability

The West Virginia Foster Care Policy has been written to ensure that the state maximizes federal reimbursement for providing child welfare services under Title IV-B and Title IV-E of the Social Security Act.

Title IV-E of the Social Security Act is a federally funded program that provides financial support to care for children in Foster Care. A review of each child coming into foster care must be conducted by the Division of IV-E Finance to determine the child's eligibility for Title IV-E funds. When a child is determined to be eligible and reimbursable for Title IV-E funds, the DHHR is reimbursed a percentage of the expenses incurred in providing room, board and supervision to the foster child.

Under Title IV-B of the Social Security Act, states are required to have a systematic plan for child welfare services. This ensures that children receive appropriate and extensive care. The requirement that a caseworker meet with the child at least once every thirty days is enforced under Title IV-B reimbursements.

We cannot overstate the financial importance of compliance on these measures. Following procedure maximizes the federal reimbursement for providing services. Failure to follow procedure forces the state to find alternative means for funding treatment. What at times appears to outsiders as unnecessary bureaucratic red tape is often necessary to satisfy federal reporting requirements. This is an important concern when we turn to the comments of Guardian ad Litems.

Socially Necessary Services

Thus far, this report has focused on the State's Foster Care Policy and procedures as they relate to out-placement of children. However, the policy clearly notes that foster care is "a comprehensive, complex array of services" for children. The state provides these services through an "Administrative Services Organization" (ASO) which coordinates social service delivery under the label "socially necessary services". These services are differentiated from "medically necessary" services, which can be obtained through Medicaid. The ASO vets community-based service providers and authorizes them to render and bill the state for services. Policies and procedures regulating the Socially Necessary

Services system are set forth in a Utilization Management Guidelines document (APS Healthcare 2012).

While it is beyond the scope of this report to examine the ASO process in detail, it is important to recognize it as a core mediating factor in the out-of-state placement of children. As will be discussed later in this report, the Guardian ad Litems interviewed for this study found the system overly bureaucratic, bordering on incomprehensible. All conveyed anecdotes of children forced into out-of-home placement for want of appropriate community based services. The legislature may wish to commission a more thorough investigation into the ASO process.

Systemic Issues

The following sections highlight common themes raised in key informant interviews and focus groups conducted by the research team. The interviews and focus groups were conducted with a variety of different stakeholder groups, including Child Protective Service (CPS) caseworkers and administrators, state DHHR administrators, child service providers, and representatives from relevant professional groups. This section outlines some the systemic issues that the interviewed parties and focus groups associated with out-of-state placements of children, especially those under the age of 12.

Contributing Factors to Out-of-State Placements

There appear to be two broad factors leading to the out-of-state placement of children under age 12 for behavioral health treatment, the first being a lack of in-state psychiatric and residential facilities that serve children under age 12. In-state licensing of facilities is most often for ages 12-18. The number of West Virginia "beds" available for young children in Psychiatric Residential Treatment Facilities (PRTFs) is very limited and treatment specific (e.g. sexually reactive). There are also very few group home residential facilities that accept younger children. These facilities often have long waiting lists. Although there is limited in-state availability of residential-based treatment for young children, administrators within DHHR and representatives of in-state provider facilities agree that increasing the number of residential "beds" for children under age 12 is not necessarily the ideal solution.

The current policy framework emphasizes foster care (or family-based care) rather than residential treatment for young children. The shortage of community-based services, however, is a significant barrier to successfully supporting high-need children so they can remain in family-based care. A major theme raised in interviews and focus groups across a wide variety of key informants was the lack of accessible mental health services for children and parents in community settings. Caseworkers offered examples of calling

agency after agency, provider after provider, in search of outpatient community-based mental and behavioral health services for children and parents. The community service gap was emphasized from all levels (e.g. CPS caseworkers, local and statewide DHHR administrators, and residential providers). These stakeholders report that there are very limited services for families in the community, and even if some services are available, many families cannot access them because of Medicaid reimbursement limitations.

Service gaps exist for both child and adult mental and behavioral health services. For children, there appears to be a severe shortage of child psychiatrists, psychologists, and other child-focused providers (e.g. social workers and counselors) across the state. If children do not have access to these specialized providers in a community setting, their behavioral health problems often escalate to the point of requiring residential placement.

Another service limitation noted was the lack of behavioral health resources for parents. Parents struggling with mental health and substance abuse problems face a shortage of providers and long waiting lists to access services. It was suggested that many child placements could be prevented if caseworkers could access appropriate and accessible treatment for parents. In addition to the need for clinical services, respite services and other community-based support services are also needed to limit the need for residential placement. Across the board, stakeholders believe that many more children could remain in family-based care if appropriate and accessible community-based clinical and support services were available to families.

Process of Out-of-State Placement

There are two overall groups of young children who receive behavioral health treatment out-of-state: children within DHHR custody, who are placed out-of-state either through DHHR placement decision or by judicial order, and children in parental custody, who are placed in an out-of-state treatment facility by their parents.

Ideally a full clinical review process is completed prior to a child in DHHR custody being placed out-of-state. There is a Clinical Coordinator for each West Virginia System of Care Region who is responsible for facilitating clinical review teams to examine children at risk of being placed out-of-state or children already placed out-of-state. Although not all children placed out-of-state have a review conducted, a review is completed for most children in the younger age group. A child's caseworker can request a clinical review or the Clinical Coordinator can call a review based on his/her case log. The goal of the clinical review is to ensure the child is receiving appropriate treatment. All efforts are made to exhaust in-state options before a child is placed out-of-state. The review process includes contracting with a provider to complete a full psychiatric and psychological assessment, completing the CANS assessment, (Child and Adolescent Needs and Strengths), and meeting with DHHR staff and local providers. The clinical review coordinators and caseworkers use the West Virginia Placement Network, which is updated daily, to determine current availability of needed residential services in-state.

Once it is determined that a child needs out-of-state placement (because the appropriate level of treatment is not available in-state), the caseworker and other staff start investigating out-of-state options. The multidisciplinary clinical review teams make recommendations for placement based on the best interests of the child. In some cases, the clinical review process may happen after a child is already in placement out-of-state. This occurs when the level of the child's need necessitates immediate out-of-state placement (before a clinical review can be conducted) or when a child is placed out-of-state by judicial order (again, before a clinical review can be conducted). Judges vary in how familiar they are with the clinical review process; participants note that judicial decision-making may not always be assessment driven.

Although the majority of this report focuses on young children within state custody, it is important to note that many West Virginia children in parental custody also receive behavioral health treatment in out-of-state facilities. There appear to be numerous

barriers for parents to directly place children in West Virginia facilities, leading them to seek out-of-state options. These barriers include: West Virginia facilities that are licensed only to accept children within state custody; the absence of a funding stream other than BCF (Bureau of Children and Families) to pay for room, board, and supervision components of psychiatric treatment (in-state providers are therefore concerned about fiscal liabilities and may not accept direct placement from parents); and in-state facilities that will not accept direct placement from parents due to belief that parents may "pull the child out" at the first sign of a consequence or adjustment difficulty. These barriers converge resulting in funding mechanisms to access resources that may necessitate parents to relinquish custody of their children in order for them to access residential treatment in in-state facilities.

