MEDICAID REPORT 2011
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2010 SUMMARY

INTRODUCTION

Nevada children's mental health services in philosophy and practice are based upon System of Care values and principles. System of Care incorporates a comprehensive spectrum of mental health and other necessary services for children with emotional and behavioral disorders. These services are organized into a coordinated network to meet the multiple, changing and challenging needs of children and their families. Mental health services offered under System of Care practice principals need be responsive to the cultural context and characteristics of the populations they serve. It is imperative that the Nevada Division of Child and Family Services (DCFS) appraises the children and families receiving mental health services and makes every effort to solicit feedback from the service recipients on the perceptions they have regarding the adequacy and quality of the mental health services they receive.

DCFS Programs for Southern Nevada Child and Adolescent Services (SNCAS) and Northern Nevada Child and Adolescent Services (NNCAS)

SNCAS	NNCAS
Community-Based Services	
Children's Clinical Services (CCS)	Outpatient Services (OPS)
Early Childhood Mental Health Services (ECMHS)	Early Childhood Mental Health Services (ECMHS)
Wraparound in Nevada (WIN)	Wraparound in Nevada (WIN)
Treatment Homes	
Oasis On-Campus Treatment Homes (OCTH)	Adolescent Treatment Center (ATC)
	Family Learning Homes (FLH)
Residential Facility and Psychiatric Hospital	
Desert Willow Treatment Center (DWTC)	

QUALITY ASSURANCE / PERFORMANCE QUALITY IMPROVEMENT

DCFS Children's Mental Health Services (CMHS) quality assurance (QA) and performance quality improvement (PQI) activities are conducted in accordance with the QA/PQI Plan. The CMHS QA/PQI Plan consists of activities comprising four primary focal areas or Plan Domains:

Plan Domain I.	Quality Assurance and Regulatory Standards. CMHS activities are to be conducted in compliance with relevant Statutory, Regulatory, Medicaid, Commission approved DCFS policy and professional best practice standards.
Plan Domain II.	Service Effectiveness. Are CMHS clients benefiting from the services provided them? Outcome indicators include such measures as client functioning, symptom reduction and quality of life indices.
Plan Domain III.	Service Efficiency. Focus is on CMHS operations and functions as they relate to client services' accessibility, availability and responsiveness.

Plan Domain IV.	Consumer Satisfaction. This domain features systematic child, family and stakeholder feedback regarding the quality of services provided with specific focus on such service attributes as accessibility, general satisfaction, treatment participation, treatment information, environmental safety, cultural sensitivity, adequacy of education, social connectedness and positive treatment outcomes.

Over the past year, the DCFS Planning and Evaluation Unit (DCFS/PEU) initiated and/or continued several key components of its expanding system for monitoring populations entering service, service recipient satisfaction and service delivery compliance as required under the QA/PQI Plan.

Treatment Population

Descriptive Summary of Children's Mental Health Services
[Plan Domain(s): II, III]

A detailed Descriptive Summary was completed this past year that looked at the 3121 children served by the DCFS Children's Mental Health Services in Fiscal Year 2010 (July 1, 2009 through June 30, 2010). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 3121 children served by DCFS programs, 2222 (71.0%) received services in Clark County and 899 (28.8%) were served in Washoe County/Rural.

Community based programs (outpatient, early childhood services and wraparound services) served 87.6% of the clients statewide. The remaining 12.4% were served in residential and inpatient treatment settings.

Of all children served, 56.8% were 12 years of age or younger and 57.8% were male. Caucasian children accounted for 70.9% of all those served and African-American youngsters 23.6%. Children of Hispanic origin came to 24.2%.

In FY10, 51.4% of the children admitted to mental health services statewide were in the custody of their parent or family, 46.4% were in Child Welfare custody and 0.8% were in Youth Parole custody.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY10. (Attachment A)

Service Recipient Satisfaction

It is the policy of DCFS that all children, youth and their families/caregivers receiving mental health services have an opportunity to provide feedback and information regarding those services in the course of their service delivery and later at the time of their discharge from treatment.

Children's Mental Health Services Surveys

[Plan Domain(s): IV]

DCFS/PEU conducted two youth and family service surveys during calendar year 2009.

DCFS Community-Based Mental Health Services

A parent/caregiver version and a youth version of the DCFS community based mental health services survey were administered in April and May (Spring) of 2010. In the survey, five Neighborhood Family Service Center sites were polled in Las Vegas and three were polled in Reno. Responding to the survey were 348 parents/caregivers and 134 youth still in services. Spring survey results indicated a statewide average 89% parent / caregiver positive rating and a 78% youth positive rating for the program areas targeted for review. Results of the Spring parent/caregiver and youth surveys were also reported to the federal Center for Mental Health Services as one requirement for Nevada's participation in the Community Mental Health Services Block Grant.

A summary of the community-based survey results can be found in the appended DCFS Community Based Services Parent/Caregiver – Youth Survey Results Statewide Spring 2010 report. (Attachment B).

DCFS Residential and Psychiatric Inpatient Services

A parent/caregiver and a youth version of the DCFS Residential and Psychiatric Inpatient Services Survey was administered in mid-October through November (Fall) of 2010. The two Northern Nevada Child and Adolescent Services (NNCAS) residential program areas were polled as were the two Southern Nevada Child and Adolescent Services (SNCAS) residential / inpatient program areas. Responding to the survey were 41 parents/caregivers and 73 youth still in program. Results of the Fall survey indicated a statewide average 90% parent/caregiver positive rating and a 72% youth positive rating for the program areas targeted for review.

Following publication of the residential/inpatient services survey results, staff from the participating programs met to discuss issues raised in the survey and to propose solutions for increasing client satisfaction with their treatment experience. This process resulted in each program area formulating an Action Plan to be implemented by identified program staff during the next 12 months.

A summary of the residential/psychiatric inpatient survey results can be found in the appended DCFS Residential and Psychiatric Inpatient Services Parent/Caregiver – Youth Survey Results Statewide Fall 2010 report. (Attachment C).

Youth and Parent/Caregiver Consumer Surveys At Discharge

By reason of its Joint Commission certification, the Desert Willow Treatment Center (DWTC) currently conducts patient and/or parent/caregiver consumer service evaluations at time of patient discharge from the facility. DCFS/PEU has drafted and disseminated discharge survey instruments to additional residential programs and is now incorporating program feedback into rewrite versions of the documents. DWTC staff representatives and staff representatives from the remaining DCFS residential and inpatient treatment programs have now initiated a workgroup for developing a mutually serviceable discharge instrument.

Service Delivery Compliance

DCFS policy requires that its children's mental health services promote clear, focused, timely and accurate documentation in all client records in order to ensure best practice service delivery and to monitor, track and analyze client outcomes and quality measures.

Risk Measures and Departure Conditions
[Plan Domain(s): III]

Risk measures are indicators based on the structure of a treatment home program and how it responds to and subsequently documents select critical incidents. Risk measures target safety issues that can arise with children and youth having behavioral challenges. Client demographic, clinical and other descriptive information is collected at the program level for such high risk areas as suicidal behavior, medication errors by type and outcome, client runaways (AWOL) with attendant information and incidents of safety holds including circumstances and outcomes. Risk measure data can serve to indicate treatment population trends and might suggest program areas in need of improvement.

In September 2008, client departure condition data were added to the risk measures data collection and analysis efforts. Departure condition data are captured for each client who leaves a treatment home. Information collected includes demographic and clinical variables, client Child and Adolescent Service Intensity Index scores upon admission and at departure, reason for departure and with what disposition, and was treatment considered completed.

Summaries of the high risk areas and departure conditions captured for DCFS community treatment home programs will be found in three appended Risk Measures and Departure Conditions Reports for SNCAS Oasis, NNCAS Adolescent Treatment Center, and NNCAS Family Learning Homes respectively (Attachments D, E and F).

Supervisor Checklists
[Plan Domain(s): I, III]

Mental health supervisors continue to use the two DCFS/PEU developed service-specific case review checklists to help guide their feedback to staff when directing and improving direct service provider and/or targeted case management service provider adherence to relevant policy and documentation requirements.

A Supervisor File Review evaluation was implemented by the DCFS Children's Mental Health Management Team in the fourth quarter of FY 2010. The purpose of the Review was to review client file documentation and evaluate the rate of compliance with service standards and required documentation indicators. DCFS/PEU conducted the four month evaluation. SNCAS supervisors participated in the project with 126 file reviews including 46 Direct Service Clinical Supervisor Checklists and 80 Targeted Case Management Supervisor Checklists. NNCAS supervisors submitted 77 file reviews including 47 Direct Service Clinical Supervisor Checklists and 30 Targeted Case Management Supervisor Checklists. A total of 203 client file Reviews were evaluated statewide. Results indicated generally mid-range compliance rates that varied across programs. WIN client files scored the highest ratings and suggested that WIN wraparound principals generally tended to inform their targeted case management process. Lessons to be learned from this initial Review included valuable feedback from supervisors and staff regarding improving the clarity of the review tools

themselves; attendant difficulties in readily capturing some of the required client information; and some process requirements involving aftercare/transitional planning and establishing adequate medical necessity documentation. A recently convened workgroup made up of supervisors and front-line staff has been charged with updating the Supervisor Checklist instruments. Results of this Review will prove valuable to that group's efforts.

A report entitled DCFS Children's Mental Health Services Supervisor File Review describes the evaluation project and is appended to this document (Attachment G).

Program Quality Assurance Monitoring
[Plan Domain(s): I - IV]

Desert Willow Treatment Center (DWTC) is a licensed 58 bed psychiatric inpatient facility providing mental health services in a secure environment to children and adolescents with severe emotional disturbances. In SFY 2010, DWTC served 157 children in its acute care programs and 106 children in its residential programs. Under the leadership of Linda K. Santangelo, PhD, DWTC hospital Clinical Program Manager, and Nabil Jouni, MD, Medical Director, this inpatient facility is accredited by Joint Commission since 1998. As the Division's sole Joint Commission credentialed treatment facility, DWTC continues to conduct its programs in strict compliance with the Commission's operational mandates and quality assurance proscriptions. DWTC patients and/or their parents/caregivers are administered consumer service evaluations upon discharge with monthly reports being forwarded to the Joint Commission. Several DWTC internal committees review monthly such patient-related care areas as Restraint and Seclusion data, treatment outcome measures and incident and accident data. Monthly Health and Safety Checklists are completed as is a Joint Commission Readiness walkthrough facility/programs inspection. Patient charts are audited daily and typical medical facility infection control activities/reports and medication audits/reports are conducted as well. Consumer complaints and Denial of Rights are reviewed, addressed and reported. Staff medical and clinical peer reviews and program utilization reviews occur monthly. Facility nutritional services undergo quarterly review. The entire facility undergoes an annual performance review that drives facility performance improvement projects. The facility's most recent Joint Commission Survey in January 2011 once again recognized the accomplishments of DWTC leadership and staff by renewing their accreditation status.

Client Case Record Data
[Plan Domain(s): I - III]

Client case record documentation begins with timely data entry by appropriate staff. The management information system that houses the data must then be maintained and regularly monitored for client data accuracy and completeness. DCFS employs several processes in seeking to maximize the adequacy and integrity of its client data.

Data Clean-up

PEU engages in on-going efforts to identify, isolate, remediate and monitor specific data deficiencies in the Avatar management information systems. Five cleanup reports are now developed for distribution to respective program areas: Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), Juvenile Justice, Education and Missing Demographics.

Currently data quality monitoring and reporting occurs on a 90 day cycle. The data cleanup committee convenes regularly to analyze and provide program area feedback on quarterly report results. Committee members also address any new cleanup process developments, data extract requests, and occasionally suggested report improvements/modifications.

Mutual Advocacy for Data Workgroup (MAD)

This workgroup is composed of key DCFS Information Management System (IMS) and DCFS/PEU personnel and is based upon a shared desire to have a close and informed relationship exist between mental health program service areas and the technical information system that captures, maintains and reports those services' clinical, demographic and financial client data. MAD has graduated to a "special issues" meeting schedule in continuing to be available as needed in support of the DCFS commitment to its data quality, adequacy and integrity.

Wraparound Service Delivery Model Fidelity Evaluation
[Plan Domain(s): I - IV]

DCFS/PEU has been partnering with Wraparound-in-Nevada (WIN) program managers and supervisors to evaluate model fidelity for services being provided to wraparound clients. This past year PEU completed that evaluation.

The DCFS/PEU study evaluated the WIN program in Northern and Rural Nevada for their adherence to the wraparound model. Standard Wraparound Fidelity Index (WFI) instruments and interview protocols were used that assess a program's degree of adherence to the principles and core activities of the wraparound service delivery model. The study compiled 193 WFI interviews for 79 youth. There were 79 facilitator interviews, 72 parent/caregiver interviews and 42 youth interviews. Resultant interview data were entered into a database maintained by the Wraparound Evaluation and Research Team. Study results looked at four key aspects of the wraparound fidelity model: engagement, planning, implementation and transition. Study results indicated that overall fidelity in the Northern and Rural areas met or exceeded wraparound national standards. Staff has nearly completed WFI case interviews in a fidelity study being conducted for the SNCAS WIN program. A summary of the Northern and Rural WIN study can be found in the appended Wraparound Fidelity Index (WFI-4) Summary Report June, 2010 WIN North and Rural Programs (Attachment H).

Washoe County Wraparound-In-Nevada (WIN) Expansion
[Plan Domain(s): II]

DCFS WIN is partnering with Washoe County Department of Juvenile Services, Washoe County School District, Sierra Regional Center, and SNCAS Outpatient Services to implement a WIN expansion program. Each agency contributed a position that would provide wraparound process to their population. The additional positions provide wraparound for children in the custody of their families. WIN managers and supervisors provide training and supervision to the wraparound approach for the additional positions. The Washoe County WIN Expansion Committee is the state-county interface group responsible for bringing the program on-line. DCFS/PEU is in partnership with the Washoe County WIN Expansion Committee and has been charged with developing and implementing an evaluation of the program. Working closely with the program expansion committee, DCFS/PEU is identifying both process outcomes and project outcomes that include education, juvenile justice, child welfare and mental health measures. An evaluation protocol instructs WIN facilitators in the use of relevant program client

data instruments and the collection process to follow for data submission. DCFS/PEU is responsible for WIN data capture, developing and maintaining required database storage capacity, committee updates and producing scheduled and as-required reports.

Seclusion/Restraint of Clients
[Plan Domain(s): I, III]

DCFS residential programs and private facilities in the State of Nevada operate under a Nevada Commission on Mental Health and Developmental Services mandate to report all client denial of rights involving seclusion and emergency restraint procedures. DCFS/PEU captures seclusion and restraint data from residential facilities across the State and inputs that data into a DCFS/PEU designed and maintained statewide database. Regular reports requested by the Commission are generated from the database and it is available for other DCFS reporting or data needs as well. The most recent Commission report on seclusion/restraint can be found in the appended Seclusion and Restraint Emergency Procedures for Children and Youth Denial of Rights (Attachment I).

Additional Program Evaluation Unit Activities

Community Mental Health Block Grant
[Plan Domain(s): I - IV]

The State of Nevada has been a long time participant in a Community Mental Health Block Grant (CMHBG) provided through the federal Center for Mental Health Services. This grant assists participating states to establish or expand their capacity for providing organized and on-going mental health services for adults with severe mental illness (SMI) and children with severe emotional disturbance (SED). DCFS has represented children's mental health services in this grant since the Division was created by State legislative action in 1992.

CMHBG participation requires state accountability for funds expended and outcomes achieved. The CMHBG meets this goal by requiring that states use and report on a set of uniform National Outcome Measures. These measures identify five areas or "indicators" important for a state's mental health programming success.

Grant implementation reporting also requires that states use a Center for Mental Health Services Uniform Reporting System (URS). The URS is made up of 21 separate tables of select client and program specific data that detail such information as the number and socio-demographic characteristics of children served by DCFS, outcomes achieved as a result of that service, client assessment of care received and so on.

The DCFS/PEU supports State of Nevada participation in the CMHBG by capturing, collating, analyzing and formatting and reporting children's mental health program data noted above.
Last year, DCFS/PEU submitted ahead of schedule all CMHBG data and documentation required for the State's initial 2011 Federal Grant Application and the subsequent 2010 Implementation Report.

Clinical Tool Training

The CAFAS is an evaluative tool used in children's mental health for assessing a youth's day-to-day functioning across critical life domains and for determining a youth's functional improvement over time.

Select PEU staff continue to help provide regional training to clinical staff on the CAFAS and how to use it when evaluating their clientele. The PECFAS is a similar instrument used to evaluate young children on their day-to-day functioning across critical life domains and for determining a child's functional improvement over time. Select ECMHS staff continue to provide regional training to regional staff on this instrument and how to use it when evaluating young children.

The Child and Adolescent Service Intensity Instrument (CASII) is an instrument that quantifies the type and intensity of services that a child needs to meet their mental health needs. DCFS program staff at SNCAS and NNCAS continue to provide training to DCFS and partner agency staff in this instrument. In 2010, select ECMHS staff statewide were trained as trainers to the Early Childhood Service Intensity Instrument (ECSII) and all ECMHS staff were trained on this new instrument which is the companion to the CASII for young children. DCFS ECSII trainers have begun to provide this training to other providers.

Ongoing Reports

Since last year's Medicaid report, a new case data integrity report has become fully operational. A client activity report identifies cases that have been open for more than 24 months or more. The report is used by managers and supervisors to ensure that clients' are receiving appropriate treatment and that treatment plans include a discharge plan. A second client activity report identifies all open cases inactive for 90 days or more and six months or more. The report identifies clients by name, program, therapist, and case supervisor. The report supports decision making for closing those cases that are no longer in need of treatment services.

CONCLUSION

The DCFS quality assurance and quality improvement model encompasses efforts to understand and optimize all possible factors influencing service delivery and outcomes. DCFS/PEU is tasked with developing a clear plan for measuring service delivery impact upon outcomes and for improving our understanding of the building blocks that lead to effective programs. Understanding the process of service delivery and evaluating and appreciating consumer satisfaction are all based upon the development of quality assurance and quality improvement standards. DCFS/PEU partners with DCFS program managers in developing these standards within the different service areas and in measuring their effectiveness. Information generated by on-going outcome measurement allows characterization of program effectiveness and at times may indicate the need to refine or revise a standard for greater effectiveness. The CMHS QA/PQI Plan incorporates quality assurance and quality improvement efforts that continue to address system of care operations at the child and family level, at the supervisory level and at the managerial and community stakeholder level.

We endorse the Medicaid Report 2011 DCFS Performance and Quality Improvement 2010 Summary and are pleased to submit it on behalf of all of our dedicated DCFS Children's Mental Health Services program managers and staff.