Monitoring of Out-of-State Placements

Once a West Virginia child in state custody is placed in an out-of-state facility, the child is visited by a caseworker once per month. These visits are deemed a "top priority," and examples of caseworkers flying out (in cases of child-placement in neighboring or distant states) on the last day of the month upon realizing a visit had not been completed. Regular multidisciplinary team meetings and court hearings (every 90 days) are also part of the monitoring process to ensure child needs are being met. Out-of-state providers supply progress reports and treatment plans, and caseworker visits are summarized for the court report. Child protective caseworkers and administrators report overall high-quality of out-of-state treatment facilities. Conversely, in-state providers report that many out-of-state facilities do not adhere to the high standards of excellence found in West Virginia facilities and note that out-of-state services are not regulated as closely as services in-state. All out-of-state placements, however, require an interstate compact agreement (which can take a week to a month to complete) that provides some assurance that out-of-state facilities are monitored and licensed by the state in which they are located.

Despite differing perceptions of quality of out-of-state facilities, caseworkers, administrators, and providers agree that once a young child is placed out-of-state, he/she is likely to remain out-of-state for many years. Usually the level of care needed is too high for the child to return to family or foster care. Moreover, once the child's needs are appropriate for foster care, out-of-state facilities are likely to arrange local foster care and continue to monitor the child. This is deemed in the best interests of the child as the out-of-state facility is most familiar with the child's behavior issues and support needed. However, this process results in many children remaining out-of-state for multiple years.

Process to Transition back to West Virginia

Most young children who transition from out-of-state placement back to West Virginia transition back to foster or pre-adoptive homes. Ideally, this is a slow, supported transition beginning with weekend visits, but sometimes the transition happens more abruptly with the child moved directly into the family-based care setting. Participants report that younger children do not struggle as much with the transition back to the West Virginia education system as compared with older children. The Department of Education provides transition specialists to assist in this move. There has been some recent effort to develop and implement community-based teams to assist with the transition process back to West Virginia, but stakeholders note that these teams are not yet operating as intended.

Professional Perspectives

As previously noted, the research team conducted a series of interviews and focus groups that involved parties including Child Protective Service (CPS) caseworkers and administrators, state DHHR administrators, child service providers, and representatives from relevant professional groups, in order to gain a real-world perspective of the out-of-state child placement process. The section provides a discussion of key recommendations that emerged from synthesizing the qualitative data collected from the interviews and focus groups. Interviews with court professionals and a survey of psychologists will be discussed in later sections.

Strategies to Reduce Out-of-State Placements

All stakeholders interviewed were asked about strategies to reduce out-of-state placements. Almost none recommended increasing in-state residential facilities or "beds" for younger children, with the exception of possibly a few more "acute care" options. Across the board, stakeholders agreed that resources would be better spent on strengthening community-based services and treatment-focused foster care rather than on an in-state residential facility for young children. Perhaps most notably, even current in-state residential providers, who could possibly benefit economically from the development of increased residential "beds", clearly state that introducing "more beds" is not the solution. There was remarkable consensus across multiple groups that West Virginia children should remain in West Virginia, or close to home, whenever possible, and that young children are best served in a family setting.

Caseworkers, administrators, and providers note how the current system often re-traumatizes children again and again, leading to multiple losses (e.g. separation from family of origin, separation from siblings, change of school system, multiple changes of foster placements etc), with each one increasing the likelihood of group-based rather than family-based care. All efforts should be made to avoid placing young children in long-term

residential care as both empirical evidence (Little, Kohm, & Thompson, 2005) and anecdotal reports from West Virginia stakeholders suggest that this is usually not in the best interest of the child and may increase the likelihood of poor developmental outcomes. Upon synthesizing the data collected from a variety of key stakeholder groups, several recommendations emerged related to reducing out-of-state placement and improving the outcomes of West Virginia children. The following recommendations will likely be most effective if implemented as a package, as they are overlapping and interdependent.

Key Recommendations

Develop and Implement a Unified Statewide Strategic Plan to Meet the Behavioral Health Needs of West Virginia Children and Families

At all levels, stakeholders report that the current services are fragmented and redundant. One participant stated, "There is one group doing this, one doing that, and lots of redundancy of effort – both in research of the problem and how to address it." Others noted that there are "so many silos," so many entities operating independently of each other. When asked about the "biggest challenge facing the West Virginia child welfare system," the majority of participants mentioned the fragmentation of services and lack of collaboration. Many noted that the lack of collaboration has been improving, but that there are still varying goals and philosophies among different entities in the system, making it difficult to move forward with a unified plan.

Recent practice efforts have addressed the formation of Community Based Teams (to assist with transition back to West Virginia of children placed out-of-state); Permanency Roundtables (training funded by the Casey Foundation to move to permanency more quickly for children under age 5); and WV DHHR policy changes requiring additional evaluation for children under age 9 prior to being placed out-of-state. There have also been multiple research efforts, including the ongoing work of the West Virginia Commission to Study Residential Placement of Children, the comprehensive

clinical review of all youth ages 16-21 in out-of-state placements, and the current study, *Identifying and Meeting Children's Behavioral Health Needs: Feasibility and Effectiveness of In-state and Out-of-state Alternatives.* Developing and implementing a statewide strategic plan to meet the behavioral health needs of West Virginia children and their families would likely facilitate more efficient use of resources, reduce the number of out-of-state placements, and promote improved child and family outcomes. Drawing from data collected as part of the current study, the following four recommendations should be incorporated as part of the strategic plan.

Focus Resources on Prevention and Early Intervention

Representatives from multiple stakeholder groups identified the need to focus resources on prevention and early intervention as a key strategy for reducing the need for residential placement of children. This is supported by recent national research and federal policy priorities, indicating that effective prevention services are an essential component of a comprehensive strategy to reduce mental and behavioral health problems. National research shows that half of all adult mental health disorders start by age 14 (Kessler, et al, 2005), and on average, first symptoms appear 2-4 years prior to an individual meeting diagnostic criteria for a mental health disorder (O'Connell, et al., 2009). A recent report by M.E. O'Connell et al. states that the federal government should make preventing mental, emotional, and behavioral disorders in young people a national priority, as they take a tremendous toll on the well-being of youth and their families, costing the United States an estimated $247 billion per year. The report notes that, "Interventions before the disorder occurs offer the greatest opportunity to avoid the substantial costs to individuals, families, and society that [mental health] disorders entail," (2009).

Interview and focus group participants emphatically voiced their support for state efforts to address the behavioral health needs of young children. They noted that West Virginia has recently focused efforts on examining older children in out-of-state placements and on the transition process for these children back to West Virginia or to adulthood. Until the

current study, however, not many efforts have focused on children in the younger age group. All see the need for early intervention as key to changing system outcomes. Many mentioned the need to "turn off the faucet." If we miss the opportunity to intervene early, we are "just wasting resources and spinning our wheels." Stakeholder experience suggests that if a child enters group care at a young age, he/she is likely to remain in group care throughout childhood or rotate in and out. Participants mentioned how difficult it is for young children to not become "institutionalized" in a group setting and note that young children have a hard time returning to a community setting once placed in group care.

Study participants noted that early intervention, prevention, and holistic care approaches supported by local community investment are critical to achieving success. They identified programs such as Head Start and Early Head Start, emphasizing the need for adequate funding for these programs to appropriately identify children in need and refer families to accessible services. Once children enter school, school-based services are an essential component of a comprehensive plan to meet children's behavioral health needs. Studies show that approximately 70-80 percent of children who receive mental health services receive them in a school setting, and for many, school-based services may be their only form of mental health treatment (Burns, et al., 1995; Hoagwood et al., 2001). As such, there is an ongoing national movement to expand school-based mental health programs. These programs, called expanded school mental health (ESMH) provide comprehensive mental health care to youth in the school setting (Tashman et al., 2000). Providing mental health services at school improves access and provides an entry point to a full continuum of services.