Approved by:

_____	_____
Susan L. Mears, Ph.D. Planning and Evaluation Unit, DCFS	Date
_____	_____
Patricia Merrifield, Deputy Administrator Children's Mental Health, DCFS	Date
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ATTACHMENT INDEX

ATTACHMENT A

Division of Child and Family Services

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2010

CONTENTS

INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2010, from July 1, 2009 through June 30, 2010. The FY 2010 Descriptive Summary provides an expanded analysis of DCFS programs. This FY 2010 report examines served data statewide and by programs. Children served are those who received a service sometime during the fiscal year. This report provides descriptive information on each DCFS Children's Mental Health Services program.

This descriptive report summarizes demographic and clinical information on the 3121 children served for mental health services across the State of Nevada in DCFS Children's Mental Health programs. DCFS Children's Mental Health Services are divided into Southern Nevada Child and Adolescent Services (SNCAS), with locations in southern Nevada, and Northern Nevada Child and Adolescent Services (NNCAS), with locations in northern Nevada. NNCAS includes the Wraparound in Nevada program serving the rural region. Programs are outlined in the following table.

Programs for Southern Nevada Child and Adolescent Services (SNCAS) and Northern Nevada Child and Adolescent Services (NNCAS)

SNCAS	NNCAS
Community-Based Services	
Children's Clinical Services (CCS)	Outpatient Services (OPS)
Early Childhood Mental Health Services (ECMHS)	Early Childhood Mental Health Services (ECMHS)
Wraparound in Nevada (WIN)	Wraparound in Nevada (WIN)
Treatment Homes	
Oasis On-Campus Treatment Homes (OCTH)	Adolescent Treatment Center (ATC)
	Family Learning Homes (FLH)
Residential Facility and Psychiatric Hospital	
Desert Willow Treatment Center (DWTC)	

SURVEY COMMENT FROM A SATISFIED PARENT

I have learned how to protect my son....

CHILDREN'S MENTAL HEALTH

Number of Children Served

Statewide	NNCAS	SNCAS
3121	899	2222

Admissions

Statewide	NNCAS	SNCAS
1481	401	1080

Discharges

Statewide	NNCAS	SNCAS
1415	429	986

CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

The average age of children served Statewide was 11.1, NNCAS was 11.5, and SNCAS was 10.9.

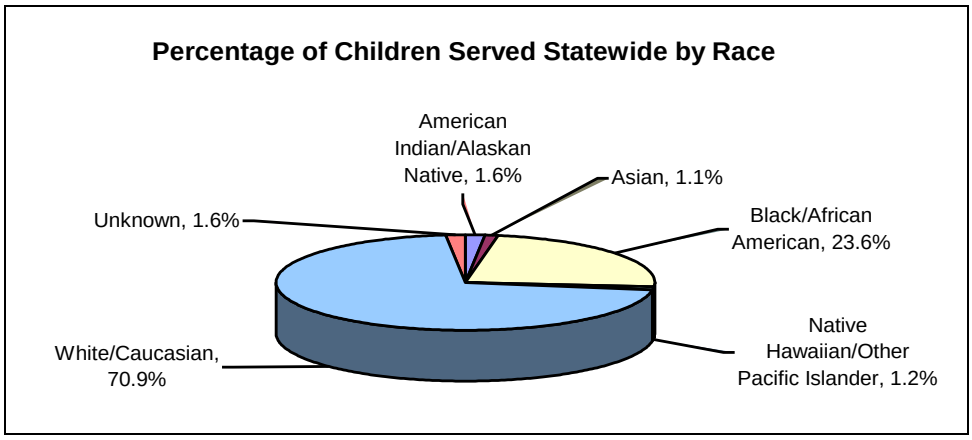
Age Group	Statewide	NNCAS	SNCAS
0–5 years old	744 (23.8%)	167 (18.6%)	577 (26%)
6–12 years old	1030 (33%)	336 (37.4%)	694 (31.2%)
13–18 years old	1300 (41.7%)	383 (42.6%)	917 (41.3%)
19+ years old	47 (1.5%)	13 (1.4%)	34 (1.5%)

Gender

	Statewide	NNCAS	SNCAS
Male	1805 (57.8%)	508 (56.5%)	1297 (58.4%)
Female	1316 (42.2%)	391 (43.5%)	925 (41.6%)

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	50 (1.6%)	26 (2.9%)	24 (1.1%)
Asian	34 (1.1%)	2 (.2%)	32 (1.4%)
Black/African American	736 (23.6%)	75 (8.3%)	661 (29.7%)
Native Hawaiian/Other Pacific Islander	39 (1.2%)	10 (1.1%)	29 (1.3%)
White/Caucasian	2212 (70.9%)	771 (85.8%)	1441 (64.9%)
Unknown	50 (1.6%)	15 (1.6%)	35 (1.6%)
Ethnicity	**Statewide**	**NNCAS**	**SNCAS**
Hispanic Origin	754 (24.2%)	189 (21%)	565 (25.4%)



How Clients Served by NNCAS and SNCAS Reflect the Race and Ethnicity of Washoe and Clark Counties

Race	NNCAS	Washoe County [1]	SNCAS	Clark County [1]
American Indian/Alaskan Native	26 (2.9%)	1.9%	24 (1.1%)	.7%
Asian	2 (.2%)	4.9%	32 (1.4%)	7.1%
Black/African American	75 (8.3%)	2.3%	661 (29.7%)	9.6%
Native Hawaiian/Other Pacific Islander	10 (1.1%)	.5%	29 (1.3%)	.6%
White/Caucasian	771 (85.8%)	79.2%	1441 (64.9%)	71.8%
Unknown	15 (1.6%)	-	35 (1.6%)	-
Ethnicity	**NNCAS**		**SNCAS**	
Hispanic Origin	189 (21%)	20.7%	565 (25.4%)	27.7%

Custody Status at Admission

	Statewide	NNCAS	SNCAS
Parent/Family	1605 (51.4%)	505 (56.2%)	1100 (49.5%)
Child Welfare	1448 (46.4%)	375 (41.7%)	1073 (48.3%)
DCFS Youth Parole	26 (.8%)	3 (.3%)	23 (1%)
Other	33 (1.1%)	15 (1.7%)	18 (.8%)
Missing	9 (.3%)	1 (.1%)	8 (.4%)

Severe Emotional Disturbance Status at Admission

Statewide	NNCAS	SNCAS
2750 (88.1%)	843 (93.8%)	1907 (85.8%)

[1] U.S. Census Bureau, 2006-2008 American Community Survey. Retrieved on April 2, 2010 from http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&geo_id=05000US32031&_geoContext=01000US%7C04000US32%7C05000US32031

Demographics by Program

Community-Based Services

Outpatient Services (OPS) – NNCAS and Children's Clinical Services (CCS) – SNCAS

Number of Children Served

Statewide	OPS	CCS
1410	403 (28.6%)	1007 (71.4%)

Age

The average age of children served Statewide was 14, OPS was 14.3, and CCS was 13.9.

Age Group	Statewide	OPS	CCS
0–5 years old	1 (.1%)	1 (.2%)	-
6–12 years old	504 (35.7%)	128 (31.8%)	376 (37.3%)
13–18 years old	887 (62.9%)	270 (67%)	617 (61.3%)
19+ years old	18 (1.3%)	4 (1%)	14 (1.4%)

Gender

	Statewide	OPS	CCS
Male	844 (59.9%)	232 (57.6%)	612 (60.8%)
Female	566 (40.1%)	171 (42.4%)	395 (39.2%)

Race and Ethnicity

Race	Statewide	OPS	CCS
American Indian/Alaskan Native	17 (1.2%)	7 (1.7%)	10 (1%)
Asian	18 (1.3%)	-	18 (1.8%)
Black/African American	285 (20.2%)	26 (6.5%)	259 (25.7%)
Native Hawaiian/Other Pacific Islander	25 (1.8%)	6 (1.5%)	19 (1.9%)
White/Caucasian	1048 (74.3%)	360 (89.3%)	688 (68.3%)
Unknown	17 (1.2%)	4 (.9%)	13 (1.3%)
Ethnicity		**OPS**	**CCS**
Hispanic Origin	373 (26.5%)	91 (22.6%)	282 (28%)

Custody Status at Admission

	Statewide	OPS	CCS
Parent/Family	1054 (74.8%)	353 (87.6%)	701 (69.6%)
Child Welfare	320 (22.7%)	36 (8.9%)	284 (28.2%)
DCFS Youth Parole	10 (.7%)	3 (.7%)	7 (.7%)
Other	19 (1.3%)	10 (2.5%)	9 (.9%)
Missing	7 (.5%)	1 (.2%)	6 (.6%)

Early Childhood Mental Health Services (ECMHS) – NNCAS and SNCAS

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
971	291 (30%)	680 (70%)

Age

The average age of children served by ECMHS Statewide was 5.1, ECMHS (NNCAS) was 6, and ECMHS (SNCAS) was 4.7.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	670 (69%)	156 (53.6%)	514 (75.6%)
6–12 years old	301 (31%)	135 (46.4%)	166 (24.4%)

Gender

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	556 (57.3%)	163 (56%)	393 (57.8%)
Female	415 (42.7%)	128 (44%)	287 (42.2%)

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	10 (1%)	7 (2.4%)	3 (.4%)
Asian	10 (1%)	1 (.3%)	9 (1.3%)
Black/African American	243 (25%)	28 (9.6%)	215 (31.6%)
Native Hawaiian/Other Pacific Islander	7 (.7%)	3 (1%)	4 (.6%)
White/Caucasian	692 (71.3%)	251 (86.3%)	441 (64.9%)
Unknown	9 (.9%)	1 (.3%)	8 (1.2%)
Ethnicity	**Statewide**	**ECMHS (NNCAS)**	**ECMHS (SNCAS)**
Hispanic Origin	246 (25.3%)	66 (22.7%)	180 (26.5%)

Custody Status at Admission

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	351 (36.1%)	100 (34.4%)	251 (36.9%)
Child Welfare	615 (63.3%)	189 (64.9%)	426 (62.6%)
Other	4 (.4%)	2 (.7%)	2 (.3%)
Missing	1 (.1%)	-	1 (.1%)

SURVEY COMMENT FROM A SATISFIED YOUTH

I understand why I'm in foster care now.

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
758	149 (19.7%)	120 (15.8%)	489 (64.5%)

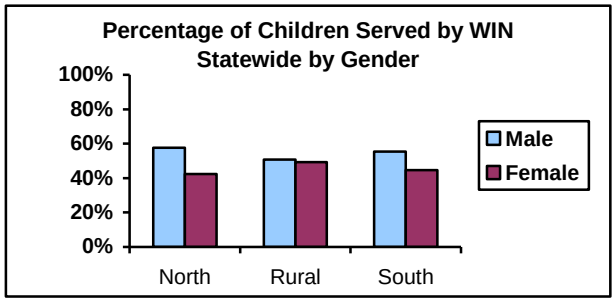
Age

The average age of children served Statewide was 13.6, North was 14.3, Rural was 12.3, and South was 13.7.

Age Group	Statewide	North	Rural	South
0–5 years old	16 (2.1%)	3 (2%)	10 (8.3%)	3 (.6%)
6–12 years old	307 (40.5%)	51 (34.2%)	57 (47.5%)	199 (40.7%)
13–18+ years old	407 (53.7%)	89 (59.7%)	50 (41.7%)	268 (54.8%)
19+ years old	28 (3.7%)	6 (4%)	3 (2.5%)	19 (3.9%)

Gender

	Statewide	North	Rural	South
Male	418 (55.1%)	86 (57.7%)	61 (50.8%)	271 (55.4%)
Female	349 (44.9%)	63 (42.3%)	59 (49.2%)	218 (44.6%)

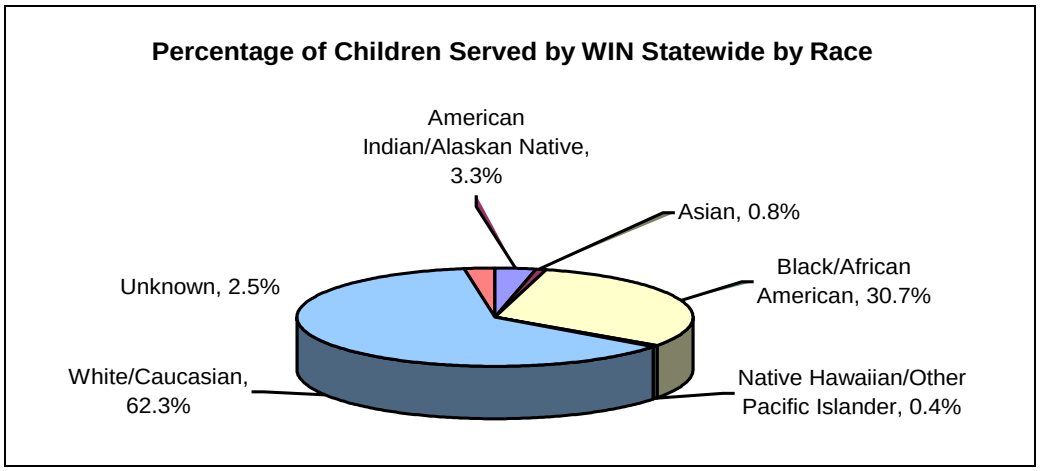


Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	25 (3.3%)	7 (4.7%)	10 (8.3%)	8 (1.6%)
Asian	6 (.8%)	-	1 (.8%)	5 (1%)
Black/African American	233 (30.7%)	17 (11.4%)	8 (6.7%)	208 (42.5%)
Native Hawaiian/Other Pacific Islander	3 (.4%)	-	1 (.8%)	2 (.4%)
White/Caucasian	472 (62.3%)	124 (83.2%)	90 (75%)	258 (52.8%)
Unknown	19 (2.5%)	1 (.7%)	10 (8.3%)	8 (1.6%)
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	124 (16.4%)	30 (20.1%)	17 (14.2%)	77 (15.7%)

SURVEY COMMENT FROM A SATISFIED PARENT

Light at the end of the tunnel ... hope.



Custody Status at Admission

	Statewide	North	Rural	South
Parent/Family	120 (15.8%)	57 (38.3%)	32 (26.7%)	31 (6.3%)
Child Welfare	627 (82.7%)	91 (61.1%)	87 (72.5%)	449 (91.8%)
DCFS Youth Parole	1 (.1%)	-	-	1 (.2%)
Other	10 (1.3%)	1 (.7%)	1 (.8%)	8 (1.6%)

Treatment Homes

Adolescent Treatment Center (ATC) – NNCAS, Family Learning Homes (FLH) – NNCAS, On-Campus Treatment Homes (OCTH) – SNCAS

Number of Children Served

Statewide	ATC	FLH	OCTH
180	59 (32.8%)	42 (23.3%)	79 (43.9%)

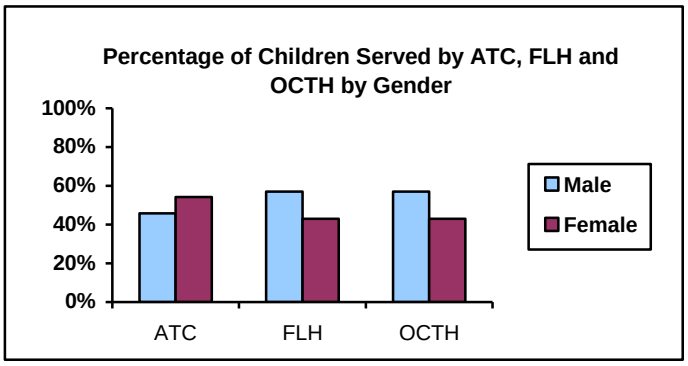
Age

The average age of children served Statewide was 14.5, ATC was16.1, FLH was 13.3, and OCTH was 13.9.

Age Group	Statewide	ATC	FLH	OCTH
6–12 years old	49 (27.2%)	-	18 (42.9%)	31 (39.2%)
13–18 years old	130 (72.2%)	59 (100%)	24 (57.1%)	47 (59.5%)
19+ years old	1 (.6%)	-	-	1 (1.3%)

Gender

	Statewide	ATC	FLH	OCTH
Male	96 (53.3%)	27 (45.8%)	24 (57.1%)	45 (57%)
Female	84 (46.7%)	32 (54.2%)	18 (42.9%)	34 (43%)



Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	5 (2.8%)	3 (5.1%)	-	2 (2.5%)
Asian	1 (.6%)	-	-	1 (1.3%)
Black/African American	37 (20.6%)	5 (8.5%)	1 (2.4%)	31 (39.2%)
Native Hawaiian/Other Pacific Islander	2 (1.1%)	1 (1.7%)	-	1 (1.3%)
White/Caucasian	132 (73.3)%	49 (83.1%)	41 (97.6%)	42 (53.2%)
Unknown	3 (1.7%)	1 (1.7%)	-	2 (2.5%)
Ethnicity		**ATC**	**FLH**	**OCTH**
Hispanic Origin	32 (17.8%)	13 (22%)	5 (11.9%)	14 (17.7%)

Custody Status at Admission

	Statewide	ATC	FLH	OCTH
Parent/Family	115 (63.9%)	44 (74.6%)	37 (88.1%)	34 (43%)
Child Welfare	51 (28.3%)	14 (23.7%)	4 (9.5%)	33 (41.8%)
DCFS Youth Parole	3 (1.7%)	-	1 (2.4%)	2 (2.5%)
Other	4 (2.2%)	1 (1.7%)	-	3 (3.8%)
Missing	7 (3.9%)	-	-	7 (8.9%)

Residential Facility and Psychiatric Hospital

Desert Willow Treatment Center Acute Hospital (Acute) and Residential Treatment Center (RTC) – SNCAS

Number of Children Served

Acute	RTC
157	106

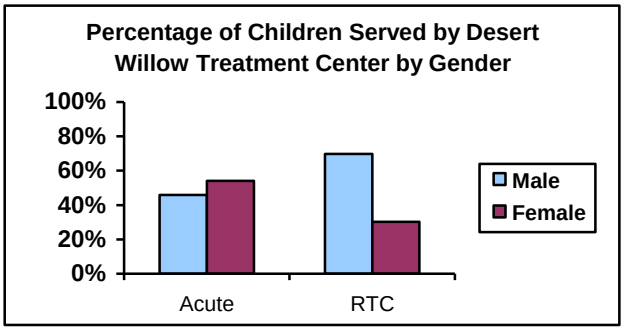
Age

The average age of children served by Desert Willow Acute was 15.2 and 16 for the Desert Willow Residential Treatment Center.

Age Group	Acute	RTC
0–5 years old	-	-
6–12 years old	28 (17.8%)	4 (3.8%)
13–18 years old	129 (82.2%)	99 (93.4%)
19+ years old	-	3 (2.8%)

Gender

	Acute	RTC
Male	72 (45.9%)	74 (69.8%)
Female	85 (54.1%)	32 (30.2%)



Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	1 (.6%)	3 (2.8%)
Asian	4 (2.5%)	1 (.9%)
Black/African American	33 (21%)	21 (19.8%)
Native Hawaiian/Other Pacific Islander	6 (3.8%)	1 (.9%)
White/Caucasian	109 (69.4%)	75 (70.8%)
Unknown	4 (2.5%)	5 (4.7%)
Ethnicity	**Acute**	**RTC**
Hispanic Origin	58 (36.9%)	14 (13.2%)

Custody Status at Admission

	Acute	RTC
Parent/Family	138 (87.9%)	85 (80.2%)
Child Welfare	15 (9.6%)	6 (5.7%)
DCFS Youth Parole	3 (1.9%)	14 (13.2%)
Other	-	-
Missing	1 (.6%)	1 (.9%)

SURVEY COMMENT FROM A SATISFIED FAMILY

We feel that the services we receive are like a family.
Everyone works together for a common goal.

CHILDREN'S CLINICAL CHARACTERISTICS AND OUTCOMES

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their child has encountered. Of the 51 problems listed, the seven problems identified below (and listed in order of prevalence) accounted for about fifty-one percent (50.8%) of all problems reported.

- Adjustment Problems (10.6%)
- Child Neglect Victim (9.0%)
- Depression (8.4%)
- Physical Aggression (6.9%)
- Parent-Child Problems (5.9%)
- Oppositional (5.1%)
- Suicide Attempt-Threat (4.9%)

Adjustment problems remained the most prevalent presenting problem in FY2010. Child neglect victim surpassed depression this year in prevalence, and joining the list was oppositional, which surpassed suicide attempt-threat. Depression has remained in the top five for the second year after not making the top five in FY2008. In addition, physical aggression surpassed parent-child problems.

Diagnosis

In FY 2010 39% of children served met criteria for more than one diagnostic category. The tables below show the most prevalent Axis I diagnoses of children by age category and gender.

Age Group 0-5.99

Overall	Female	Male
Disruptive Behavior Disorder	Adjustment Disorder	Disruptive Behavior Disorder
Adjustment Disorder	Disruptive Behavior Disorder	Adjustment Disorder
Neglect of Child	Neglect of Child	Neglect of Child
Anxiety Disorder NOS	Anxiety Disorder NOS	Parent-Child Relational Problem
Parent-Child Relational Problem	Deprivation/Maltreatment Disorder	Anxiety Disorder NOS
Deprivation/Maltreatment Disorder	Parent-Child Relational Problem	Sensory Stimulation-Seeking/Impulsive

Age Group 6-12.99

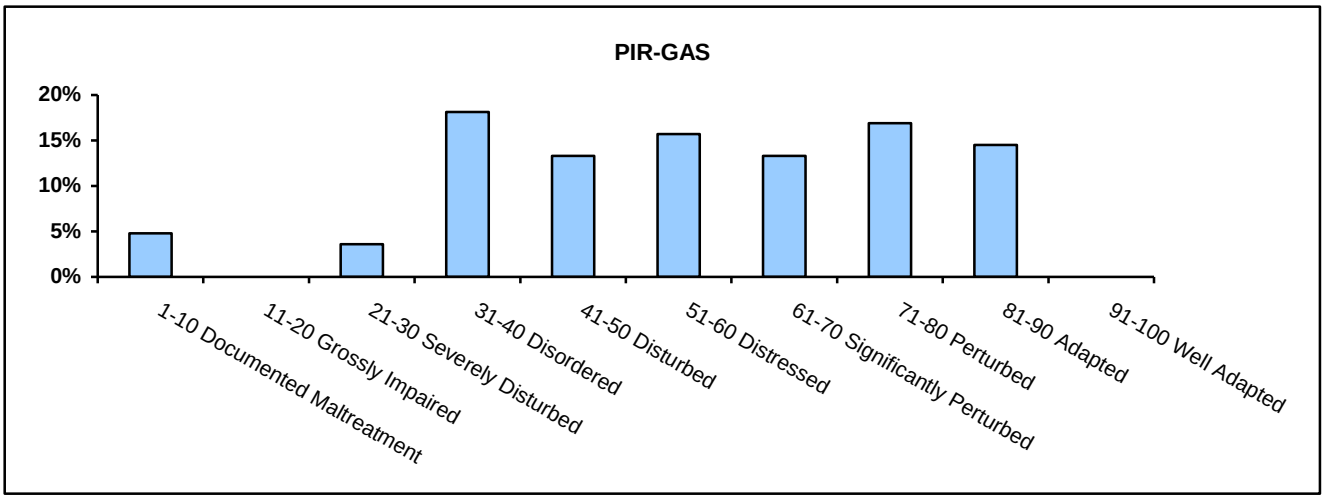
Overall	Female	Male
Attention-Deficit/ Hyperactivity Disorder	Posttraumatic Stress Disorder	Attention-Deficit/ Hyperactivity Disorder
Adjustment Disorder	Adjustment Disorder	Adjustment Disorder
Posttraumatic Stress Disorder	Attention-Deficit/ Hyperactivity Disorder	Oppositional Defiant Disorder
Oppositional Defiant Disorder	Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Disruptive Behavior Disorder	Reactive Attachment Disorder	Disruptive Behavior Disorder
Mood Disorder NOS	Disruptive Behavior Disorder	Mood Disorder NOS

Age Group 13-18+

Overall	Female	Male
Major Depressive Disorder	Major Depressive Disorder	Attention-Deficit/ Hyperactivity Disorder
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder	Oppositional Defiant Disorder
Oppositional Defiant Disorder	Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Attention-Deficit/ Hyperactivity Disorder	Depressive Disorder NOS	Mood Disorder NOS
Mood Disorder NOS	Mood Disorder NOS	Major Depressive Disorder
Adjustment Disorder	Adjustment Disorder	Adjustment Disorder

Parent-Infant Relationship Global Assessment Scale

The Parent-Infant Relationship Global Assessment Scale (PIR-GAS) is used to assess the quality of the infant-parent relationship in order to develop a diagnostic profile for infants, toddlers, and young children. The PIR-GAS is part of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.[2] The PIR-GAS scores are classified as 81-100 an Adapted Relationship, 41-80 Features of a Disordered Relationship, and 0-40 a Disordered Relationship. The graph below shows the PIR-GAS rating on 83 infants, toddlers and children at admission served by Early Childhood Mental Health Services statewide.



Child and Adolescent Functional Assessment and the Preschool and Early Childhood Functional Assessment

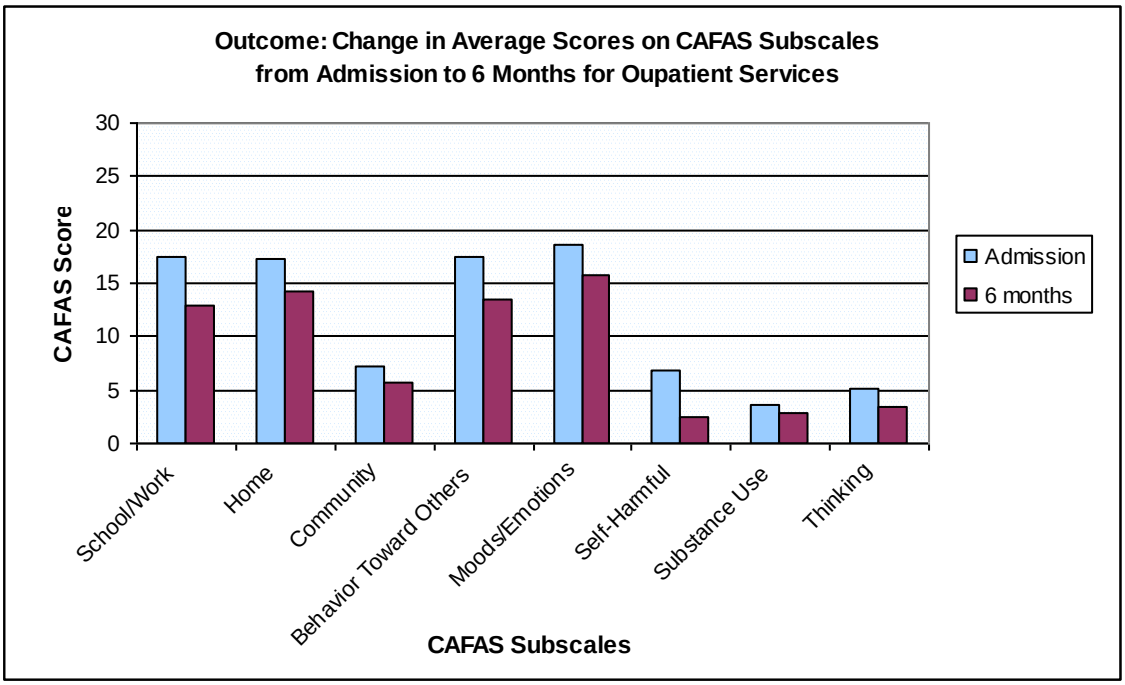
The Child and Adolescent Functional Assessment Scale (CAFAS)[3] is designed to assess in children ages 6 to 18 years the degree of functional impairment regarding emotional, behavioral, psychiatric, psychological and substance-use problems. CAFAS scores can range from 0 to 240, with higher scores reflecting increased impairment in functioning.

The Preschool and Early Childhood Functional Assessment Scale (PECFAS)[4] was also designed to assess degree of impairment in functioning of children ages 3 to 7 years with behavioral, emotional, psychological or psychiatric problems. PECFAS scores range from 0 to 210, with a higher score indicating greater impairment.

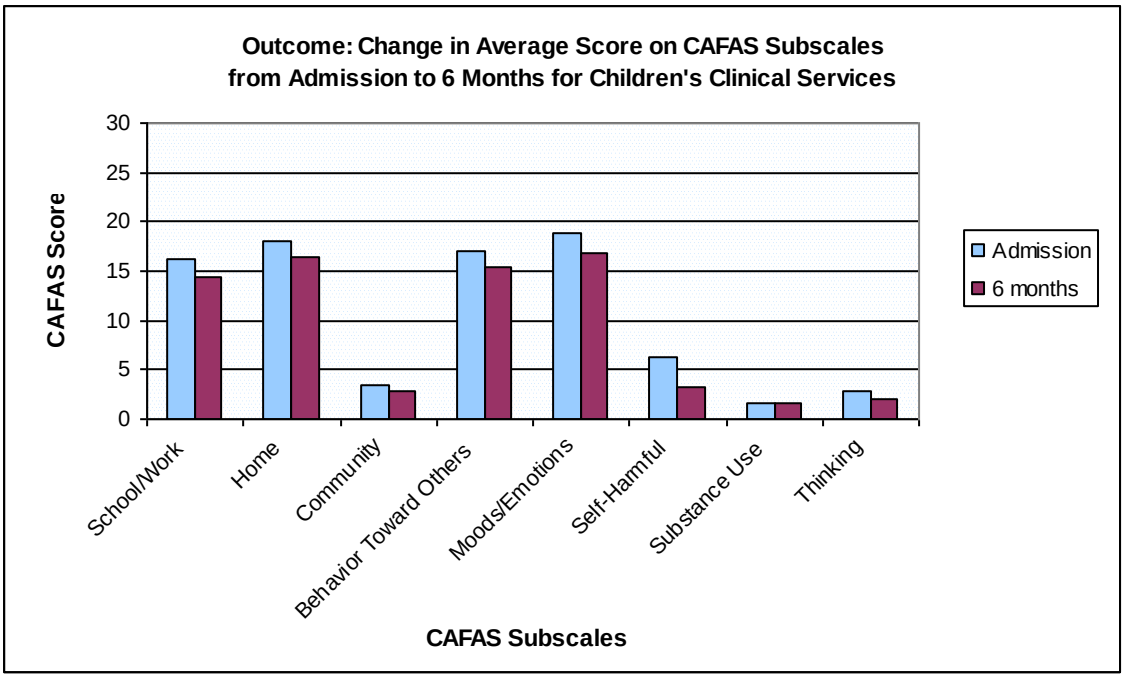
The CAFAS and the PECFAS are standardized instruments commonly used across child-serving agencies to guide treatment planning and as a clinical outcome measures for individual clients and program evaluation (Hodges, 2005). The CAFAS and the PECFAS are used as outcome measures for DCFS Children's Mental Health.
The following graphs show pre and post CAFAS or PECFAS average subscale scores by program area.

[2] ZERO TO THREE. (2005). Diagnostic classification of mental health and developmental disorders of infancy and early childhood: Revised edition (DC:0-3R). Washington, DC: ZERO TO THREE Press.
[3] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.
[4] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.

Outpatient and Children's Clinical Services

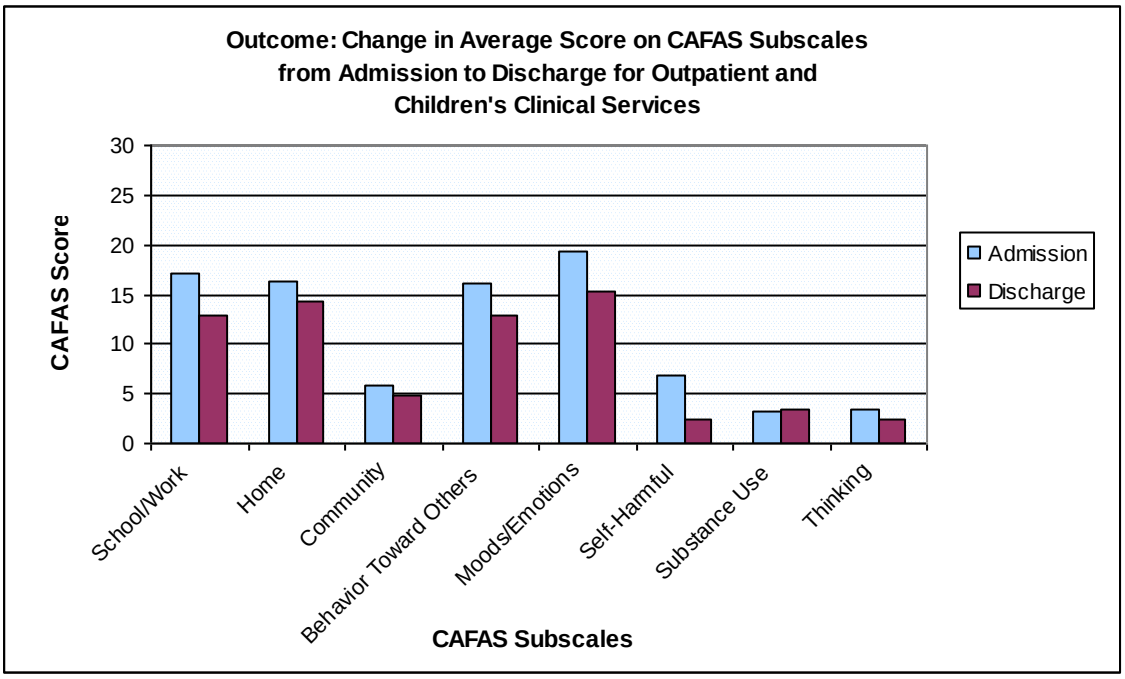


Outpatient – Based on 181 pairs, the average CAFAS score was 93.70 at admission. At 6 months into services, the average CAFAS score decreased to 70.66, which indicates a statistically and clinically significant improvement in overall daily functioning. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.



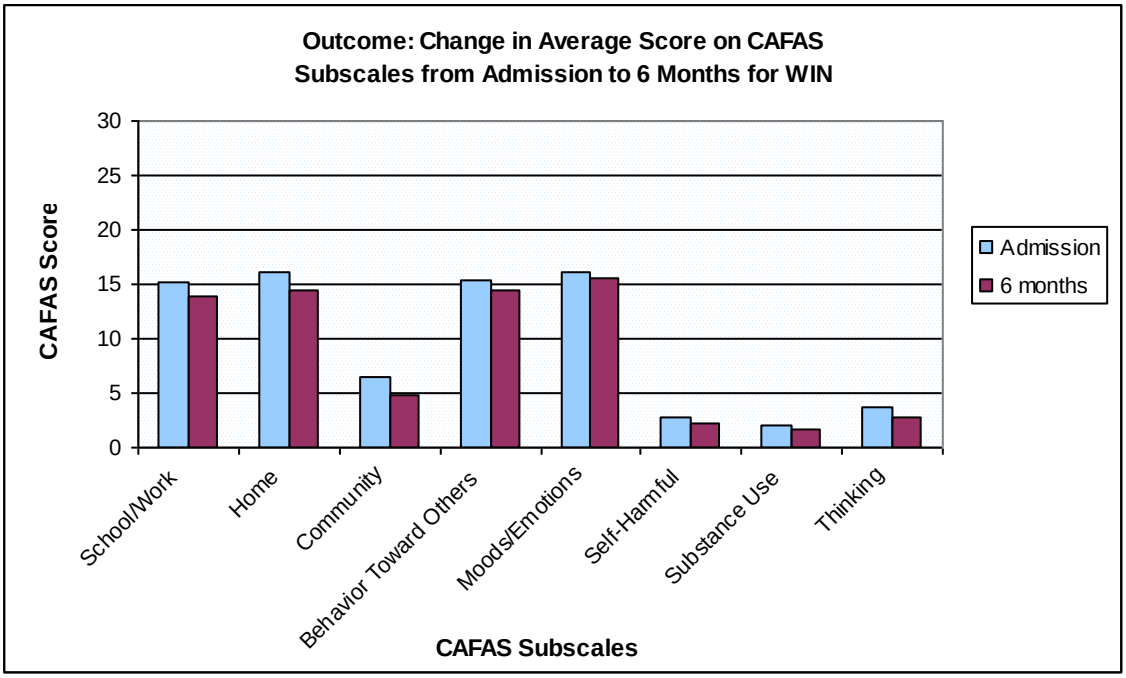
Children's Clinical Services – Based on 250 pairs, the average CAFAS score was 84.40 at admission. At 6 months into services, the average CAFAS score decreased to 72.84, which indicates a statistically

significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

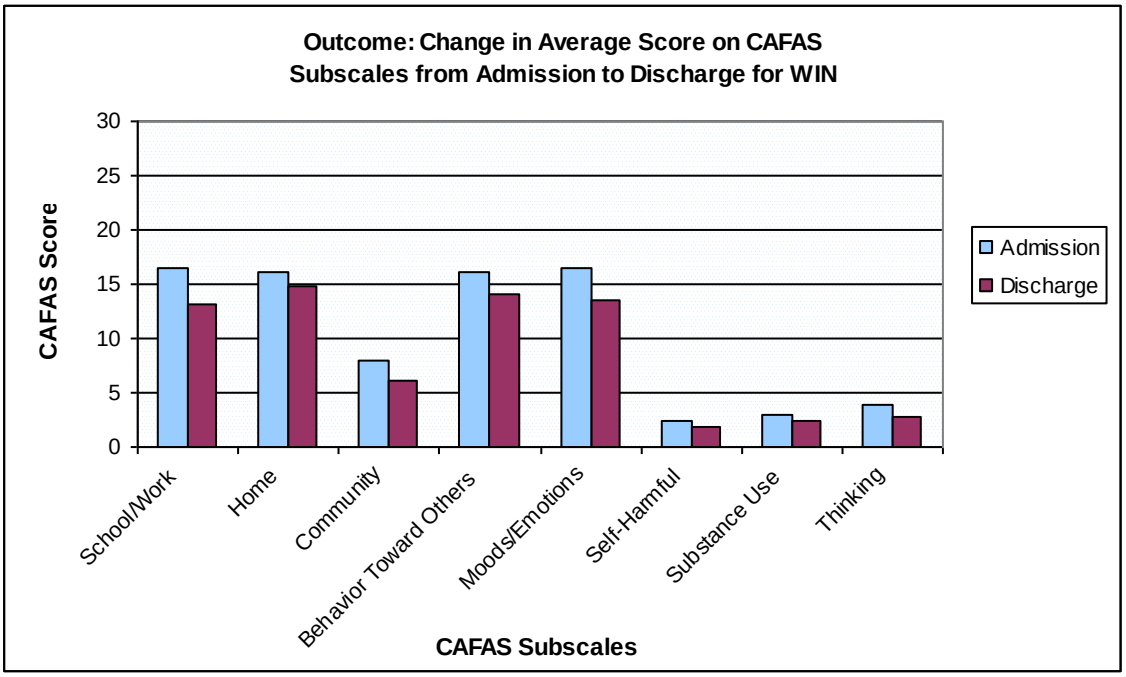


Outpatient and Children's Clinical Services – Based on 245 pairs, the average CAFAS score was 88.16 at admission. At discharge, the average CAFAS score decreased to 69.10, which indicates a statistically significant improvement in overall daily functioning and a nearly clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