An example of this is Tucker County's implementation of the Expanded School Mental Health (ESMH) model. Tucker County has embraced this model and implemented an effective school-based mental health service system. Administrators within DHHR note that the rate of out-of-home placement has decreased in Tucker County following the implementation of ESMH. Currently in West Virginia, 68 School-based Health Centers serve

80 schools in 28 counties. Of these 68 centers, 35 provide behavioral health services. The West Virginia ESMH model emphasizes the full continuum of prevention, early intervention and treatment, and shared responsibility between schools and community mental health providers. Fully implementing the ESMH model throughout West Virginia counties is an important step to identifying and meeting the behavioral health needs of West Virginia children.

Strengthen Community-Based Services for Children and Families and Reduce Barriers to Access

Interviews and focus groups conducted with key informants suggest a critical shortage of community-based behavioral health services for children and parents. Part of this shortage of accessible services appears to be linked to Medicaid reimbursement policy. Representatives from various stakeholder groups note the need for community services that are reimbursed by Medicaid. For example, CPS caseworkers state that they face a continuous struggle to access mental and behavioral health services for children and families. Workers describe needing to call and "beg" for services for their clients, noting the few places who will accept their clients are so overbooked that they are unable to keep pace with the service demand.

One aspect of the struggle involves the Medicaid policy of not reimbursing for an evaluation of the "capacity to parent." Caseworkers often need this evaluation to make case decisions regarding the best interests of the child, but psychologists are no longer reimbursed for this assessment by Medicaid. Another example given is that Medicaid does not reimburse licensed social workers and licensed professional counselors at the same rate as other providers of independent practice, making it difficult for these professionals to operate independently of a behavioral health facility. Therefore, when parents seek independent professionals for child behavioral health assessment and treatment, they often must see psychologists or psychiatrists, who may be less available and more expensive. Often parents cannot access appropriate outpatient services prior to the

situation escalating to crisis level, at which point they move on to seeking residential or acute care, which is reimbursed by Medicaid.

This is currently a time of massive change in health care systems and delivery across the nation. The passage of the Affordable Health Care Act (ACA) in 2010 will likely lead to millions more Americans accessing health insurance through Medicaid, the Children's Health Insurance Program (CHIP), and the implementation of Health Insurance Exchanges. Behavioral health benefits will be included in these policies and covered at parity with physical health coverage based on the 2008 enactment of the Mental Health Parity and Addiction Equity Act. A recent Issue Brief from the Substance Abuse and Mental Health Services Administration (SAMHSA) summarizes key changes under the ACA as related to children's behavioral health (Wotring & Stroul, 2011). The brief notes that specific provisions of the ACA encourage states to integrate behavioral health and primary care for individuals with chronic problems through the use of health homes. States are also granted some flexibility through the development of essential benefits packages for Medicaid and for other insurance policies.

To optimize children's behavioral health outcomes, it is recommended that state Medicaid policies cover a comprehensive array of services, including services and supports that have not traditionally been covered under insurance benefit packages. This approach has been shown to redirect limited resources in a way that reduces the need for residential care. Specifically, traditional plans "typically include only a very basic behavioral health benefit, often limited to traditional outpatient and inpatient services rather than the wider range of services that is optimal for children's behavioral health. As a result, children with serious and complex behavioral health disorders do not receive intensive services and supports, and are often placed in costly residential and inpatient settings due to lack of coverage for community-based alternatives," (Wotring & Stroul, 2011). The above statement reflects what was reported from key stakeholders in the West Virginia child

welfare system regarding the lack of accessible community-based services for families covered under Medicaid. The SAMHSA brief reports that:

> Under Medicaid, both the Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration and the Money Follows the Person (MFP) initiatives are showing that *the use of this broader array of services and supports can successfully maintain children with serious disorders in their home, schools, and communities, and that this approach is more cost effective than expensive long-term residential treatment*. On the prevention side, some states that provide early childhood mental health consultation in early child care and education settings are realizing cost savings by intervening early to address potential problems before they develop into more serious problems requiring intensive and costly interventions at a later stage. (p. 12, emphasis added)

West Virginia should closely investigate the new Medicaid regulations under the ACA, including potential use of waivers, in order to craft a statewide Medicaid package that includes the full range of supports and services that optimizes children's outcomes and reduces the need for residential care.

A particular lack of services for children who have experienced trauma was highlighted in several interviews and focus groups. Professionals noted the severe lack of professionals in West Virginia trained or certified to work with young children who have experienced trauma. Anecdotal evidence from caseworkers suggests that most young children placed out-of-state have experienced trauma. When discussing the prevalence of trauma among young children placed out-of-state, caseworkers noted that the diagnosis of bipolar disorder appears to be related to trauma experience. Caseworkers and administrators mentioned that the rate of diagnosis of bipolar disorder in young children is dramatically increasing. Direct quotes include "bipolar is the new ADHD" and "It's gotten to the point where 'bipolar' doesn't mean anything because it is so frequently used." Workers are familiar with the recent efforts in West Virginia to implement "trauma-informed practice," but note the reality seems to be a young child is given a diagnosis such as bipolar disorder and then the trauma experience is not fully examined or addressed.

Caseworkers indicate that when young children are placed out-of-state, one of the main factors in determining an out-of-state placement facility is the ability to treat trauma-related problems. It is possible that strengthening the West Virginia professional workforce capacity to address specialized issues such as trauma experiences of young children may reduce the need for out-of-state placement of young children.

Strengthening clinical and support services for children in community settings must also be accompanied by enhanced services for parents. Integrated services for both children and parents are needed to support the goal of children and families remaining together. Integrated service delivery models are especially needed when addressing child and family mental and behavioral health needs as children of parents with a mental health disorder are at much higher risk than other children for the development of mental health problems. For example, the family risk and transmission of depression (Beardslee & Podorefsky, 1998; Lieb et al., 2002) clearly suggests the need for an integrated approach to child and family prevention and treatment of this disorder, yet an integrated approach with this population is not common practice (Weissman & Olfson, 2009). Implementing models of service delivery that identify and effectively address both child and parent or guardian mental and behavioral health needs is critically needed in order to support families, therefore reducing the need for the residential placement of young children.

Caseworkers cite mental health and substance abuse treatment as the most needed services for parents involved with DHHR. In order to support the goal of keeping families together, integrated models of mental health and substance abuse treatment are clearly needed. Although co-occurring mental health and substance abuse disorders are quite common, treatment interventions are typically separated and target either the mental health disorder or substance abuse without addressing how the two intertwine and affect each other. Treatment models for co-occurring mental health and substance abuse disorders are often either parallel, with services often fractured and delivered by different clinicians, or sequential, with clients treated for one diagnosis at a time (Petersen & Zettle

2009). Treatment models that address both issues in an integrated fashion, however, lead to better outcomes for patients (Chi, Satre, & Weisner, 2006). Integrated models of treatment are especially needed in rural areas as studies show that rural clients with co-occurring mental health and substance abuse disorders usually receive treatment for only one issue, not both (Anderson & Gittler, 2005). When moving forward with a statewide strategic plan to meet the behavioral health needs of children and families, West Virginia should explore models of integrated treatment for rural parents with co-occurring mental health and substance abuse disorders.

In order to strengthen community-based services for children and families, the state must focus on building the behavioral health workforce capacity. The West Virginia Bureau of Behavioral Health and Health Facilities (BBHHF) is currently in the process of completing a behavioral health workforce capacity assessment. This assessment, funded by a SAMHSA Strategic Prevention Enhancement Grant, is the first of its kind in West Virginia and was implemented to augment the anecdotal evidence that pointed to lack of behavioral health workforce capacity. Results from this statewide assessment should be available soon and will be used to inform the state workforce goal to "Build the capacity and competency of West Virginia's Behavioral Health Workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services" (WV BBHHF, 2011). The state should continue to support the efforts of the BBHHF to assess and build statewide behavioral health workforce capacity. A particular focus on developing capacity to serve the behavioral health needs of West Virginia children and families should be emphasized as part of these efforts.

The West Virginia System of Care has put considerable effort into assessing service gaps in various communities through the Service Array Assessment process. The West Virginia Service Array is a comprehensive process currently used to examine services for families across the state. This comprehensive process guides communities to examine services offered, how these services are offered, and determine what services are most needed in the

community. As the state works to strengthen community-based services for children and families and reduce barriers to access, the Service Array process will provide valuable information and direction regarding what types of services are most needed in each community.

Implement a Statewide Treatment-Focused Foster Care Model

Several concerns regarding West Virginia's capacity to provide specialized or treatment-focused foster care emerged during the interviews and focus groups conducted with key informants. Administrators within DHHR note this as a key service gap in the West Virginia child welfare system. Specifically, there is no evidence-based treatment foster care model in place in West Virginia. The specialized foster care system that began in the mid-1980s is not perceived as a true treatment foster care model, as the current model is not funded at a level needed for this service to be successful. Examples were provided of treatment foster care models that support wrap-around care and access clinical expertise in the community and/or are funded at a level that would allow treatment foster care to operate as a full-time job for one parent in a foster family. Participants note that each treatment foster care family should support only one child, with the family serving as the permanent placement for that child. If operated as intended, many believe that an evidence-based treatment foster care model could prevent a large number of residential placements for young children.

Several evidence-based foster care models have been shown to be cost-effective and successful when evaluated using rigorous research designs. For example, Multidimensional Treatment Foster Care (MTFC) was developed as an alternative to group or residential treatment and has been shown to be one of the most cost-effective early intervention programs, with a net savings of $24,290 per youth (Aos et al., 2004). Another model, the Casey Family Program, is estimated to save $6.3 billion per year if implemented with all youth entering foster care nationwide (Zerbe, 2009). The authors note that "there will be real net benefits for states that are moving their foster care systems in new directions by having their public agencies accredited by national organizations, lowering

caseload sizes, and providing an array of high quality services." In addition, "investments in quality foster care for [youth] are associated with dramatic reductions in the rates of mental disorders and substance abuse later in life" (2009). West Virginia should consider adopting an evidence based treatment foster care model as part of a strategic plan to meet the behavioral health needs of West Virginia children and families.

Although most interview and focus group discussion regarding foster care focused on treatment-based foster care, participants also noted that the general foster care system in West Virginia needs improvement. Specific needs mentioned included better training for foster families, more focus on the "matching" process, and funding allocated for recruitment of foster families. Providers note that if they are successful in their permanency efforts to transform a foster home into an adoptive home for a child, they "lose" that family as a foster family. They offered examples of other models that provide a "bonus" to agencies upon successfully reaching adoption that is then spent on recruiting a new foster family. Representatives from various stakeholder groups highlighted the critical need for success in the foster placement process. Each failed placement results in another "loss" for a child who has already experienced multiple losses. If there is no other foster family available upon a failed placement, children may be unnecessarily placed in group home care, exposing them to behaviors and social influences that may negatively affect their individual development. In the words of providers, young children "see things they don't need to see"; "We can all tell stories of group care that doesn't need to be." Strategically using resources to strengthen the overall foster care system and implement an evidence-based treatment foster care model would likely reduce the number of young children placed in residential settings.

Allow Current Residential Providers Greater Flexibility in Service Provision

This recommendation draws mostly from discussion with representatives from ten in-state provider agencies, ranging from inpatient psychiatric facilities to group home residential facilities. Notably, none of the providers who participated in the interviews and

focus groups recommended adding additional residential slots or "beds" to in-state facilities. Instead, they stressed the need to comprehensively examine: what kind of in-state residential care is available; what kind of in-state residential care is needed; and which facilities are willing to reconfigure in order to meet the current needs of the state.

Although providers clearly communicated their willingness to re-configure services if needed, they also emphasized the focus for young children should be to keep them in a family setting. One specific need mentioned involved the ability to provide respite care to meet the needs of families in the community. Providers noted that allowing current in-state providers greater flexibility in service provision would allow residential facilities to provide a few beds for short-term respite care. Several providers stated that many of their residential youth leave the facility for weekend home visits. As the facilities retain their staff and services over the weekend, flexibility in service provision would allow them to offer short-term respite care for families in the community. Respite care is known to provide a key support for families and may assist in preventing failed placements for foster and adoptive families struggling with difficult child behavioral issues.

Another specific need identified by DHHR administrators was an in-state option for non-custodial children (i.e. children remaining in parental custody) in out-of-state psychiatric facilities to "step-down" in care once they no longer meet the medical necessity requirements for the out-of-state facility. Due to licensing and funding restrictions in West Virginia, most in-state residential facilities provide services only to youth in state custody. As mentioned earlier in this report, the lack of in-state options for non-custodial children may place families in the difficult situation of having to choose between out-of-state care options or voluntarily relinquishing custody to the state so their children can access in-state services. Addressing these barriers to in-state residential care for non-custodial children would decrease the number of West Virginia children in out-of-state facilities.

Current state efforts to creatively utilize residential facilities should be supported. For example, the goal of the West Virginia "Bridges" program is to transform residential

facilities into a “hub” of excellence in communities. Under this model residential facilities would offer a full continuum of care services for children and families, with the goal of keeping children in family-based care whenever possible. When discussing this effort, as well as other creative service option possibilities, providers highlight the need for funding flexibility in order to pursue these innovative service approaches.

Guardian ad Litems

While all of the agents operating in the Child Welfare system are pledged to pursue "the best interest of the child", only the Guardian ad Litem has the child's specific interests as his or her sole responsibility.

Role of the Guardian ad Litem

The Guardian ad Litem (GAL) is an officer of the court appointed to protect the child's objective interests. GALs represent the child's interests and position from the time a petition is filed, which initiates the child's involvement with the court, through the disposition of the case. The GAL is responsible for minimizing the disruption of a child's permanency (see "Guardians Ad Litem", Rule 21 - West Virginia Trial Court Rules).

More than a mere fact-finder, the GAL is charged with carefully assessing the child's circumstances and zealously advocating for his or her best interest (See Syl. Pt. 5, In Re: Jeffery R.L (1993). Under no circumstances should the Guardian ad Litem defer to other parties in a case, such as the parents or a State agency, when doing so would contradict the best interests standard (ABA, 1996).