WIN

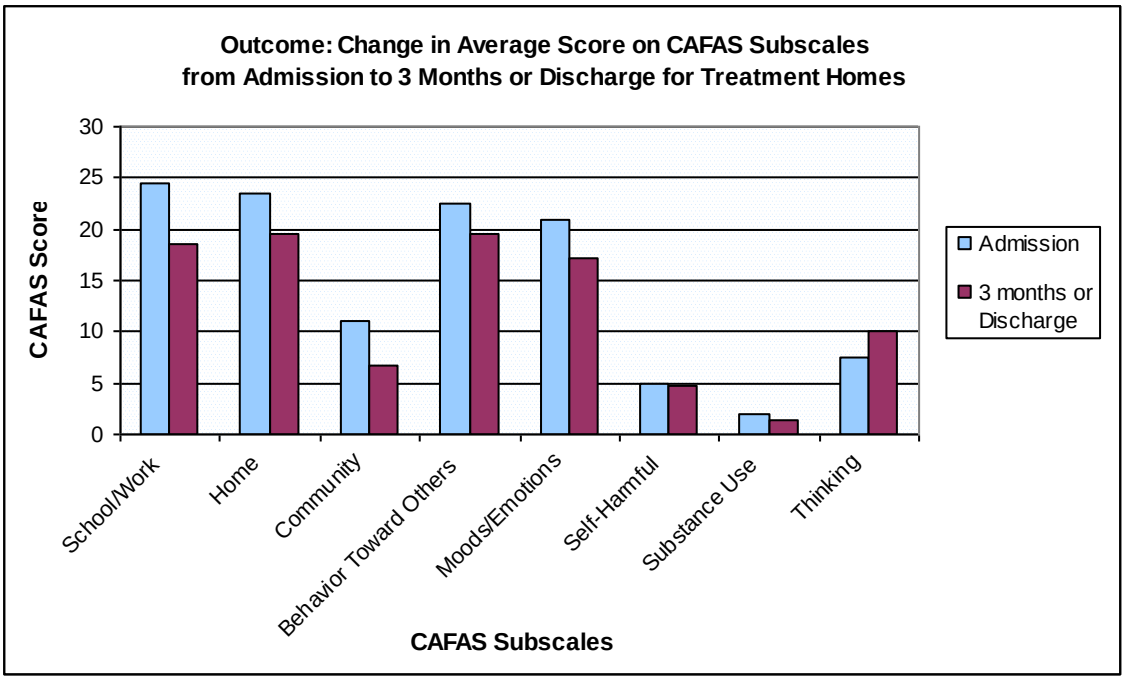


Based on 213 pairs, the average CAFAS score was 77.93 at admission. At 6 months into services, the average CAFAS score decreased to 69.44, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

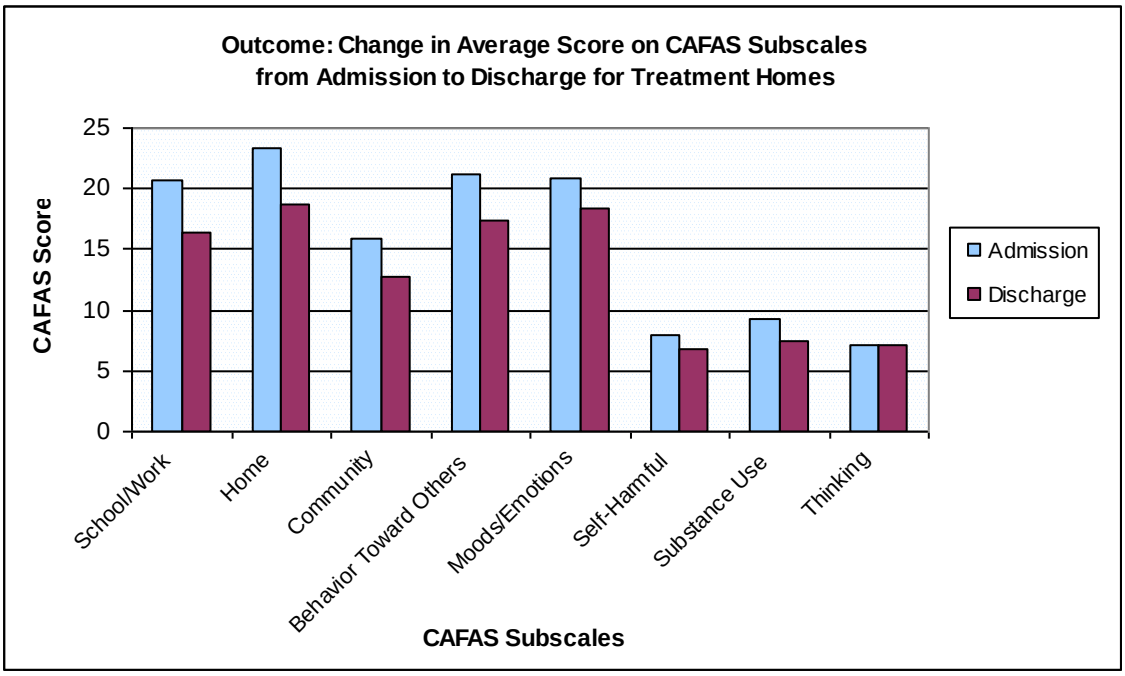


Based on 92 pairs, the average CAFAS score was 82.72 at admission. At discharge, the average CAFAS score decreased to 69.24, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

Treatment Homes

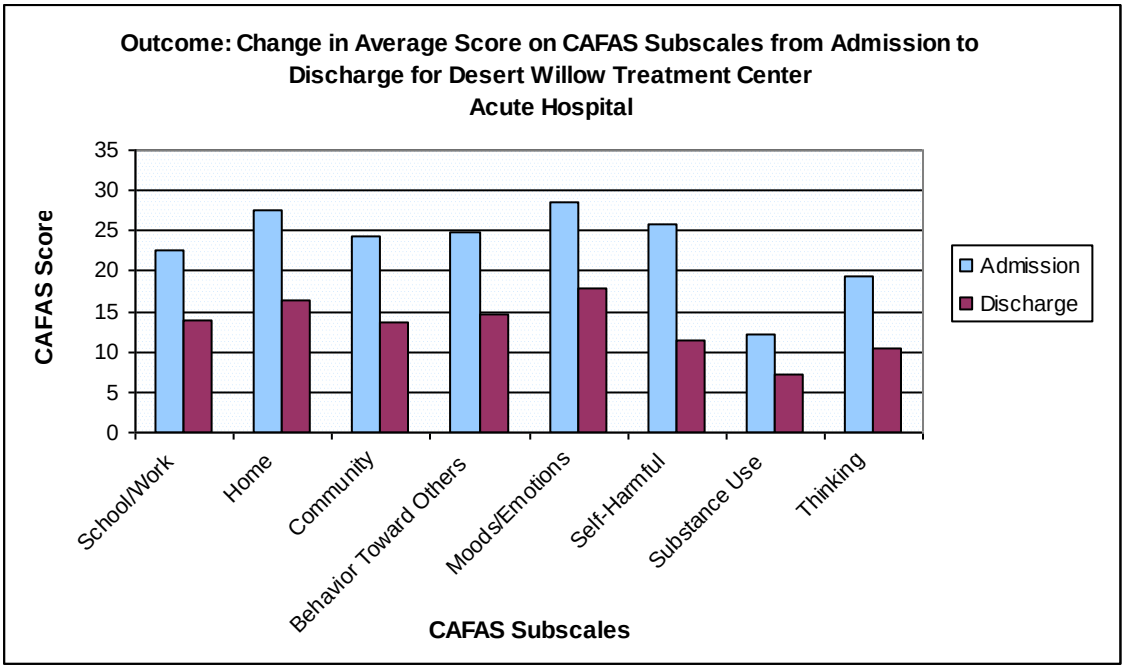


Based on 20 pairs, the average CAFAS score was 117.00 at admission. At 3 months into services or at discharge, the average CAFAS score decreased to 98.00, which indicates a statistically and a nearly clinically significant improvement in overall daily functioning. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.



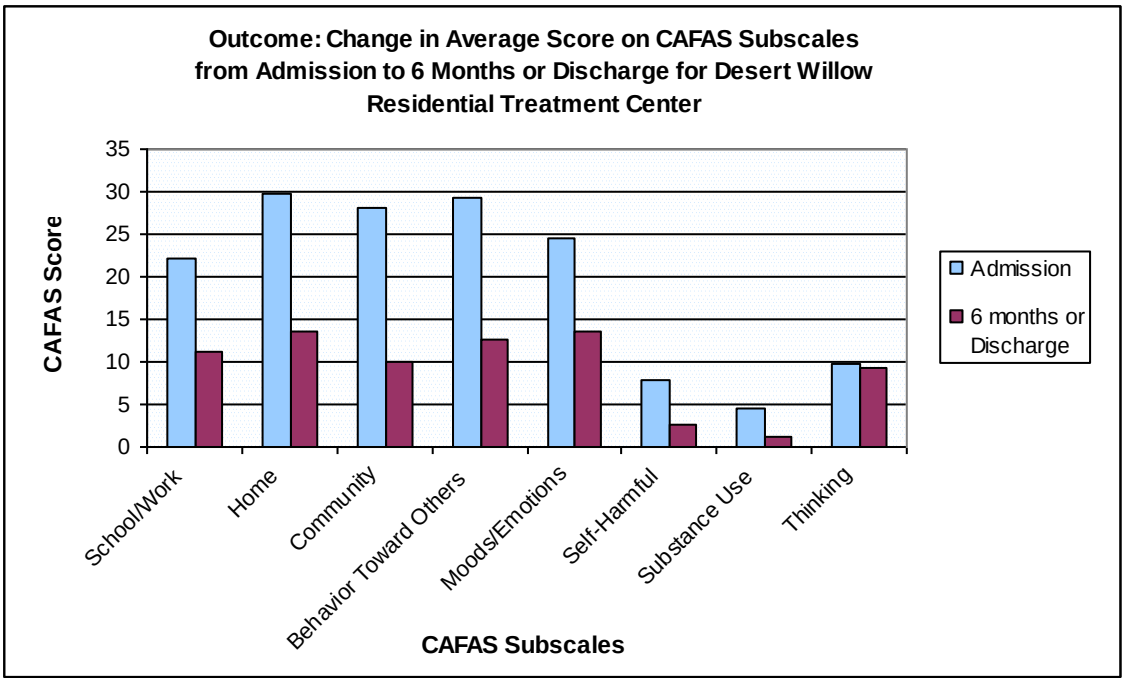
Based on 57 pairs, the average CAFAS score was 126.49 at admission. At discharge, the average CAFAS score decreased to 105.26, which indicates a statistically significant improvement in overall daily functioning and a clinically meaningful reduction in impairment. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

Desert Willow Treatment Center Acute Hospital



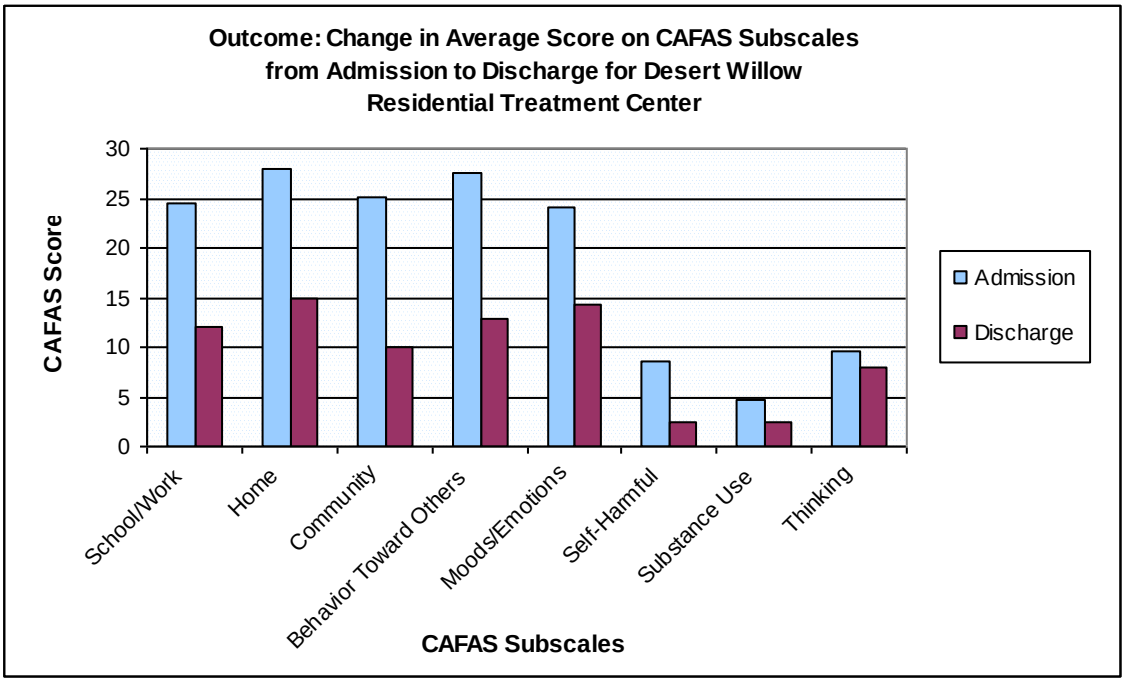
Based on 166 pairs, the average CAFAS score was 185.00 at admission. At discharge, the average CAFAS score decreased to 105.54, which indicates a statistically and clinically significant improvement in overall daily functioning. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

Desert Willow Treatment Center RTC



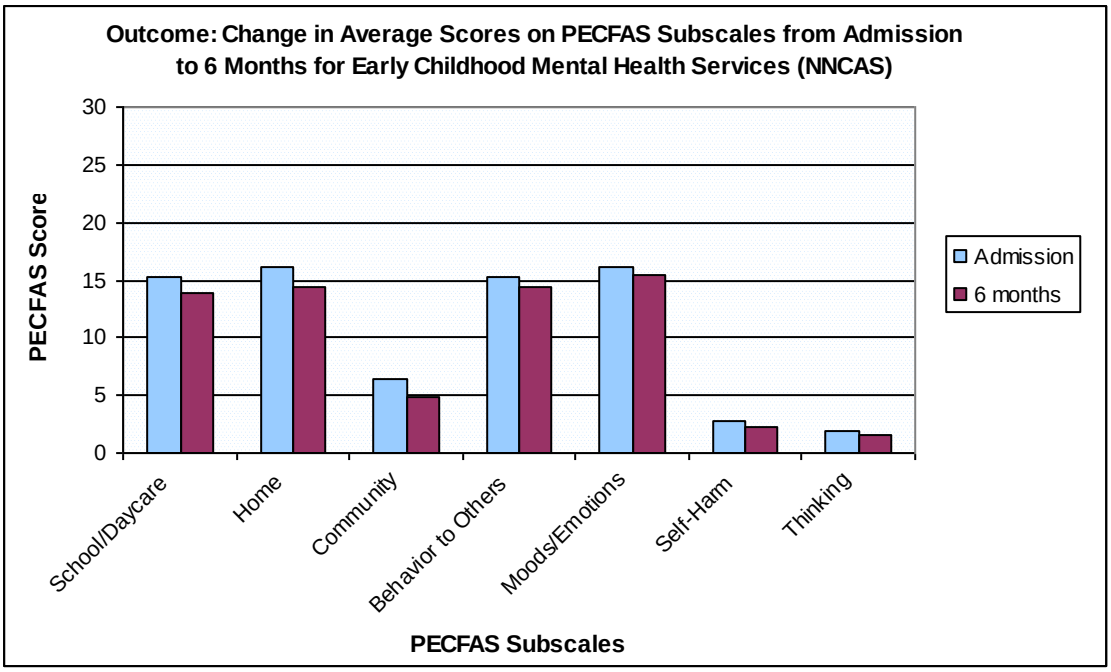
Based on 31 pairs, the average CAFAS score was 155.81 at admission. At 6 months into services or at discharge, the average CAFAS score decreased to 74.19, which indicates a statistically and clinically

significant improvement in overall daily functioning. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

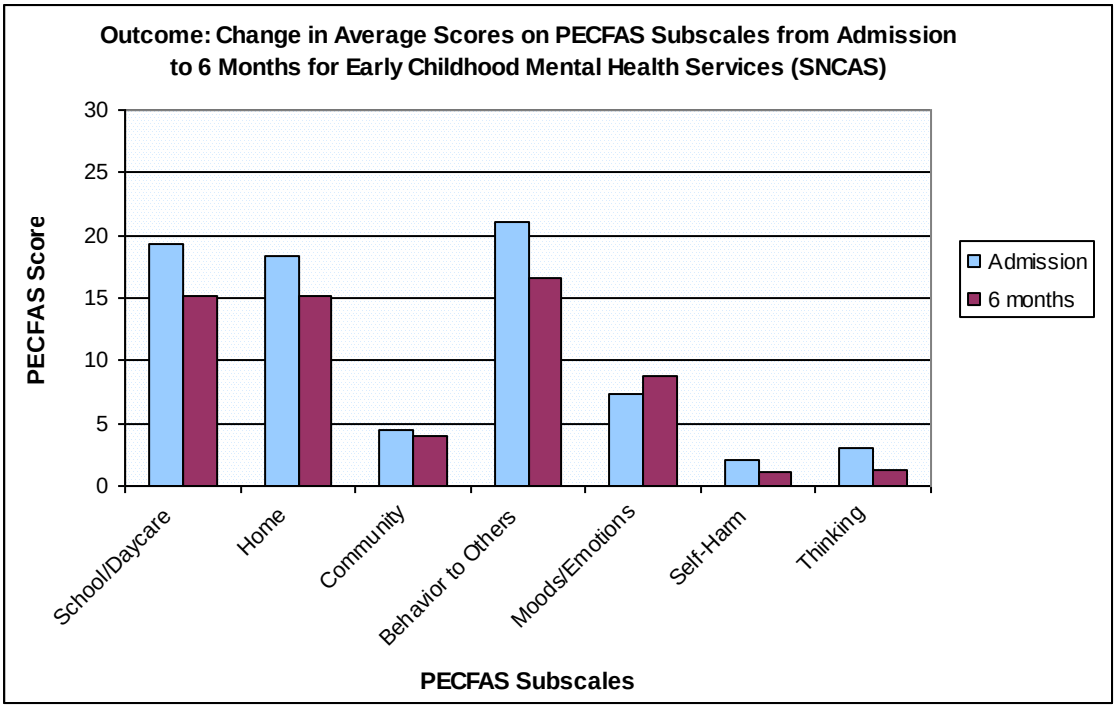


Based on 54 pairs, the average CAFAS score was 152.04 at admission. At discharge, the average CAFAS score decreased to 77.04, which indicates a statistically and clinically significant improvement in overall daily functioning. A clinically meaningful reduction in overall impairment must be a total score decrease of 20 or more points.