The child's various needs and interests almost always come into conflict. For instance, the decision to place a child in an out-of-home facility may be necessary on safety or therapeutic grounds, yet it undermines the child's developmental need for stability and familiarity. A properly functioning Guardian ad Litem critically assesses the conflicting concerns and investigates plausible alternatives. The best interest position is then advanced on the basis of this assessment.

The American Bar Association (1996) has identified five specific actions that Guardian ad Litems should always take with children in abuse and neglect cases. We believe these actions extend to all other court activities in which a Guardian ad Litem is appointed:

1) *Meet With the Child:* An effective Guardian ad Litem establishes a relationship with the child. This allows them to determine the child's needs and concerns, as well as explain the complicated (and often frightening) procedures taking place in the court. The GAL should be someone the child can trust.

2) *Investigate:* The Guardian ad Litem should carry out an independent and broad investigation of the child's needs and concerns. He or she should review all pertinent medical, social, educational, and legal records for the child and family; and contact other parties in a legal action, such as the parents in an abuse and neglect proceeding, the probation officer in a delinquency proceeding, or a counselor if the child is in a residential placement. The child clients of GALs are often embedded in multiple social systems that influence their lives. The Guardian ad Litem is often the only participant in a juvenile proceeding that has access to information held by the others. GALs should actively verify the information coming from these sources.

3) *File Pleadings:* The children in the state's custody are entitled to be heard before the court. Actions taken by other parties (parents, treatment providers, school personnel, caseworkers, etc.) that are contradictory to the child's best interest may be presented to the court for remedy.

4) *Request Services:* While other parties have a responsibility in treatment planning and coordination, the Guardian ad Litem has the explicit responsibility of advocating for the services that will benefit the child. The GAL is authorized to make requests that go above and beyond treatment or service recommendations promulgated from the clinical review process if such requests are in the child's best interest.

5) *Negotiate Settlements:* Contentious differences of opinion emerge in child welfare cases. An effective Guardian ad litem seeks expeditious resolutions of disagreements that are congruent with the best interest of the child.

Perspective of Guardian ad Litems

The research team interviewed several professionals affiliated with the courts (a Judge, an administrative supervisor with the State's Supreme Court of Appeals, and several Guardian ad Litems). The consensus view emerging from these stakeholders is that children should be kept in their homes whenever possible, and should be kept close to home when external placement is necessary; the state's DHHR caseworkers do a reasonably good job trying to keep children in their home communities despite impossible caseloads; the state severely lacks community-based resources to support clients in the community and flexible policies; and the state's child welfare bureaucracy at times works against the best interest of their clients.

Background

Three attorneys who each currently represent juvenile clients as Guardian ad Litems and one attorney who functions as a counsel to Children and Families within a state government agency agreed to be interviewed for this study. They were asked four specific questions:

1) Under what circumstances (medical diagnoses, presenting problems, family dynamics, etc) would you consider a psychiatric hospital / residential facility placement to be in the best interest of your client?

2) Have you had direct professional contact with a case in which a child was placed in a residential facility outside the state of West Virginia? If yes, please describe the circumstances and the case outcome.

3) What resources do your clients need to remain in the community? In your opinion are those resources available? Where do you look to find them?

4) What, if any, changes would you like to see in the system of care for West Virginia's Children.

These Guardian ad Litems uniformly cautioned the legislature not to treat all out of state placements as equal.

On the Need for Residential Placement Options

As a general rule, the Guardian ad Litems interviewed for this study prefer to keep clients in their home communities. Distant placements strain already fragile family relationships. Accordingly, each attorney told us that all other options should be exhausted before pursuing a distant out-of-state placement. One remarked, "The more I [send kids out of state] the less I like it. And I didn't like it to begin with." Another remarked, "Thank God someone is starting to ask these questions. I hate kids going out of state, it screws them up terribly. We should be able to care for them closer to home."

The attorneys stressed that they are first and foremost responsible for looking after the "best interest of the child". Ideally, the children should remain in or close to their normal home, but other circumstances complicate the ideal. The child's medical, mental, and behavioral issues may force an out-of-home placement. Often, a residential placement is in the child's "best interest" when these issues are severe. "I'm talking about your budding antisocials; your predatory sex offenders. These are kids with deep-seated issues and I can't just let them go anywhere." Another attorney expressed frustration at the limited options she has for her clients dually diagnosed with a substance abuse condition and sexual misbehavior condition (elsewhere referred to in this report as "sexually reactive") or sex offender status. There may be services for the drug user and there may be services for the "sexually reactive" child, but it's increasingly difficult to find placements for the child meeting both classifications.

In the abstract a placement close to home is preferable to placements far away. However, the GALs don't believe that all residential facilities provide equal service or are equally effective. The GAL is obligated to advocate for the most effective services that will serve the child's best interest. "You need a professional therapist who will develop a plan

with a beginning, a middle, and an end. I get monthly progress reports from real counselors. (In contrast,) from these others, many in state, you only get what is necessary to bill Medicaid... not what you need to plan treatment." This GAL prefers to see his clients placed in out-of-state facilities that will properly engage in the therapeutic needs of the child, if the alternative is to keep the child in state but not provide proper treatment services.

The attorney quoted above also believes that children with issues severe enough to be placed in residential treatment should have a licensed therapist, "not just anyone who gets on the [DHHR's] list." Several of the GALs interviewed don't believe many of the instate facilities truly deliver the services they advertise. "We are putting together a list of facilities for a behavioral health committee I sit on. We ask the facility if they provide psychiatric care, and they say yes because they have a psychiatrist on their letterhead and maybe sets foot in the facility once a month, but he or she really doesn't provide those services."

The takeaway is that these attorneys believe their clients placed in facilities within West Virginia may not get the quality of care they need to succeed. "While I don't like sending them away, I do see results with my clients who are out-of-state. I generally find that my clients get good therapists out-of-state. I don't know why can't we accomplish this at home."

Capacity is also a concern. An attorney indicated there have been several instances where instate providers would not accept her client on referral, or put her client on a waiting list. "Maybe they'll have a bed in 60 days. Do you know how long is a semester to an eleven year old? I'll tell you, it's a lifetime!" These issues led her to seek out-of-state placements if only to get the process moving.

Lastly, in addition to perceptions of quality imbalance and capacity constraints, the Guardian ad Litems provided examples from recent cases where distant placements were preferable to treatment in the local community.

> Some of these kids have extreme reactive attachment disorders. That is, things in the home have deteriorated to a point that we need to get distance. The dynamic with Mom was triggering some extreme behavior. Getting separation from the family and home had real therapeutic value for both the child and parents. Now, if we're going to do that, then the kid needs to go to a facility with the staffing and expertise to really deal with the underlying issues. Those beds are hard to come by in state.

On the Need for an Improved System of Care

If West Virginia is to decrease its reliance on out-of-state placement, the attorneys interviewed for this study believe there will need to be greater investment in the system of care infrastructure, beginning with enhanced support for foster care providers and extending to a greater range of mental health services.

Foster care is currently the workhorse of West Virginia's child welfare system. Foster parents provide a full range of services to the children entrusted to their care. Each of the Guardian ad Litems interviewed in this study expressed admiration for the hard work done by foster parents. There are many effective strategies for working with a child placed in a quality foster home, but even the best foster care provider requires financial, logistical, and emotional support.

Placing severely troubled children into foster care arrangements without a proper support structure in the community—for the child or the foster care providers—is a recipe for disaster. One attorney who practices in southern West Virginia told us that some of his clients are placed with foster parents who lack dependable transportation. "They have good hearts; what they need is a good car! My client needs weekly therapy… it's in her treatment plan backed by the judge's order, but her foster family couldn't get her into town

and she missed some appointments. The court was going to hold my 12 year old client accountable for not driving herself to therapy!"

Here we have a situation where logistics impede the child's therapeutic needs. This attorney indicated that over the course of her career, she has had many clients put into residential care who might have been maintained in the community had there been more accessible support services available. But when frequent, intense therapy is appropriate, and the nearest therapist some 40 miles away, the need for accessible therapy trumps the also important need to maintain community ties.

The Guardian ad Litems also remind us that these are challenging children. "Sometimes no foster care parent will take my client. That's a sad truth, and it happens more than it should. I had a kid placed in a psychiatric hospital for a long time because we couldn't find a foster care placement for her. They said that no one would take her, and that was the truth." This attorney thought that better support services for foster parents would make it easier to find placements for these challenging clients.

The GALs also noted that staff turnover in the child welfare sphere (staff turnover at the DHHR and at the contracting agencies that provide services) are detrimental to their clients.

> Some of these agencies don't actually provide the services they are contractually bound to provide! Of course, in the case that I'm talking about the foster care agency had so much turnover they were incapable of providing the services. I objected in court; my client was not being served. That was a losing battle for me to fight. The agency was going to be paid no matter what I did.

In summary, the GALs consistently reported that reliance on out-of-state placement of children can only be reduced when the system of care in West Virginia is improved. We note from the interviews with other key informants that this is congruent with the view point of treatment professionals and social workers.

On the Service Provision Bureaucracy

The GALs experience the state's social service system as overly bureaucratic and opaque. They remind us that their task is to vigorously advocate for the child's best interest, not the best interest of the State or its child welfare agencies. On this front, every stakeholder associated with the courts expressed frustration with the bureaucracy established to provide child welfare services in West Virginia. "Instate providers don't take our referrals. APS won't pay for the services my client needs. Support services don't do what they've contracted do… I often feel like I'm fighting a losing battle."

Another lamented,

> Sometimes you run into problems based on the bureaucratic stuff the Department (DHHR) does. I couldn't count the number of caseworkers the kids have had. Every time they reorganize the caseworkers get shuffled. The caseworkers aren't supposed to be the connection for the kids, but they should be. The system is supposed to provide a connection (continuity for the kids) but no one but the GAL is.

All the GALs expressed concern that the DHHR caseworkers do not make personnel connections with the children in care. They believe caseloads may play a partial role here: "Of course, how can they? Their caseloads are obscene!" Sometimes, interchangeability of caseworkers leads to treatment recommendations that miss the mark: "They sent somebody to interview my client who didn't know my client. I had to push hard to be involved in the clinical review. This guy is making all of these recommendations for the treatment of my client based on two interviews."

Some of the GALs believe that financial interests trump therapeutic concerns:

> There are all these dirty secrets about placements. They file progress reports indicating that the child is improving as long as they are getting payment. The day that they were not going to get paid anymore they kick them out the door. Without any input for me.

Lastly, the GALs complain that service availability is often based on arbitrary administrative classifications:

> Because they are in placement on an abuse and neglect finding and not juvenile offender petition, they were not eligible for services in the home. They [APS Healthcare] would not provide additional services, because the foster care agency is supposed to provide that support. But the agency wouldn't do that. For example the foster care agency was supposed to send out a supportive staff once a week, but they wouldn't. I threatened to file a writ of Mandamus to no avail.

This point requires further clarification. Each of the GALs provided examples from recent cases where they believed the child required particular services, but for which the state would not provide that service due to the child's administrative classification. Children who have placed in the state's custody due to an abuse and neglect petition are not entitled to the same suite of services available to status offenders or juvenile delinquents. Even though the GAL argues that these services will serve the best interest of the child, bureaucratic regulations impede service delivery.

Each of the GALs also identified worker caseloads as a factor that undermines their ability to maintain children in the community. There is a tendency to blame "the Department" for the variety of problems faced by children in residential care. For instance, one of the attorneys described the challenge he faced in getting a client discharged from her residential facility in a state some 1,000 miles away. In his frustration he remarked that "the Department promotes people to the level of their own incompetence." When asked if he thought we should encourage the Legislature to review the qualifications of workers hired to serve the state's youth, he replied:

> We are asking more of those people than they are capable of. It could be training; it could be a time factor…. Really, to be fair, we are expecting more than can be done in 24 hours per day. These people are saints; even the dullest among them. They have so much on their plate; and they are so burned out. We have hearing after hearing and what we need is not done. Maybe it's not competence so much as time. It's more staffing than competence. Even out of people I consider to be the worst, when they have

> time to do stuff, they get it done. None of this is rocket science. We could get some of our kids sooner if the Department could just find the time to fill out the discharge planning papers.

This comment is worth careful reflection. The attorney suggests that West Virginia's caseworkers do not have enough time to do the things that would minimize out-of-state placements. This is a function of caseloads. In the past two West Virginia Child and Family Service Reviews (Children's Bureau 2002; 2009), the issues of staff turnover and unrealistic caseloads were mentioned multiple times as "areas on need of improvement". In particular, the most recent review noted "caseworkers do not consistently visit monthly with children in foster care or in-home services cases in part to high caseloads" (Children's Bureau 2009, p. 55).

Under the West Virginia code (see §9-2-6a) the Commissioner for Human Services is to establish a committee to determine minimum and maximum caseloads appropriate in individual caseload assignments. "Caseload standards means [sic] a measurable numerical minimum and maximum workload which an employee can reasonably be expected to perform in a normal workday or workweek, based on the number, variety and complexity of cases handled or number of different job functions performed." All of the Guardian ad Litems interviewed for this study agreed that current caseload standards work against the best interest of the state's children. We encourage the legislature to follow-up with the Commissioner of the Department of Health and Human Resources to ensure that efforts are made to investigate the current conditions and that reasonable caseload standards be achieved.

When the GALs believe that state policy or practice is in contradiction to their client's best interest, they are obligated to file pleadings in court to seek remedy. As was mentioned earlier in this report, from the clinical point of view judges appear to vary in the extent to which their decisions are "assessment driven". However, from the Guardian ad Litem's point of view, a judge's flexibility to consider a variety of factors is a crucial advantage to ensure that the child's needs are met. The Guardian ad Litem is often the only

professional who remains with the client through his or her time in the state's custody. If judges were only allowed to render judgments that are consistent with a formal review process, the Guardians would be unable to meet their professional mandate to vigorously advocate for the child.

Conclusions

Guardian ad Litems play a crucial role in overseeing the care of children placed into residential care. The GAL is the only party with an exclusive mandate to look after and advocate for the child's "best interest". Formally, GALs are required to regularly meet with the child, investigate the child's circumstances, file pleadings to the court on the child's behalf, request services that will benefit the child, and negotiate settlements when there are disagreements concerning the child's care.

Based on the perspective of four key informants, this report emphasizes that some children require the structure and resources that are only available in residential treatment centers. More children could be served locally in West Virginia communities with improvement to the state's system of care. The state's social service delivery mechanisms can get bogged down in bureaucratic red tape, for which appealing to a judge's authority is the best remedy. Lastly, these Guardians believe that the state's case management capacity is a limiting factor in maximizing the number of children who are served locally rather than in out of state placements.