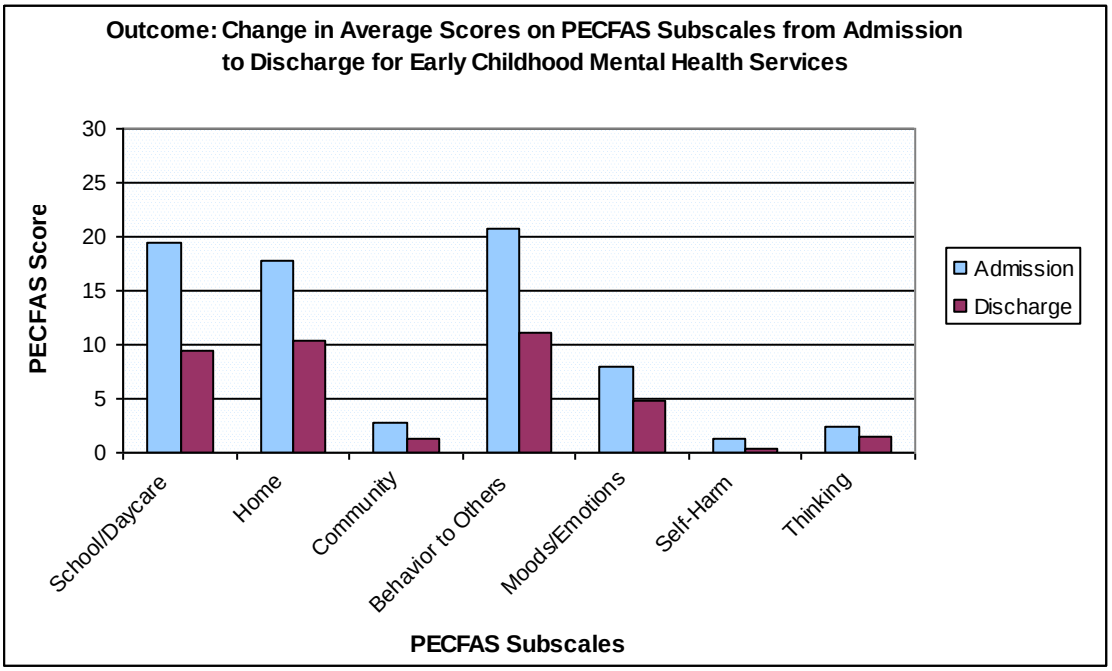
Early Childhood Mental Health Services NNCAS and SNCAS



Early Childhood Mental Health Services NNCAS – Based on 76 pairs, the average PECFAS score was 73.42 at admission. At 6 months into services or at discharge, the average PECFAS score decreased to 58.82, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment.



Early Childhood Mental Health Services SNCAS – Based on 197 pairs, the average PECFAS score was 75.69 at admission. At 6 months into services or at discharge, the average PECFAS score decreased to 62.13, which indicates a statistically significant improvement in overall daily functioning but not a clinically meaningful reduction in impairment.



Early Childhood Mental Health Services NNCAS and SNCAS – Based on 82 pairs, the average PECFAS score was 72.44 at admission. At discharge, the average CAFAS score decreased to 38.78, which indicates a statistically significant improvement in overall daily functioning and a clinically meaningful reduction in impairment.

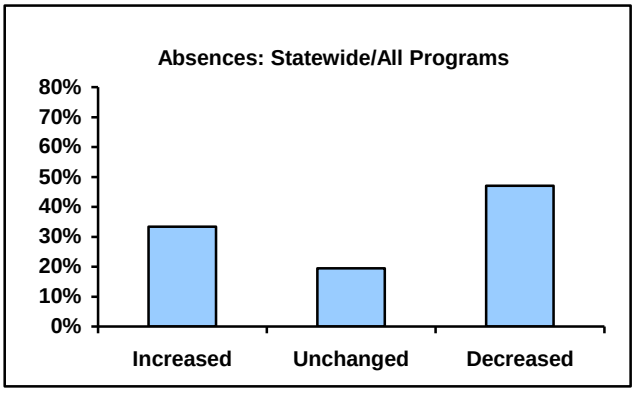
All DCFS Children's Mental Health Services programs showed improvement on the CAFAS or the PECFAS. This suggests that children's day-to-day functioning is improving.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

He is safe, and he will get the help he needs.

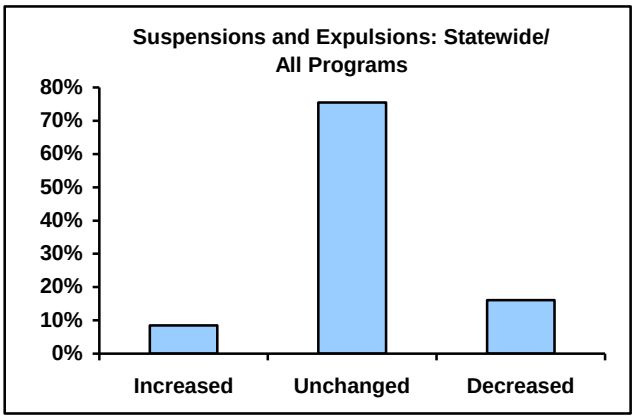
Education Outcomes

Absences: Statewide/All Programs



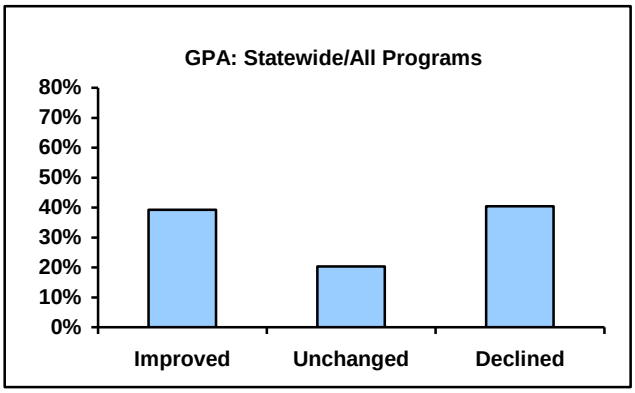
Clients tend to fluctuate from period to period in terms of school absences, so absences in the current grade period were compared to the average number of absences each student had over a number of grading periods to see if there was improvement against the average. The rationale is that if a student is, despite some fluctuation from period to period, reducing their absences, then the current period absences will be less than the average, thereby pulling the average down toward zero. In FY2010, 497 clients had education data for multiple grade periods from which an average could be constructed. Improvement in performance was seen in 234 (47.1%) of the clients, e.g. absences were down versus their average, a decrease in performance was seen in 166 (33.4%) of the clients (absences were up versus their average), and 97 (19.5%) of the clients saw no change in the current period absences versus their average. Of the 97 clients who stayed the same versus their average, 68 (70.0%) had a zero average that stayed zero due to zero absences in the current period. It is worth noting that approximately three clients showed improvement for every two that showed a decline in performance.

Suspensions and Expulsions: Statewide/All Programs



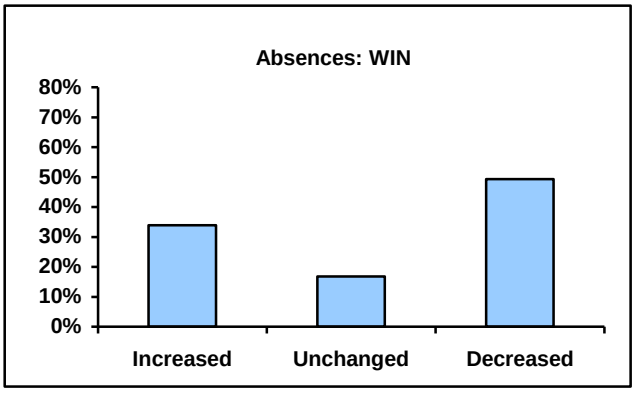
Clients tend to fluctuate from period to period in terms of suspensions and expulsions from school as well. So, in similar fashion, suspensions and expulsions were compared to the average number of suspensions and expulsions each student had over a number of grading periods to see if there was improvement against the average. The rationale is that if a student is, despite some fluctuation from period to period, reducing their suspensions and expulsions, then the current period suspensions and expulsions will be less than the average, thereby pulling the average down toward zero. In FY2010, 497 students had education data for multiple grade periods from which an average could be constructed. Improvement in performance was seen in 80 (16.1%) of the clients (the number of suspensions in the current period was less than their average number of suspensions and expulsions). A decrease in performance was seen in 42 (8.5% of the clients). There was no change in performance for 375 (75.5%) of the clients (the number of suspensions and expulsions in the current period was the same as the average). Of the 375 clients that showed no change in current suspensions and expulsions versus their averages, 365 had no suspensions or expulsions to date. It is worth noting that twice as many clients showed an improvement in performance than showed a decline in performance.

Grade Point Average (GPA): Statewide/All Programs



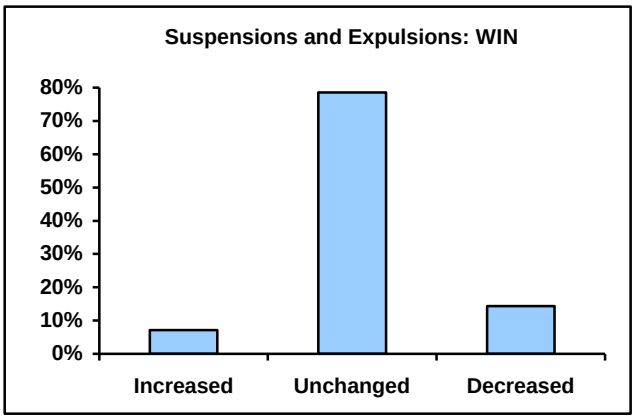
As with absences, suspensions, and expulsions, GPA tended to fluctuate from period to period so current GPAs were compared to the average GPA of each student over a number of grading periods to see if there was improvement against the average. In FY2010, 408 clients had grade point average data over multiple grading periods. Improvement in GPA against their averages was seen in 160 (39.2%) of the clients, and the average improvement was .3628 GPA points.

Absences: WIN



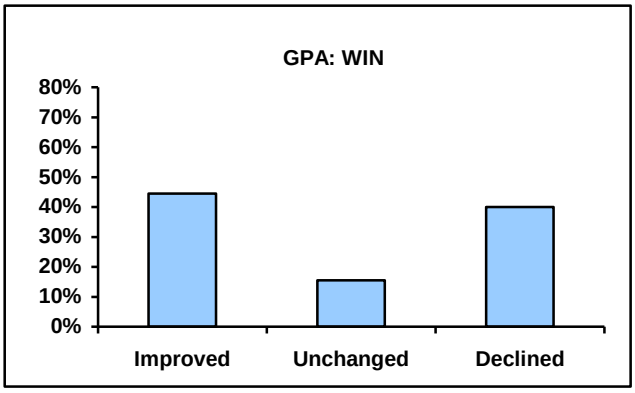
The Wraparound In Nevada (WIN) program accounted for 280 cases of the 497 cases with absence data over multiple periods. When isolated from the other programs, improvement in performance was seen in 138 (49.3%) of the WIN clients (absences were down against their averages), while performance declined in 95 (33.9%) of the WIN clients (absences were up against the average), and 47 (16.8%) of the WIN clients' absences stayed the same versus their average. Of the 47 clients that stayed the same versus their average, 30 (63.8%) had a zero average that stayed zero due to zero absences in the current period. Three WIN clients improved on their absences for every two that declined.

Suspensions and Expulsions: WIN



The WIN program accounted for 280 cases of the 497 cases with suspensions and expulsions data over multiple periods. When isolated from the other programs, improvement in performance was seen in 40 (14.3%) of the WIN clients (suspensions and expulsions were down against their averages), while performance declined in 20 (7.1%) of the WIN clients (suspensions and expulsions were up against the average), and 220 (78.6%) of the WIN clients' suspensions and expulsions stayed the same versus their average. Of the 220 clients that stayed the same versus their average, 214 (97.3%) had a zero average that stayed zero due to zero suspensions or expulsions in the current period. Two WIN clients improved on their suspensions or expulsions for every one that declined, and the majority had none prior to the current period and continued to have none in the current period.

Grade Point Average (GPA): WIN



Of the 408 clients with GPA data over multiple periods, 245 were in the WIN program. When isolated from the rest of the programs, 109 (44.5%) of the WIN clients improved their GPAs versus their averages.

SURVEY COMMENT FROM A SATISFIED YOUTH

They help me when I need it the most.

SURVEY RESULTS

It is both system of care best practice and a policy of DCFS that all children and their families/caregivers receiving mental health services through the Division be provided an opportunity to give feedback and information regarding the services they receive. One of the ways DCFS fulfills this policy is through annual consumer satisfaction surveys. In the fall of every year, DCFS conducts a statewide survey of the children's residential and psychiatric inpatient mental health service programs offered through NNCAS and SNCAS. In the spring of every year, a similar statewide survey is conducted for NNCAS and SNCAS children's community-based mental health programs. In both surveys, parent/caregivers with children in treatment and the children themselves (age 11 or older) are solicited to voluntarily participate in completing their respective survey instruments.

Survey participants are asked to disagree or agree with a series of statements relating to seven areas or "domains" that the federal Mental Health Statistical Improvement Program prescribes whenever evaluating mental health programming effectiveness.

The following tables present respective annual survey positive response percentages for both parent/caregivers and for age-appropriate children. Where available, National Benchmark positive response percentages are included for parents surveyed under community-based services nationwide.

SURVEY COMMENT FROM A SATISFIED PARENT

Thank you for providing a safe, clean environment for my child.

Percent of Positive Response for Each Survey Domain

Community Based Services Survey – Spring 2010	Parent % positive	Youth % positive	National Benchmark for Parent Response[5]
Service are seen as accessible and convenient regarding location and scheduling	90	78	84
Services are seen as satisfactory and helpful	91	80	83
Clients get along better with family and friends and are functioning better in their daily life	73	70	65
Clients feel they have a role in directing the course of their treatment	90	74	89
Staff are respectful of client religion, culture and ethnicity	96	86	93
Clients feel supported in their program and in their community	93	75	NA
Clients are better able to cope and are doing better in work or school	76	71	NA
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff (community based domain)	89	72	NA

Residential / Inpatient Services Survey – Fall 2010	Parent % positive	Youth % positive
Service are seen as accessible and conveniently scheduled	97	75
Services are seen as satisfactory and helpful	88	70
Clients feel they have a role in directing the course of their treatment	80	63
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff	74	66
Services are provided in a safe, comfortable and private environment	86	70
Staff are respectful of client religion, culture and ethnicity	96	73
Client educational needs are met while in treatment	56	78
Clients feel supported in their program and in their community	82	74
Clients feel they have a role in directing the course of their treatment	68	73

[5] 2009 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/dataoutcomes/urs/2009/palau.pdf

ATTACHMENT B

DCFS Community Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2010

From mid April to the end of May, 2010, DCFS conducted its spring survey of children's community based mental health service programs. Parent/caregivers with children in treatment and the children themselves (if age 11 or older) were solicited to voluntarily participate in completing the survey instrument. Participants were asked to disagree or agree with a series of statements relating to seven areas or "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness. An eighth domain surveyed select items of interest to community-based service program managers.

The seven MHSIP domains include statements concerning the ease and convenience with which respondents received services (Access); whether they liked the service they received (General Satisfaction); the results of the services (Positive Outcomes); respondent ability to direct the course of their treatment (Participation in Treatment); whether staff were respectful of respondent religion, culture and ethnicity (Cultural Sensitivity); whether respondents felt they had community-based relationships and support (Social Connectedness); and how well respondents seem to be doing in their daily lives (Functioning). The eighth domain (Interest Items) includes statements regarding client treatment and confidentiality issues, family dynamics/relating skills and client awareness of available community support services.

Survey Results Format

For this report, community based services survey results are in table format and are presented by type of service: Children's Clinical Services, Wraparound in Nevada and Early Childhood Mental Health Services under the Southern Nevada Child & Adolescent Services (SNCAS) and Outpatient Services, Wraparound in Nevada, and Early Childhood Mental Health Services under the Northern Nevada Child & Adolescent Services (NNCAS). Parent/caregiver and youth responses appear together under each domain. Statements listed under each domain are from the Parent/caregiver survey instrument. Youth responded to the same statements that had been reworded to apply to them. Early Childhood Mental Health Services have only parent/caregiver responses as the children served are too young (six years or less) to self-report on a survey instrument

The Parent/Caregiver and Youth Positive Response numbers appearing under each domain are percentages. A percentage number represents the degree to which a particular domain statement was endorsed or rated positively by respondents. Since not every survey respondent answers every statement, each statement's percentage numbers are based upon the actual number of responses to that particular statement.

You will notice that any statement on the survey with less than a 60% Positive Response number is "courtesy highlighted". Courtesy highlights call attention to any survey item having a respondent endorsement rate that is approaching the lower end of the frequency scale. Children's Clinical Services/Outpatient, Wraparound in Nevada or Early Childhood programs having courtesy highlighted items may wish to monitor these particular items in subsequent surveys should similarly low endorsement rates re-occur. Programs might opt to give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action might be taken. Programs may also want to compare results with previous survey findings.

Following each service area's domain results, you will find listed whatever remarks respondents offered regarding what was the most helpful thing about the services they received, what would improve upon the services they received and any additional comments they might have had.

A final section on survey participation concludes the report.

Survey Participants

Parents or caregivers with children receiving community based mental health treatment and the children themselves when age appropriate were participants in this spring survey. Responding to the survey were 260 parents/caregivers and 134 youth still in program. Survey participants were solicited by clerical/other office staff at the different locations providing the clients' mental health services. Survey questionnaires were self-administered and when completed put into closed collection boxes. Some caregivers and parents chose to complete the surveys at home and mail them to Planning and Evaluation Unit offices. Survey participation was entirely voluntary and survey responses were both anonymous and confidential.

The following table presents the number of parent/caregiver and number of youth surveys received from each region and treatment site. The parent/caregiver section of the table also includes the percentage of clients served who were sampled by the respective area's survey. Youth percentages are not given since not all clients served were age eligible for survey participation so any percentage would be non representative.

REGION & SITE	SURVEYS			
	Parent/Caregiver			Youth
	Number of Surveys	Number of Clients Served	Survey Sample Percent	Number of Surveys
SNCAS				
Children's Clinical Services	40	536	8%	37
WIN	30	285	11%	51
Early Childhood Mental Health Services	102	341	30%	NA
SNCAS Total	172	1162	15%	88
NNCAS				
Outpatient Services	24	209	12%	12
WIN –Reno/Rural	57	155	37%	34
Early Childhood Mental Health Services	7	164	4%	NA
NNCAS Total	88	528	17%	46
Statewide Total	260	1690	15%	134

Note: SNCAS = Southern Nevada Child and Adolescent Services
WIN = Wraparound in Nevada
NNCAS = Northern Nevada Child and Adolescent Services

DCFS Community Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2010

SNCAS
Children's Clinical Services Results

Parent/Caregiver N=40; Youth N=37 Total Served = 536 Sample = 8%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	93	89
Services were scheduled at times that were right for us.	100	81
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	86
The people helping my child and family stuck with us no matter what.	95	86
I felt my child and family had someone to talk to when he/she was troubled.	98	86
The services my child and family received were right for us.	97	86
I received the help I wanted for my child.	93	86
My family got as much help as we needed for my child.	92	86
POSITIVE OUTCOMES		
My child is better at handling daily life.	85	86
My child gets along better with family members.	83	76
My child gets along better with friends and other people.	77	76
My child is doing better in school and/or work.	72	69
My child is better able to cope when things go wrong	69	78
I am satisfied with our family life right now.	75	65
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	97	63
I helped to choose my child and/or family's treatment goals.	97	74
I participated in my child's and family's treatment.	100	72
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	92
Staff respected our family's religious/spiritual beliefs.	100	84
Staff spoke with me in a way that I understood.	100	86
Staff was sensitive to my family's cultural and ethnic background.	95	86
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	98	N/A
I have people that I am comfortable talking with about my child's problems.	98	N/A
In a crisis, I would have the support I need from family or friends.	80	76
I have people with whom I can do enjoyable things.	90	76
I am happy with the friendships I have.	N/A	70
I feel I belong in my community.	N/A	78
FUNCTIONING		
My child is better at handling daily life.	85	86
My child gets along better with family members.	83	76
My child gets along better with friends and other people.	77	76
My child is able to do the things he/she wants to do.	80	76
My child is doing better in school and/or work.	72	69

My child is better able to cope when things go wrong.	69	78
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	92	86
Staff explained my child and my family's rights and confidentiality issues.	100	89
I receive support and advocacy from my Nevada PEP Family Specialist.	87	76
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	90	75
Our family is aware of people and services in the community that support us.	98	78
I am better able to handle our family issues.	88	81
I am learning helpful parenting skills while in services	95	81
I have information about my child's developmental expectations and needs.	90	78

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • First of all the medication that she had at facility wasn't right until I came here for doctor's help and she became 100% better. • CFT meetings • Having Resources. Not feeling hopeless • School flexibility • (Staff) is the most helpful therapist we have ever had and are very happy to have her. • Keeping him happy and aimed in the right direction • They work very well with the children and they make me feel at ease • The Light at the end of the tunnel - hope • Awesome therapy • The concern (staff) displays towards my daughter, and the way she helps us in matters, decisions and ideas to help solve issues and concerns. • Regardless of what I may say, I am grateful • It has given us peace of mind with the counseling, and trying to find the right meds for him. • Being able to talk and someone else outside of the family unit • (Client) is improving. He likes coming to see his therapist. (Client) will be a better person. He needed someone to talk to. • The personal care and attention we have gotten • Learning to cope with every day disappointments • Flexibility to work on issues as they arrive. • I know how to get her to do what she is supposed to do now. • The most helpful thing that helped my family was improving • Friendly, positive attitude from staff. Both children have a good bond with staff and are practicing what they are suggested. • They are really helping me. • They are really helping me to understand a lot of things • Better understanding of my child and her problems • At least we are finally receiving some services • Our worker's persistence and motivation • Helping them to understand right and wrong, teaching them to focus and listen to adult authority • Someone to talk to • Seeing (staff) every week so my son can talk and make goals • My child is now more capable of coping with adversity • (Staff) being able to relate and reach my child. Having my child open up and being able to talk about his anger etc. • Available when needed • That he is able to internalize what they are saying; and effective communicate appropriately! • Feel better • Understanding his issues and learning about the parenting skills that I need to develop more to help him. • My daughter is controlling her attitude • The best that my son received is treatment and control of his illness. It is very good. • That she has someone to talk to and can confide in other people • In the Desert Willow Treatment Center I thank them very much because they returned my son like he was when he was a good child. He talks a	1. What has been the most helpful thing about the services you received? • They help me with the things I need and to help me with my daily life • Being able to express my feelings • PSR and basic skills • Bus passes, baby supplies and (Staff) helping me get back into school • How to deal with anger and stress • Medication keeps my mood stable • People listen to my problems • The therapy and my friends' opinions • My counselor • I have changed my negative action in positive interactions. I am very responsible • If I show a teacher that I want to learn then it will be easier to get a good grade • The help with my anger and having helped me in other ways • The most helpful thing about the services was the coping and listening • Talking to my therapist about my depression • I can cope with my behavior better • CASA • That I learned more about holding my anger back a little bit and ignoring people when they bug me • Nothing • Being able to talk to someone and learn to cope with some of my anxiety • Feel better • The coping skills • The information/help • Talking to someone older than me of my problems • It's fun. I can calm down • It gives me someone to talk to • Having someone to talk to without feeling judged

Parent/Caregiver comments	Youth comments
lot and has changed to a good child now.	
2. What would improve services your child and the family received? • Additional and more contacts and visits with caseworker • Having appt. to come in and talk to the doctors and therapist to better our family and understand the needs for the that's sick and needs help with socializing with others not just the family. • More info to parent • I can't think of anything more you can do. We love the services here. • Not sure at this point • You need more dollars for meds for people diagnosed and in need of meds, who can not afford or some assistance with payments. • If we got in touch with PEP • Need to have more family counseling. Need to have more parenting classes for families with SED kids. • So far I am satisfied • The help we have received to date has been awesome, hard to improve on all that good • Location and facility need a place for foster siblings to play while waiting for therapy • Try not to put so much emphasis on how long it takes to help someone. Some people take a longer time to understand and change because it is a lifestyle changes for some. • My family received a lot of services • What they do has helped with my boys • They're doing good with their services • Everything in places. Worker, therapist, PSR • More consistent in doing thirty day check-up by the DCFS worker/caseworker. However the services received were great. • I don't believe there is more that could have been done or that have helped more. • The best thing is that he has been behaving much better and the good thing is that he is already cured. • Everything is very good. thanks • Trust and family participation	2. What would improve services you received? • I wouldn't • Need more of them • Make it more entertaining • Nothing, (staff) was more than helpful. She's great • I feel the services are fine • Nothing. Everything is perfect • Therapy should not be mandatory • If they - you know who your are - :(wouldn't cancel on me • I am not sure right now at this time • I wouldn't • Nothing. Me being a boss of CCS • Maybe a little flexibility patient wise • No thoughts now things are going good • I can have a happy day with my mom • Make us feel like normal children. Less "labels" • The services are fine • More money • If we can do certain things at a certain time for example: games for ten minutes, then talking for ten minutes, then writing for ten minutes etc • Everything is fine the way it is • Talking about how life was for them when they were smaller like my age • Nothing
3. Additional Comments • I love it here and I intend to make an effort to keep appt. which it's good therapy for (client) and our family. Thanks to those who help me in living a better life w/ Dr. and therapist. If I have a question I'll give a call. • (Staff) is always willing to work with us and has a variety of therapeutic options for our family. She always gives the extra effort needed to meet our needs. • I really do appreciate everything that the employees and counselors do for our family. I feel comfortable with them. • Thank you (staff) for everything • (Staff) is very proactive with (client) and myself with all issues that we brought up. We are lucky to have her. • See # 45. when you have nothing • (Staff) is a wonderful therapist • Our worker was very understanding. She took the time to help me understand things. I can be pretty thick headed at times and she just didn't write me off. I don't think she will ever know how much she did for me and my girlfriend and I thank her and the services with all my heart. • They love the people that I know helping me with my boys • Very content with the program. I am glad this was available to my family and me in the time of crises in which we found ourselves. • They are very caring • I really like the people that we have helping us with my sons • Thank you very much for being here • The comment I have is that I am very grateful for everything; the services and help that my son has been given. Many thanks for everything. • Thanks for the services received • I feel very grateful for the services that I am receiving that already helped my children who needed so much. Thanks that God sent them.	3. Any additional comments? • Sometimes it gets very boring because it feels like I'm in the dean's office • (Staff) really helped me with a lot of my issues. I couldn't ask for more. She's a great listener and very understandable • Therapy helps me a lot • I was wondering if I could get back on my medication • Best baller alive #23 watch me on ESPN • Nope • It's fun ☺ • Yes. She's the best counselor ever • You guys have been a lot of help

SNCAS WIN Results		
Parent/Caregiver N=30; Youth N=51 Total Served = 285 Sample = 11%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	83	71
Services were scheduled at times that were right for us.	80	78
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	79	96
The people helping my child and family stuck with us no matter what.	90	75
I felt my child and family had someone to talk to when he/she was troubled.	97	80
The services my child and family received were right for us.	83	69
I received the help I wanted for my child.	83	76
My family got as much help as we needed for my child.	83	80
POSITIVE OUTCOMES		
My child is better at handling daily life.	67	73
My child gets along better with family members.	73	67
My child gets along better with friends and other people.	73	75
My child is doing better in school and/or work.	66	60
My child is better able to cope when things go wrong	67	65
I am satisfied with our family life right now.	69	52
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	65	54
I helped to choose my child and/or family's treatment goals.	82	72
I participated in my child's and family's treatment.	97	71
CULTURAL SENSITIVITY		
Staff treated our family with respect.	90	80
Staff respected our family's religious/spiritual beliefs.	86	86
Staff spoke with me in a way that I understood.	97	82
Staff was sensitive to my family's cultural and ethnic background.	89	69
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	93	N/A
I have people that I am comfortable talking with about my child's problems.	93	N/A
In a crisis, I would have the support I need from family or friends.	93	80
I have people with whom I can do enjoyable things.	93	82
I am happy with the friendships I have.	N/A	73
I feel I belong in my community.	N/A	80
FUNCTIONING		
My child is better at handling daily life.	67	73
My child gets along better with family members.	73	67
My child gets along better with friends and other people.	73	75
My child is able to do the things he/she wants to do.	73	76
My child is doing better in school and/or work.	66	60
My child is better able to cope when things go wrong.	67	65

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	82	65
Staff explained my child and my family's rights and confidentiality issues.	80	76
I receive support and advocacy from my Nevada PEP Family Specialist.	82	46
My Nevada PEP Family Specialist supports me in leading my child's	88	52

treatment planning or Child and Family Team meetings.		
Our family is aware of people/ services in the community that support us.	80	76
I am better able to handle our family issues.	83	62
I am learning helpful parenting skills while in services	79	82
I have information about my child's developmental expectations and needs.	86	67

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • Undecided • Support • Can't really say • Can't really say because I feel my children have become angry since services have been in place and also overwhelm with services. • I like the fact there is someone else to speak to besides the worker • The kids in our care have very severe problems that have no quick fixes. If we are assuming the role of their parents, then it will require their entire childhood to repair prior damage done by loss of family. We have met many dedicated workers who are attempting this feat, but we will never replace the loss of biological mom and dad. • When I need to talk about the children and their situation (staff) and (staff) really listen to me • Well the most helpful thing would have been to get me to be independent and living on my own with full custody of my daughter. • Just help and support with my youth in the home • Having the support and another pair of eyes to supervise and care for her. • Working in getting the license issue taken care • The knowledge • Consistent messages - she is important, she matters, self confidence, self-reliance • financially and with aftercare for my son (after school) • Maintains D.F.S. rules and regs. Makes sure family visits are available to everyone, lets clients know what is going on. Proactive in goals. • Good workers • Communicate better. Have more interest in others • He needed the counseling, and someone to care so that he could begin to care again. • Watching the progress • She has more people that care that she can confide in, and redirect her when needed. • Visits by worker • The most helpful thing is the support we all give to her. • They're able to cope more with changes in their behavior	1. What has been the most helpful thing about the services you received? • I learned the things I need to know. They will help me in the future • Basic skills for independent living and the community • Ms (staff), Ms (staff), Ms (staff) • Don't talk when someone else is talking and don't be afraid to ask questions • I am learning better ways to deal with things • I don't remember • When to walk away when things get crazy • Yes, (staff) • Let me go places and then learn from it • I get to talk to everyone and they open up my eyes to more things. Then have fun with them • Just about everything really • The helpful staff • Undecided. I haven't been in WIN long enough and the case worker for family services only comes once a month so he doesn't really help. WIN worker is doing good as far as I can tell • Helping me with problems • Interaction • I have learned more from this experience • CASA attorney • They check on me to make sure I'm okay and good and healthy • She has helped with everything • To control my behavior a little better, also talk about my issues sometimes • Talking with one another • I get along better with my friends • PSR worker • All the support • My support group. My family bring safe. Everything I have been provided • They look out for me. They help me stay out of trouble • They get things done fast • Being able to talk to someone, or just having the option to talk to someone there if I want to use it • That they listen to what I have to say • Medication • My case worker and the Gravate horse • Helping me strive for my goals • They have been there for me • My therapist. PSR WIN worker foster family • I do not know ye • The support they provided • Counseling • PSR • Support and CFTs • I can get a lot off my chest. Also cope with things the right way • It helped me so far to be a calmer person and take care of my daughter in a calm and relaxed way and achieve the goals I want to.
2. What would improve services your child and the family received? • Service should be limited to the needs and not what the department feels the needs are. Every child is different and too many services can be to much for any adult. • Not much at all. They're doing a great job already • Services are designed to provide the emotional stability, and practical life skills to enable a child to grow into a productive, responsible adult. Too many young people do not view this as an important goal, and resist services that are not "fun" oriented. The foster care system (Licensing, DFS, DCFS, CPS) can be very adversarial. It has also become very complicated because of the constant flux with Medicaid regulations and the economy etc. • The funding got out. And I think that helps youth get things they can't	2. What would improve services you received? • Have more fun and food and thing • My relationship with worker a little bit • I don't really want to change anything • Nothing • Bus passes. Health card • I would want to change my day treatment hours because I feel that it is not doing anything for me • Talk more and get to know people • None at the moment • If there was more one-on-one. If more time was spent with children. And more programs/activities are done • Playing football and skateboarding

afford • I wouldn't change anything or any one on my team. They are very wonderful to associate with. • I am very pleased and grateful with the services • There is nothing they should change • Giving me all the community resources available to them. • Nothing • Don't know • More convenient location and times that don't interfere with work/school schedules • Nothing I can think of. (Staff) is wonderful • Put things in place that prepare kids for the real world. This requires their recognizing the need for discipline, not entitlement, and requiring school participation. • I don't really know right now • All good. All the services wrap around has provided fits our needs. • More focus groups about FAS • Having it available even after case close with same worker. • Everything's been good • Satisfied with services as is	• Doing more in the community • See parents more often • It is good as is • To teach me a little more about life in details like how to buy a car, sign up for an account • Get me out of glass house for starters • I think she has helped me with all I need • More hands on help with me directly • Nothing, it's going fine it needs no improvement • Therapy should not be mandatory • Nothing, it's going fine it needs no improvement • Nothing is perfect • More funds for different things and group activities • Seeing them when I want • Doing it my way • Can't think of anything I pretty much like it the way it is.
3. Additional Comments • (Staff) is a great provider. She rocks • I have watched (client) go from a happy lovable kid to an angry kid within 6 months of services. • The wrong questions are being asked. Need real solutions • I am glad for the help and I thank you for helping me become successful in life. It's a lifetime memory I'll never forget. • Keep up the good and respectful work that you do • (Staff) is the best. Understanding, patient, respectful to all members of the family at all times. • Not at this time • Kids need to know that there are serious consequences for their actions. Because of the rules, DFS kids don't believe that the realities of life will be as hard on them as on others. Their lack of ambition, motivation and participation is testimony to the message being sent. • (Staff) is a wonderful wrap around worker • Great service from the PCW and good support from rrfsc • I've really enjoyed your services • For #'s 32-42 I already had the ability to handle those situations without services.	3. Any additional comments? • Not applicable • The system sucks • Yes, I need to go to the doctor for my nose bleeding. A lot! • I love (staff). Keep what you are doing • (Client) is doing great. He is doing better at making sure our needs are met then anybody in the system • I am thankful for all of my workers and their support