Survey of West Virginia Psychologists

A survey of licensed psychologists in the state of West Virginia was conducted in order to determine professional psychologists' perspectives on out-of-state residential placement of young children and their recommendations for improved mental health service delivery.

As an initial step, six licensed clinical psychologists in Morgantown, WV participated in individual key informant interviews. These interviews served as a pilot for items to be used in a more widely administered electronic survey. For the final survey, an invitation link was sent by email to 102 individuals licensed through the West Virginia Board of Examiners of Psychologists for whom valid contact information was available. Thirty-four licensed psychologists completed the survey. The resulting 33% participation rate was somewhat higher than that typical for most surveys in social science research (typically less than 20 percent). While, the complete survey results can be found in the Appendix of this report, a brief summary is offered below.

Summary of Results

Results of the survey of WV licensed psychologists were largely consistent with previous reports and commission findings. The overwhelming majority of psychologists surveyed were of the opinion that local options for outpatient mental health services—particularly for young children—are insufficient. These professionals are concerned about unwarranted hospitalization of young children and stress the need for early intervention options that will enable families to receive assistance in their local communities, which in turn will lead to reduction in out-of-home placements.

Recommendations for Improved System of Care

To enhance the system of care for families in West Virginia, the research team recommends the formation of Multi-systemic Therapy (MST) Teams within the major

catchment areas/population centers in the state. MST is an intensive family- and community-based treatment program for youth at risk for out-of-home placement due to issues of child abuse and neglect, psychiatric and substance abuse disorders, and juvenile offending. There has been no more thoroughly researched and empirically supported approach to outpatient treatment for such youth than MST.

Across multiple studies, including over 5000 participants, the number of days in out-of-home placement for youth receiving MST was reduced by 47 to 64 percent over traditional mental health and social service provision (e.g., Henggeler, Schoenwald, & Pickrel, 1995; Ogden & Halliday-Boykins, 2004; Ogden & Hagen, 2006; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010;). Further, MST has yielded better outcomes and has proven to be more cost-effective than psychiatric hospitalization for youth with serious behavioral and emotional disorders (Henggeler et al., 1999; Henggeler et al., 2003; Huey et al., 2004). In a randomized trial of 113 youths presenting for intake to a psychiatric hospital, half were provided outpatient MST and half admitted to the inpatient unit for treatment as usual. MST prevented any subsequent need for psychiatric hospitalization for 57 percent of the participants and reduced the overall number of days hospitalized by 72 percent (Schoenwald, Ward, Henggeler, & Rowland, 2000). Notably, reduction in hospitalization was not offset by increased use of other placement options; MST reduced days in other out-of-home placements by 49 percent.

At present, there are licensed MST teams in 34 states and 13 countries, but none in West Virginia. This may be remedied in relatively short order with coordinated effort through the Departments of Psychology and Social Work at West Virginia University and Marshall University. While the training and licensing of MST teams will require initial financial investment from the state government, the cost savings would prove substantial over the long term.

References

ABA. (1996). American bar association standards of practice for lawyers who represent children in abuse and neglect cases. Washington DC: American Bar Association.

Anderson, R. L., & Gittler, J. J. (2005). Unmet need for community-based mental health and substance use treatment among rural adolescents. *Community Mental Health Journal*, *41*, 35-49.

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). Benefits and costs of *prevention and early intervention programs for youth*. Olympia: Washington State Institute for Public Policy.

APS Healthcare (2012) Bureau for Children and Families. Socially Necessary Services Utilization Management Guidelines. Revised 2/13/2012. http://www.wvdhhr.org/bcf/aso/documents/Social%20Necessary%20UM%20Manual%20V2.0.pdf

Beardslee, W. R. & Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: The importance of self-understanding and relationships. *American Journal of Psychiatry, 145*, 63-69.

Burns, B. J., Costello, E. J., Angold, A., et al. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14, 147-159.

Chi, F. W., Satre, D. D., & Weisner, C. (2006). Chemical dependency patients with cooccurring psychiatric diagnoses: Service patterns and 1-year outcomes. *Alcoholism: Clinical & Experimental Research, 30*, 851-859.

Colyer, C. J., & Plein, L. C. (2008). Multidisciplinary teams in West Virginia: Final report of the 2007-2008 West Virginia Multidisciplinary Team Study. Morgantown, West Virginia: West Virginia Court Improvement Program.

Department of Health and Human Resources. (2012a). Foster Care Policy. West Virginia Department of Health and Human Resources, Bureau for Children and Families, Office of Children and Adult Services. Revised June 14, 2012. http://www.wvdhhr.org/bcf/children_adult/foster/documents/fostercarepolicy1-12.pdf

Department of Health and Human Resources. (2012b) Youth Services Policy. West Virginia Department of Health and Human Resources, Bureau for Children and Families, Office of Children and Adult Services. Revised August 3, 2012. http://www.wvdhhr.org/bcf/policy/youth_services/yspolicy.pdf

Henggeler, S.W., Schoenwald, S.K., & Pickrel, S.G. (1995). Multisystemic therapy: Bridging the gap between university- and community-based treatment. *Journal of Consulting and Clinical Psychology, 63*, 709-717.

Henggeler, S. W., Rowland, M. R., Randall, J., Ward, D., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edwards, J. E., Zealberg, J., Hand, L., & Santos, A. B. (1999). Home-based multisystemic therapy as an alternative to the hospitalization of youth in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1331-1339.

Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C., Sheidow, A. J., Ward, D. M., Randall, J.,

Pickrel, S. G., Cunningham, P. B., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 543-551.

Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, *52,* 1179-1189.

Huey, S. J. Jr., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youth presenting psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 183-190.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R. , & Walters, E. E. (2005).

Lieb, R., Isensee, B., Hofler, M., Pfister, H., & Wittchen, H. U. (2002). Parental major depression and the risk of depression and other mental disorders in offspring: a prospective-longitudinal community study. *Archives of General Psychiatry*, *59*, 365-374.

Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 593-602.

Little, M., Kohm, A., & Thompson, R. (2005). The impact of residential placement on child development: Research and policy implications. *International Journal of Social Welfare, 14*, 200-209.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.) (2009). Preventing mental, emotional, and *behavioral disorders among young people: Progress and possibilities*. Washington D.C.: The National Academies Press.

Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. *Child & Adolescent Mental Health, 9,* 77-83.

Ogden, T., & Hagen, K. A. (2006). Multisystemic therapy of serious behaviour problems in youth: Sustainability of therapy effectiveness two years after intake. *Journal of Child and Adolescent Mental Health, 11*, 142-149.

Petersen, C. L. & Zettle, R. D. (2009). Treating inpatients with comorbid depression and alcohol use disorders: A comparison of acceptance and commitment therapy versus treatment as usual. *Psychological Record, 59*, 521.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. (2000). MST vs. hospitalization for crisis stabilization of youth: Placement outcomes 4 months post-referral. *Mental Health Services Research, 2*, 3-12.

Swenson, C.C., Schaeffer, C.M., Henggeler, S.W., Faldowski, R., & Mayhew, A.M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24*, 497–507.

Tashman, N. A., Weist, M. D., Acosta, O., Bickman, N. L., Grady, M., Nabors, L., et al. (2000).

Toward the integration of prevention research and expanded school mental health

programs. *Children's Services: Social Policy, Research, and Practice, 3*, 97-115.

United States Children's Bureau. (2002). Final Report: West Virginia child and family services review. Washington, DC: U.S. Department of Health and Human Services.

United States Children's Bureau. (2009). Final report: West virginia child and family services review. Washington, DC: U.S. Department of Health and Human Services. . http://www.wvdhhr.org/bcf/documents/management/documents/wvcfsrfinalreported041509.pdf

Weissman, M. M. & Olfson, M. (2009). Translating intergenerational research on depression into clinical practice. *JAMA, 302*, 2695-2696.

West Virginia Bureau for Behavioral Health and Health Facilities. West Virginia Department of Health and Human Resources. (2011). A State Epidemiological Profile. Retrieved May 17, 2012 from http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Documents/WV%20State%20Epidemiological%20Profile%202011.pdf.

Wotring, J. & Stroul, B. (2011). Issue Brief: The intersect of health reform and systems of *care for children's behavioral health care*. Washington DC: Georgetown University Center for Child and Human Development, National Center for Children's Mental Health.

Zerbe, R. O., Plotnick, R. D., Kessler, R. C., Pecora, P. J., Hiripi, E., O'Brian, K., et al. (2009). Benefits and costs of intensive foster care services: The Casey Family Programs compared to state services. *Contemporary Economic Policy, 27*, 308-320.

Appendix: Survey of WV Licensed Psychologists

Six licensed clinical psychologists in Morgantown, WV participated in individual key informant interviews to pilot items subsequently used in an electronically administered survey. A survey invitation link was sent by email to 102 individuals licensed through the West Virginia Board of Examiners of Psychologists for whom valid contact information was available. Thirty-four licensed psychologists completed the survey.

Survey Results

Highest educational degree:

	N	%
M.A./M.S.	11	32.4
Ph.D.	23	67.6
Total	34	

Time spent in clinical service provision (current):

	N	%
Full time	23	67.6
Part time	10	29.4
None	1	2.9
Total	34	

Full time = clinical service as primary component of employment

Part time = primary position is other than clinical service provision

None = employed strictly in research, teaching, or administrative position

Specialist in clinical child psychology:

	N	%
No	23	67.6
Yes	11	32.4
Total	34	

Have you had direct professional contact with a case in which a child was placed out of state for mental health treatment?

	N	%
No	17	50.0
Yes	17	50.0
Total	34	

If yes, did the recommendation for out-of-state placement come from you?

No – 71%
Yes – 29%

For those psychologists who had previous direct professional contact with a child who had been placed out of the state for mental health treatment, we asked whether they had any subsequent contact with that child (in effort to gage continuity of follow-up care).

57% had no subsequent contact

14% had no direct therapeutic contact but learned of disposition via social workers

14% had subsequent contact for assessment purposes only

14% continued to treat the child following discharge from the out-of-state treatment facility

Are the options for outpatient child mental health treatment sufficient in your county/region?

No – 94%
Yes – 6%

Participants were given the opportunity to respond to several open-ended questions, within the following categories:

(a) circumstances under which they would consider hospitalization or residential placement appropriate for a child aged 4-11; and separately again for a child aged 12-17

Without exception, the psychologists surveyed stressed that hospitalization or residential treatment be reserved for situations of immediate risk (danger to self or others).

(b) their involvement in cases referred for out of state treatment (number, nature, primary diagnoses)

Surveyed psychologists noted a wide range of experience. Those who had more extensive involvement with children who had been placed out of state were more likely to note PTSD and sexual abuse histories among primary diagnoses.

(c) level of satisfaction with out-of-state facilities (for those who had contact with such cases)

While specific knowledge was generally low, those commenting were generally satisfied.

(d) level of satisfaction with available mental health treatment options in their local area

Psychologists generally not satisfied with local mental health treatment options. As noted by their comments below, the number of qualified mental health providers is of most pressing concern.

- Insufficient number of child providers able to function through schools, community, etc. particularly for underinsured population.
- Limited number of providers, especially psychiatry and well-trained psychologists.
- Number of providers, more providers needed for autism spectrum, more family therapists needed.
- We have too few providers who are educated at the appropriate level to provide high quality care; the behavioral health care center seems to offer treatment but is understaffed by poorly paid providers.
- Even in Monongalia County, I am frequently asked to see children on an outpatient basis or to make recommendations. There are a limited number of licensed psychologists who treat children.

- There is a need for a residential diagnostic center where CAPS can be completed in a controlled environment and family assessment can be conducted prior to out of state placement consideration.
- Not enough options other than individual therapy.
- Intensive outpatient program, therapeutic group homes
- Not enough providers
- Limited placement if drug addicted
- Usually there is a waitlist
- Few practitioners
- Our waiting list is 2-3 months long; insufficient providers
- very few available providers (especially for very young children)
- Potentially we may be lacking substance abuse treatment
- If there are enough, I don't know of them. Also, unsure of the qualifications of the workforce
- Long wait lists, number accepting Medcards, nothing available for sex offending MR/DD

(e) changes they wish to see in the system of care for children in need of mental health services

Surveyed psychologists provided many constructive comments:

- Improving accessibility. Service delivery utilizing local school buildings as venue (not making the school system responsible for mental health delivery, but integrating professional psychologists and social workers (including professionals in training from WVU and Marshall) into the school systems.
- Length of time for first appointment, community awareness for services for families dealing with difficult children/adolescents for the first time

- Require that psychologists be educated at the level required elsewhere in the country (doctoral level) so that it would be feasible to require that those who provide care to children and adolescents receive specialized coursework and supervised experience in child oriented treatment approaches. Further, more money must be invested in the development of high intensity, outpatient, PHP type programs based on the best research including intensive work with families. Lastly, though I hate to see this needed, we need several well-funded and properly staffed inpatient facilities that are spread throughout the state such that families can be reasonably close by.
- It is imperative to have more options for treatment closer to home for families.
- More comprehensive outpatient options
- More providers specialized in treatment of children's mental health needs
- More options available
- Re-establish training programs for child psychiatry fellows in WV so that their chances of remaining here increase. When they leave the state for child training they do not return.
- More interdisciplinary assessments and treatments required
- Evidence-based treatment implemented in a network of community-based mental health settings for greater coverage across the state, especially in rural communities.
- These are no-brainers: need to increase access to evidence-based care, make sure qualifications of providers are up to date with best practices. Also, personality disorder treatment is not available. The whole system is overcrowded as is with more patients than providers.
- Dedicate resources to keep in home, or replicate out of state facilities/care

(f) suggested strategies for prevention/early intervention:

- More readily available and comprehensive assessment and outpatient services for children and families (including foster parents) designed to reduce incidence and severity of future problems in the areas of mental health, educational and

occupational attainment, and parenting capacity is not only humane but will save the State considerable dollars which now go to inpatient care, residential treatment, incarceration, etc.

- Possibly parent education in the pre-K programs for such disorders as ADHD, oppositional defiant disorder, autism spectrum disorders, affective disorders, impact of adult substance abuse on the family.
- Recruitment of appropriate doctoral level trained professionals
- Funding for early intervention for autism and severe externalizing behaviors in young children.
- Telehealth – mental health treatment via Skype, Mental health bus – a bus of mental healthcare providers that regularly travels around the state providing care to areas where treatment is unavailable.
- We need to figure out a way to disseminate treatments to more people, via telemedicine or use of the internet and mobile devices.