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=102; Youth = NA Total Served = 341 Sample = 30%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	92	N/A
Services were scheduled at times that were right for us.	96	N/A
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	97	N/A
The people helping my child and family stuck with us no matter what.	92	N/A
I felt my child and family had someone to talk to when he/she was troubled.	94	N/A
The services my child and family received were right for us.	92	N/A
I received the help I wanted for my child.	93	N/A
My family got as much help as we needed for my child.	91	N/A
POSITIVE OUTCOMES		
My child is better at handling daily life.	82	N/A
My child gets along better with family members.	89	N/A
My child gets along better with friends and other people.	81	N/A
My child is doing better in school and/or work.	85	N/A

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=102; Youth = NA Total Served = 341 Sample = 30%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is better able to cope when things go wrong	85	N/A
I am satisfied with our family life right now.	82	N/A
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	73	N/A
I helped to choose my child and/or family's treatment goals.	91	N/A
I participated in my child's and family's treatment.	96	N/A
CULTURAL SENSITIVITY		
Staff treated our family with respect.	96	N/A
Staff respected our family's religious/spiritual beliefs.	92	N/A
Staff spoke with me in a way that I understood.	99	N/A
Staff was sensitive to my family's cultural and ethnic background.	94	N/A
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	94	N/A
I have people that I am comfortable talking with about my child's problems.	95	N/A
In a crisis, I would have the support I need from family or friends.	92	N/A
I have people with whom I can do enjoyable things.	91	N/A
I am happy with the friendships I have.	N/A	N/A
I feel I belong in my community.	N/A	N/A
FUNCTIONING		
My child is better at handling daily life.	82	N/A
My child gets along better with family members.	89	N/A
My child gets along better with friends and other people.	81	N/A
My child is able to do the things he/she wants to do.	86	N/A
My child is doing better in school and/or work.	85	
My child is better able to cope when things go wrong.	85	N/A

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	N/A
Staff explained my child and my family's rights and confidentiality issues.	91	N/A
I receive support and advocacy from my Nevada PEP Family Specialist.	89	N/A
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	92	N/A
Our family is aware of people/ services in the community that support us.	93	N/A
I am better able to handle our family issues.	94	N/A
I am learning helpful parenting skills while in services	97	N/A
I have information about my child's developmental expectations and needs.	92	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • That she is adjusting to the separation of her parents • That you have an excellent Dr. and he is expressing his emotions and is happy. • Change of attitude is better • You have given us good advice and little worry. • It's been great for me and my child today • He has stopped biting, more mellow and cooperative, Daycare says he's doing much better • There being someone to discuss concerns and ideas • I have learned how to protect my son, and how to choose people to be trusted around my son. • I get to spend • Us being able to share daily ups and downs regarding (client) with his therapist. • I have learned to protect me and my son better and develop better and healthy relationship. • (Staff) has given the kids skills that have helped them better cope with their mother's death. • How to play with my children is a more positive way • Learning she has developmental delays due to neglect/abuse - learning how to deal with them to make the child come around and her life better, more trusting, loving relationship; knowing that someone loves her and is there for her! • Only one week • Just how to deal with him at home, behaviors, tantrums, etc. (Client) has come miles since he started seeing (staff). • The more their bonding with me and paying attention • Support me when my new baby arrives. My son has aggression to the baby and all workers been helpful and support to me and my family. • The way they have talked about their bad experience • Working with someone who goes above and beyond their position to help support you and your family. • Creative and fun • Tools to deal with behavior issues, identifying emotions, getting (client) to discuss feelings, site visit to see (client) in his daycare environment. • Developing skills to control their behavior • Allowing my daughter to have someone she feels comfortable talking to outside our family. • Just knowing that we are not alone, we have help available • Even though progress has been slow, my son would not be the same without the patient, consistent, loving support of his therapist teaching him the coping skills he needs to learn. • Learning ways to talk and learn with my daughter • Learning how to talk to my child and learning about her mental illness. • She seems to be happier • I t gives me time to bond with my kids • Understanding his behavior • Has been very helpful in helping her to identify with her feelings. • To get the kids to feel comfortable with the foster family • Teaching me better ways to help my child and teaching my child to listen better and cope better. • It helped her bond with me more • My PEP family specialist was there when I need him. I call if he doesn't answer me he calls no matter what. • To solve problems • Tailored to his needs, changes as he changes • The way it is helping us help him deal with his anger issues • Helping with communication and discipline issues and helping our family understand Post Dramatic Stress Disorder. • Transitioning between foster home and biological mom • Helping with (client) behaviors and his interactions verbally. • Ways to cope with her anger • Improvement in behavior and ability to handle stress. • (Staff) the way she talks to me and the kid. Very understanding • Just for someone (staff) to listen to him/us and not judge us. He has gotten better when we come and get the one on one. • Everything • Coping skills and support • (Staff) has been there through thick and thin all appt and school apt.	1. What has been the most helpful thing about the services you received? • NA

• Therapy was helpful • Teaching tools and staff • Day treatment to help with social skills. And with speech. A behavior emotional • The therapist is excellent and second to none • Personal attention, questions, answers, follow up, giving to my home, extra mile. • Coping with transition • Understanding what he is going through and what he trys to do without communication. • Understanding and expectations • She talks to us on our level, answers our questions, gears treatment to us individually rather than textbook quotes. • Medications • He has someone he can talk with about what is troubling him and is able to receive coping skills • How to give each time quality time alone with the parent. The discipline process • Everything that (staff) has done to train me, deal with my child's behavioral issues - she has done a FANTASTIC JOB! Thank Dr. • Emotionally she is more happy • Helping to discern his issues and find ways to help him. • Education • It has really helped my daughter in tremendous ways physically, mentally and emotionally. • (Client) speech is getting better and he is learning more • I have learned from (staff) that no matter what, she (client) does love me, and the dangers she goes through came from every situation she's ever been in. My daughter will be okay. • Every time I'm learning new things to better my son's treatment and he is getting better • Aided me in exploring all viable resources for my child and family, to aid us with more useful outcomes. Offered and educated us on what was available, but then respected our choice to choose. • (Client) really looks forward to therapy with (staff) • The breathing techniques when angry, the happy, sad, angry faces they draw to express themselves. • Allowing my grandson to show his emotions through play • The many alternatives our therapist suggests and works with child in therapy. • To learn coping skills • Everything (staff) has done for us has been wonderful • (Staff) has a special bond with my daughter and I look forward to her coming to work with her. • Therapist gives friendly supportive suggestions and communication to help me succeed at helping my child. • For him to learn to express his feelings • (Staff) has been my strongest support system in a state where I have no one to turn to. • How (staff) works so well with my child and family • Learning how to help (client) identify her feelings and express them their right way. • Better ways to learn for her age • Just started • I'm grateful for the consistent help and knowing that for every roadblock I can call and get advice on how to handle the situation.	
2. What would improve services your child and the family received? • Nothing • If we had them for a longer time • I thing everything is correct • They have done a great job so far • Nothing. I am perfectly content with the help I am receiving • Put them in our home • Best treatment to bond with my baby to get to know him more and he gets to know me more. • Continued therapy for (client) (he may need individual sessions without us in the room with him so that he can share more of his feelings) • At the moment I am content and happy with all the services I am receiving • Being able to get appointments quicker with facilities/services that are needed (I understand cutbacks, but the children are the ones who suffer for it! - they didn't ask for these things to happen to them, and there are a lot of them) • Nothing at the moment • I would like for the adoption proceedings to go more quickly. It's been 3 1/2 years. But these services from (staff) have been extremely helpful. I wouldn't change anything about the services received from (staff)	2. What would improve services you received? • NA

• Maybe more time or days • Give the workers the tools they need to provide services. • Everything is great • That each family could have their help for a longer period of time and their services would not stop because at the moment there is no issue. Issues are always arising in a child's daily life. • Everything is good • Home visits • In home services/therapy available • More visitation • Everything is great. No improvement needed • I'm not sure at this time. (Client) is doing very well at this time. • The services are just fine and I agree the services are very helpful • My child is FAS. But has not been diagnosed officially. My child needs to be assessed at Lillie Clinic. • Come out to the home and interact • Able to talk • You should have more Specialists to work with the people who need most help for example children with special needs. • Extra hours • Weekend hours • More educational classes on behavioral issues and understanding diagnosis. Also maybe a family group counseling once in a while or support groups. • More time spent with biological parents • I want him to have horse therapy. He loves animals. Also continuing with his OT. Speech. Possibly more speech. • Everything that's being done is working well • Nothing from begin to end everything has be awesome. • Needs no improvement • Its all good from our side • Nothing from begin to end everything has be awesome. • Nothing. Leave open at this time • Nothing at all services has been med • Pay attention to culture/religious beliefs • I like everything already • Two times a week • Maybe coming to the home to have better hands on in my home life that my child does. And or gets into things. • More direct work with the child • Nothing. I enjoyed all the services that were provided especially by (staff) she helps me out a lot. And I really do appreciate it. • Housing • Nothing yet • My own patience • Everything has been just fine. I'm truly happy and content with everything the whole service has done a good deed! • I think the services we have received need no further improvement • Limited access to the psychiatrist was challenging to meet the needs of my child. Difficult to schedule timely appts in general and next to impossible to schedule on an emergency basis. • A location in Laughlin or to be able to come to our home • AT this time I feel she is getting the help she needs and with the love of our family she improves daily. • Need more resources and support for medical questions and concerns • Help with paying utility bills. Help with bus pass. Respite activities for my toddler. • More access to community services • Everything works well for us • Nothing. I am very pleased • Learning more on how to be a better parent for her age.	
3. Additional Comments • Many thanks. I am grateful for everything • The county and State people have been wonderful • We have only had (client) in our home for 1 2/3 weeks, therefore we are still learning new behaviors and helping him with his new transition. • I do think the program is very helpful • I really dislike DCFS and (staff) and (staff). But (staff) gets it together. • (Staff) is great. She explains things well and I am very grateful we have her. Thank You! • Survey is a little too early to give a good assessment • They've been great. She's great with (client) and very helpful to me also. • I want to thank (staff), (staff) and (staff) for all the support to my family • Thank you so much (staff) for numerous hours of phone calls to help me be able to deal with problems with my children and never acting like she was too busy to hear my rants. Thank you again. • Great program for families	3. Any additional comments? • NA

- Wonderful!! Thank you for not giving up on him. Thank you for family gifts during holidays too - that is a great extra!
- Need to be assessed for FAS
- This is a great program. Thanks
- Way to stop his meltdown
- I hope not to go through this again
- I would like to have better customer services on your office. Language is a barrier. Thanks you for your services.
- No
- I appreciate if someone doesn't know an answer they are willing to help us find information and referrals that will help situation, Thank You
- Our caseworker is great with (client). She understands what services we need
- I just want my grandson to continue all of his services so he can thrive and become a complete and function individual.
- Thank you for your support
- I thank (staff) for coming into our life and placing a great mark of love and respect. We can't have asked for any more.
- I thank DCFS. Help with everything for my family. The help I get is a good thing.
- (Staff) is phenomenal, she's great. She's awesome
- It feels forced and like what you say means nothing. I think she sees parents as mistake makers who she needs to fix!
- (Staff) is absolutely the best therapist for kids on the planet
- We love (staff), she has been a great person to work with and has made my work easier and has helped A LOT for me to learn.
- I am very happy to meet (staff) and she is special to us
- As a foster family it is sometimes difficult when we have so many different people involved, and they typically do not agree.
- Thanks so much your services are the best I wouldn't choose another company for service.
- (Staff) has taught me how to look at life with the glass half way full. Thank You.
- A greater variety of mental health service providers for early childhood (medical recipients) would be beneficial. Our ECS worker was exceptional in meeting our needs and being a liaison when needed. Appreciate during crises times without child.
- (Staff) has been a godsend to our family and our grandson! He is exceptional at his job and with children!!
- (Staff) has been an asset for our family and her professionalism and charm are very refreshing.
- The Therapist (staff) is excellent. My child loves working with her. She has helped me a lot. She goes above and beyond.
- Thanks for your help
- Thank you so much (staff)
- I would have lost my kids or given up if not for (staff)! Thank You!
- (Staff) was and still is a very good help in my child's life as well as mine.

NNCAS

Outpatient Services Results

Parent/Caregiver N=24; Youth N=12 Total Served = 209 Sample = 12%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	83	58
Services were scheduled at times that were right for us.	79	83
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	96	92
The people helping my child and family stuck with us no matter what.	75	58
I felt my child and family had someone to talk to when he/she was troubled.	83	67
The services my child and family received were right for us.	88	67
I received the help I wanted for my child.	83	58
My family got as much help as we needed for my child.	74	58
POSITIVE OUTCOMES		
My child is better at handling daily life.	57	50
My child gets along better with family members.	54	50
My child gets along better with friends and other people.	63	64
My child is doing better in school and/or work.	42	42

NNCAS

Outpatient Services Results

Parent/Caregiver N=24; Youth N=12 Total Served = 209 Sample = 12%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is better able to cope when things go wrong	46	45
I am satisfied with our family life right now.	50	55
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	82	58
I helped to choose my child and/or family's treatment goals.	90	82
I participated in my child's and family's treatment.	96	75
CULTURAL SENSITIVITY		
Staff treated our family with respect.	96	92
Staff respected our family's religious/spiritual beliefs.	95	75
Staff spoke with me in a way that I understood.	96	83
Staff was sensitive to my family's cultural and ethnic background.	95	83
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	88	N/A
I have people that I am comfortable talking with about my child's problems.	88	N/A
In a crisis, I would have the support I need from family or friends.	74	50
I have people with whom I can do enjoyable things.	91	58
I am happy with the friendships I have.	N/A	73
I feel I belong in my community.	N/A	42
FUNCTIONING		
My child is better at handling daily life.	57	50
My child gets along better with family members.	54	50
My child gets along better with friends and other people.	63	64
My child is able to do the things he/she wants to do.	75	42
My child is doing better in school and/or work.	42	42
My child is better able to cope when things go wrong.	46	45

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	86	73
Staff explained my child and my family's rights and confidentiality issues.	83	82
I receive support and advocacy from my Nevada PEP Family Specialist.	87	44
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	88	56
Our family is aware of people/ services in the community that support us.	88	67
I am better able to handle our family issues.	70	42
I am learning helpful parenting skills while in services	86	75
I have information about my child's developmental expectations and needs.	78	36

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? • It will allow him to be seen by a psychiatrist without insurance • My son has better communication with his family and is coping a lot better now • Everyone is very supportive • Continuity of support during difficult times and unforeseen challenges • Willow Springs • People who care • Gave her options • Constant help • Really not sure	1. What has been the most helpful thing about the services you received? • I Not sure • How to say no it was not my fault • Being able to talk to someone that can help • Talking to someone who understands • I don't know • Learning to manage my anger problems • The tools to cope with things • It has gotten my family and I back together, which I appreciate a lot.

• Our therapist has been very understanding • My son's therapist has recommended many ways of structural and positive re-enforcement • They are not fighting as much anymore • Talking to someone about issues and having my child be able to have someone on her side • She is more willing to talk • Help him to be able to control his anger and what makes him lose control • He is learning to cope with everyday life • How the doctor talks to me about what is needed to be handled on that visit • He seems more peaceful and happy • That she knows or has learned better control when one tells her something. For example "Don't touch that" and she obeys all these little things that seem simple but are so important. Everything is good • The support that I receive is most helpful	
2. What would improve services your child and the family received? • We need more time to get to know his therapist • There is nothing I would improve on right now. Everything is getting better now • None • Psychosocial rehabilitation specialist (insurance does not cover) • Take all kinds of insurance • Less distance and location of support materials • I do not like changing psychiatrists every year • More interaction with her siblings. Can fix it if you don't spend time with the problem at hand. • Not sure at this time • Nothing at this time • Nothing that I can think of • Nothing, everything has been perfect	2. What would improve services you received? • Can't decide • Don't know. Everything is great • Nothing • No clue
3. Additional Comments • None • Thank you • Thank you for your help • (Staff) is doing a really good job with my kids. I appreciate all the help that I am getting • Only thanks for your help • His therapist is wonderful for him. Thank You	3. Any additional comments? • Nope • No • Nope - Fuzzy Diddly Umpkins of Doom • Thank you

NNCAS

WIN Results

Parent/Caregiver N=57; Youth N=34 Total Served = 155 Sample = 37%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	84	79
Services were scheduled at times that were right for us.	95	85
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	96	94
The people helping my child and family stuck with us no matter what.	93	91
I felt my child and family had someone to talk to when he/she was troubled.	95	88
The services my child and family received were right for us.	95	71
I received the help I wanted for my child.	95	85
My family got as much help as we needed for my child.	91	85
POSITIVE OUTCOMES		
My child is better at handling daily life.	86	88
My child gets along better with family members.	86	94
My child gets along better with friends and other people.	89	87

NNCAS

WIN Results

Parent/Caregiver N=57; Youth N=34 Total Served = 155 Sample = 37%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is doing better in school and/or work.	84	91
My child is better able to cope when things go wrong	78	91
I am satisfied with our family life right now.	86	76
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	80	79
I helped to choose my child and/or family's treatment goals.	94	91
I participated in my child's and family's treatment.	98	88
CULTURAL SENSITIVITY		
Staff treated our family with respect.	95	97
Staff respected our family's religious/spiritual beliefs.	94	91
Staff spoke with me in a way that I understood.	100	100
Staff was sensitive to my family's cultural and ethnic background.	94	97
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	96	N/A
I have people that I am comfortable talking with about my child's problems.	98	N/A
In a crisis, I would have the support I need from family or friends.	98	91
I have people with whom I can do enjoyable things.	93	91
I am happy with the friendships I have.	N/A	100
I feel I belong in my community.	N/A	82
FUNCTIONING		
My child is better at handling daily life.	86	88
My child gets along better with family members.	86	94
My child gets along better with friends and other people.	89	87
My child is able to do the things he/she wants to do.	88	82
My child is doing better in school and/or work.	84	91
My child is better able to cope when things go wrong.	78	91

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	89	80
Staff explained my child and my family's rights and confidentiality issues.	95	94
I receive support and advocacy from my Nevada PEP Family Specialist.	76	68
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	81	62
Our family is aware of people/ services in the community that support us.	98	91
I am better able to handle our family issues.	91	88
I am learning helpful parenting skills while in services	92	94
I have information about my child's developmental expectations and needs.	95	84

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? • Coordinating people and agencies • My case manager is the most helpful thing. She keeps things organized and functioning • Have (staff) and (staff) help • (Staff) helping with our family • More informed about the services • All of it • Support for my child • Support for her emotional behavior	1. What has been the most helpful thing about the services you received? • They help me when I need it the most • Everything • That I get the help I need from him, WIN, the whole thing • Helping with family and education • hey are there when I need them • The helpful staff • (Staff)'s support • Having someone to talk to and help me with decision I make • I do not know

Parent/Caregiver comments	Youth comments
• Support when things go wrong or my child needs something • Consistency and follow up • (Client) has shown more of an ability to discuss problems and seems to take more responsibility. • Given a structure routine • Not able to give one • Very helpful • Education, health and much more • (Staff) is very good at communicating with me. (Client) feels very comfortable with (staff) • Communication • Emotional support for the family • Support and all the services (staff) provided and continues to provide • Linked to Shriners Hospital, clothing, tutoring, furniture • NV PEP, tutoring, clothing, PSR, Boy Scouts, NV Energy Assistance, WIN Foods, support from family • Coping skills and support • Our WIN worker has always been someone we all could count on no matter the reason • Listening ear • Support • Undecided • Educational and emotional goals • Parenting skills. Behavior skills • (Client) looks forward to spending time with WIN worker, not always with therapist or CFT but, enjoys trips taken • We feel the services we receive are like a family. Everyone works together for a common goal • My child's worker is available all the time for any problems I may have. She assists in all aspects of my child's growth. I don't know what I would do without (staff) • WIN does a good job of keeping tabs on him • .Anger management, no longer in danger of being expelled from school • WIN absolutely WIN • WIN workers have been most helpful and accommodating in meetings and daily life. Very Supportive • Use of staff for offsite passes • Financial help with clothing and everyday necessities • The meetings (regularly) • Knowing that I have a team for my foster son that is very supportive • Support and a shoulder to lean on • We don't know what kind of counseling our children are receiving • We have another person to go to if needed • Trust and knowing she can say anything and not be afraid of what she says will not get her into trouble • The meeting with the team • I don't know what I would do without these services; I rely on them so much. Whenever I need any help I Always use (staff) as a sounding board. She is an excellent resource and support.	• I am more well-read, I am learning to ride horses, and team rope • Undecided • Tutoring, mentor, scouting, NV PEP, school supplies and clothing. Camp funds through WIN • The ability to be a kid again. And my grades • I learned better skills on how to talk to people. I have matured • Educational goals • Rides to Nora • I think the most helpful thing would be, was when I was in Reach and it would be how to channel my anger • Drug counseling, therapy, PSR • Learning more about myself and my emotions are more under control • Talking to people • Family setting • Some are positive to talk to • I feel I understand why I'm in foster care now • Have been able to do the things I want i.e. soccer • To cope with my anger and gave me a punching bag to help with my outbursts • (Staff) is there for me day or night and easy to talk to and understands and doesn't judge me • (Staff) supports me in every way She goes above and beyond I wouldn't be where I am without (staff)' support

Parent/Caregiver comments	Youth comments
2. What would improve services your child and the family received? • Have more therapy in our town • I really don't know because everyone has been so helpful to us and I'm very happy • Not sure at this time • Nothing I can think of • I would like to have guardianship or keep A in my home much longer if at all possible • I think it is all positive. I appreciate the work (staff) does • If we could have more time to get on our feet (feel,) knowing we have WIN's support • Now a 60 minute round trip • WIN worker has also been great. Thank you (staff) • Nothing I'm satisfied • We have all we need • More staff like (staff) • Improvement on living arrangements • I think to improve services for my child and family, a possible break from the daily counseling and workers would be beneficial • Weekend support from state workers • To know what kind of counseling our kids are receiving and to be involved in said counseling • Instead of gossip that gels us I'd like honest face to face information • Nothing - to always be able to help others as they have us • Having all team members in the same community • If everyone in the system cared about the children like (staff) does	2. What would improve services you received? • I don't know • I would like to see him more • I drew a happy face • Nothing • If I had more of a choice in the homes I'm in • They're perfect right now • More practice of throwing the rope around the horns of the steer • (Staff) could stay on longer • Undecided • I don't know. Everything's great • Being able to see my mom. She needs to start coming to the visits • To see family more • Talking to (staff) and talking with my brothers • A little more information but other than that nothing • By spending this time with them and more time with my friends
3. Additional Comments • Not enough families that I know of are aware of WIN. There are families that need to know about WIN; is a newsletter possible to help speed the word about the program? • I hope I can still depend on everyone if I have any problems that come up • My experience with WIN has been positive. Workers showing dedication and excellence • I'm still learning every one and how things work, but I'm very happy to have such a wonderful worker that listens to me. Thank You • (Staff) has help make healthy changes in our life • (Staff) is a wonderful support and (client) has progressed more since (staff) became involved than the whole time before we had he • (Staff) is positive and very helpful • We could not do this without this help. We are grateful to have all the services we have • My worker always stays positive even when I'm most frustrated with the parents • I have an excellent worker so I don't have any concerns. My worker goes above and beyond for my child. If I have any problems she is there to help me and facilitate with my child and his needs • WIN worker did a great job in leading the CFT • I think all the state workers pry and dwell on all the same subjects, causing my "child" to be irritable and upset • The staff with the win program has been extremely helpful to myself and my daughter in the hardest time we had to overcome. They help with our individual issues. Emotional, trust, trust others. With their help and encouragement from the Team I am in early recovery of my drug and alcohol addictions. Sober 1 year. I could trust each and every member of the team knowing I could call them anytime if i need someone to talk to. They do their job extremely well. I don't think we could have made it this far without the help of these wonderful ladies! • I don't think I could handle the children I have without the guidance I've received from (staff). I think the reason this home runs so smoothly is because I'm so lucky to be on her team. Over the last 2 years I have learned so much from her. I'm very lucky.	3. Any additional comments? • I love my WIN worker • I love (staff) and (staff) and my foster family • My WIN worker is pretty good • You Rock (staff) and everyone else!!! • Thank you for your help • I am very thankful for the services that I have been provided for me • I love (staff) she is like my family • To spend more time with friends and more of me time and less time with my services I am receiving with Maple Star and (staff).

NNCAS

Early Childhood Mental Health Services Results

MEDICAID REPORT 2011
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2010 SUMMARY

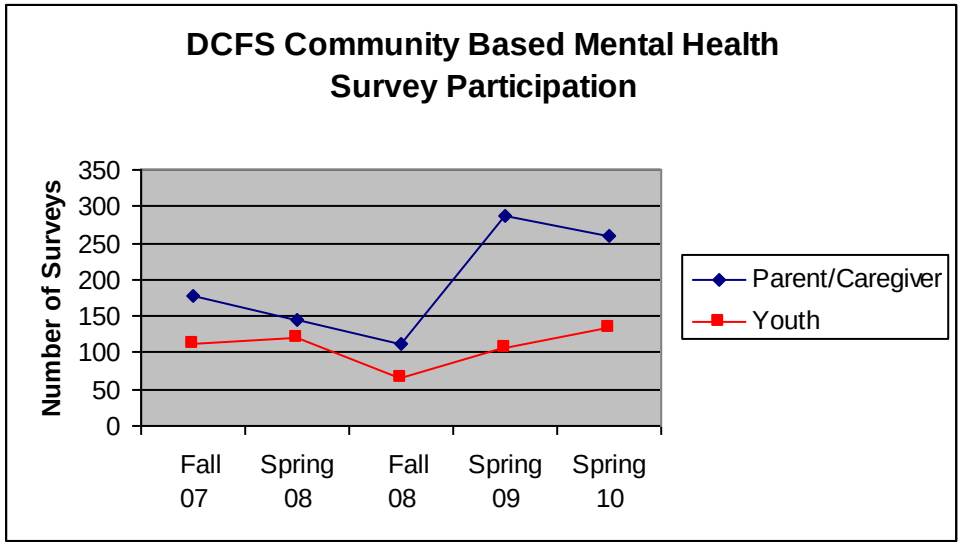
Parent/Caregiver N=7; Youth N=NA **Total Served = 164 Sample = 4%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	86	NA
Services were scheduled at times that were right for us.	100	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	NA
The people helping my child and family stuck with us no matter what.	87	NA
I felt my child and family had someone to talk to when he/she was troubled.	100	NA
The services my child and family received were right for us.	100	NA
I received the help I wanted for my child.	100	NA
My family got as much help as we needed for my child.	83	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	83	NA
My child gets along better with family members.	67	NA
My child gets along better with friends and other people.	83	NA
My child is doing better in school and/or work.	60	NA
My child is better able to cope when things go wrong	67	NA
I am satisfied with our family life right now.	50	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	NA
I helped to choose my child and/or family's treatment goals.	100	NA
I participated in my child's and family's treatment.	100	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	NA
Staff respected our family's religious/spiritual beliefs.	100	NA
Staff spoke with me in a way that I understood.	100	NA
Staff was sensitive to my family's cultural and ethnic background.	100	NA
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	100	NA
I have people that I am comfortable talking with about my child's problems.	100	NA
In a crisis, I would have the support I need from family or friends.	100	NA
I have people with whom I can do enjoyable things.	100	NA
I am happy with the friendships I have.	N/A	NA
I feel I belong in my community.	N/A	NA
FUNCTIONING		
My child is better at handling daily life.	83	NA
My child gets along better with family members.	67	NA
My child gets along better with friends and other people.	83	NA
My child is able to do the things he/she wants to do.	100	NA
My child is doing better in school and/or work.	80	NA
My child is better able to cope when things go wrong.	67	NA

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	67	NA
Staff explained my child and my family's rights and confidentiality issues.	100	NA
I receive support and advocacy from my Nevada PEP Family Specialist.	100	NA
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	100	NA
Our family is aware of people/ services in the community that support us.	100	NA
I am better able to handle our family issues.	83	NA
I am learning helpful parenting skills while in services	100	NA
I have information about my child's developmental expectations and needs.	100	NA

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? • Help her understand right from wrong. Still working on stopping • Counseling. Grandmas room • Counseling, having community services together in one place. Grandma Room • Active listening and parenting skills • My child's therapist	1. What has been the most helpful thing about the services you received? • NA
2. What would improve services your child and the family received? • Appointment communication. • More organized front desk	2. What would improve services you received? • NA
3. Additional Comments • I feel I can trust (staff) and I'm confident of her ability to achieve her goals with us. Thank you day treatment program in effect. I think the older children that are getting ready to start Kindergarten should be able to have first dibs on getting in.	3. Any additional comments? • NA

Survey participation

This current survey is the fifth statewide children's community-based services survey to date conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past five surveys.



The current survey shows a statewide decrease (9%) in parent/caregiver participation and a corresponding increase (25%) in youth participation when compared to the same survey conducted in the spring of last year. Statewide there was a combined total of 394 agency parent/caregiver and youth survey participants. This combined total matched that of the Spring 09 survey. NNCAS WIN showed an impressive 170% increase in client participation over their last year's survey.

An Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 260 parent/caregiver surveys returned statewide, 11 were in Spanish. The Spring 09 survey had garnered 22 Spanish surveys statewide.

As always, the Division of Child and Family Services Planning and Evaluation Unit extends its appreciation to all youth and parents/caregivers who participated in this survey. Equal appreciation goes to DCFS program area staff for the absolutely essential support they provided in carrying out this quality assurance project. Thanks to all.

ATTACHMENT C

DCFS Residential and Psychiatric Inpatient Services Parent / Caregiver – Youth Survey Results Statewide Fall 2010

From mid October to the first week in December, 2010, the Division of Child and Family Services (DCFS) conducted its fall survey of children's residential and psychiatric inpatient mental health service programs offered through the Northern Nevada Child and Adolescent Services (NNCAS) and the Southern Nevada Child and Adolescent Services (SNCAS). Parent/caregivers with children in treatment and youths themselves (if age 12 or older) from both agencies were solicited to voluntarily participate in completing the survey instrument.

Participants were asked to disagree or agree with a series of statements relating to nine focal areas or domains that reflect residential and inpatient participant experience. These domains include those areas deemed by the Federal Mental Health Statistical Improvement Program as reflective of mental health programming effectiveness. The nine domains covered by the survey include convenience in receiving services (Access); whether services being received are acceptable (General Satisfaction); do participants have a directive role in the course of their treatment (Treatment Participation); is important information being shared during treatment (Treatment Information); is the physical environment seen as safe and comfortable (Environment and Safety); are staff respectful of participant religion, culture and ethnicity (Cultural Sensitivity); are client educational needs being met adequately (Education); do clients feel supported in the program and are they aware of community-based support (Social Connectedness); and how well do clients see themselves functioning in daily life (Positive Outcomes).

Survey Report Format

For this report, residential and psychiatric inpatient services survey results are in table format and are presented by service type and facility name under each of the DCFS children's mental health programs (NNCAS and SNCAS). NNCAS currently has residential programs only. SNCAS has both residential and psychiatric inpatient programs. Parent/caregiver and youth responses for each program appear together under each domain.

The Parent/Caregiver and Youth Positive Response numbers appearing under each domain are reported in percentages. A percentage number represents the degree to which a particular domain statement was endorsed

or rated positively by respondents. Since not every survey respondent answers every statement, each statement's percentage numbers are based upon the actual number of responses to that particular statement.

A domain statement percentage number followed by an (*) indicates the percentage number as having matched or exceeded the rating for that item found on the last residential/inpatient survey.

You will notice, too, that statements on the survey with less than a 60% Positive Response number are "courtesy highlighted". Courtesy highlights call attention to any survey item having a respondent endorsement rate that is approaching the lower end of the frequency scale. Programs having courtesy highlighted items should monitor these particular items in subsequent surveys should similarly low endorsement rates re-occur. Programs should give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action might be taken.

Following each service area's domain results, you will find listed whatever remarks respondents offered regarding what was the most helpful thing about the services they received, what would improve upon the services they received and any additional comments they might have had. A final section on survey participation concludes the report.

Survey Participants

Participants in this Fall 10 survey included parents or caregivers with children receiving residential or psychiatric inpatient mental health treatment and the youths themselves where age appropriate. The youth survey is completed by youth ages 12 and older. Forty one parent/caregivers statewide completed the survey in addition to 73 youth statewide who were still in treatment. Planning and Evaluation Unit staff or other non-direct treatment staff solicited survey participants at the different program sites providing the clients' mental health services. Survey questionnaires were self-administered and when completed put into secure containers. Some parent/caregivers chose to complete the surveys at home and mail them to Planning and Evaluation Unit offices. Survey participation was entirely voluntary and survey responses were both anonymous and confidential.

The table on the following page presents the number of parent/caregiver and youth surveys received from each program site. The table also indicates the number of clients served during the survey time period and contrasts this number with the size of the resulting survey sample expressed as a percentage. It is necessary to note that this survey sample percentage actually under characterizes the level of adult survey participation since not all of the clients served had parents or caregivers available for responding on their behalf.

Youth percentages are not given since not all clients served were age eligible for survey participation and any percentage would be non representative.

Following the table, residential and psychiatric inpatient services survey results are presented by service type and facility name.

	SURVEYS			
	Parent/Caregiver			**Youth**
AGENCY & SITE	Number of Surveys	Number of Clients Served	Survey Sample Percent	Number of Surveys

NNCAS				
Residential: ATC	13	21	62	12
Residential: FLH	5	23	22	7
Total	18	44	41	19
SNCAS				
Residential: OASIS	2	29	7	14
Inpatient: DWTC	21	71	30	40
Total	23	100	23	54
Statewide Total	41	144	29	73

Note: ATC = Adolescent Treatment Center
FLH = Family Learning Homes
OASIS = Oasis On-Campus Treatment Homes
DWTC = Desert Willow Treatment Center

DCFS Residential Services
Parent / Caregiver – Youth Survey Results
Statewide Fall 2010

Note: The Parent/Caregiver and the Youth surveys share questions 6 through 31 in the same numerical sequence. The Parent/Caregiver survey has three additional questions (marked "caregiver") that do not appear on the Youth survey.

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES ATC		
Parent/Caregiver N=13; % Total Served = 62 Youth N=12	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	100*	83*
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	92*	58*
The people helping my child and family stick with us no matter what.	92	67*
I feel my child and family have someone to talk to when he/she is troubled.	92	75*
The services my child and family receive are right for us.	83	50*
My family gets the help we want for my child.	100*	58*
My family gets as much help as we need for my child.	91	58*
TREATMENT PARTICIPATION		
I help to choose my child's services.	92	36*
I help to choose my child's treatment goals in the treatment team meeting.	100*	64*
I participate in my child's treatment.	100*	50
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	100*	58*
Staff explain my child and family's rights and confidentiality issues.	100*	58*
I am learning helpful parenting skills while in services. (caregiver)	67	n/a

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES ATC		
Parent/Caregiver N=13; % Total Served = 62 Youth N=12	Parent/Caregiver Positive Response %	Youth Positive Response %
I have information about my child's developmental expectations and needs. (caregiver)	90	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	100*	83*
Visitation rooms are comfortable and provide privacy with my child.	62	73*
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	92	58
Staff respect my family's religious/spiritual beliefs.	82	64*
Staff speak with me in a way that I understand.	100*	75*
Staff are sensitive to my cultural and ethnic background.	91*	75*
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	92*	75
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	92	75*
Our family is aware of people and services in the community that support us.	89*	83*
POSITIVE OUTCOMES		
My child is better at handling daily life.	67	75*
My child gets along better with family members.	67	67*
My child gets along better with friends and other people.	58	83*
My child is doing better in school and/or work	67	75*
My child copes in difficult situations much better.	58	55
I am satisfied with our family life right now.	56*	67*
I am better able to handle our family issues. (caregiver)	56	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• Drug and alcohol counseling • He is learning to cope with a structured environment. Following rules and being responsible. • Weekly counseling sessions Daily sessions my daughter receives. Ideas and listening to others. • My son has ,earned some self control which helps with our one on one talk. He is still working. • (Client) was able to meet with her therapist whenever a situation arose. The nursing staff also formed a bond with the child so that she felt comfortable in opening up with them too. • Coming once a week for family sessions • I am still undecided • Being able to communicate with staff and my child. • My child is taking accountability for his actions and behaviors. • The child is more capable of making the right decisions in regards to his drug use, his anger issues and coping mechanisms. • (Client) being here and getting the help he needs is keeping me and my family safe.	• Nothing • People help me a lot • Talking about things that bother me • To talk to people I trust • Being able to talk to someone • The coping skills • My self control • I am learning to look at more of my faults rather than only some. • Being able to cope with my anger • I have seen what not to do and what things are okay to do. • I would have to say the skills
What would improve services your child and the family received?	What would improve the services you receive?
• Less mediators	• Nothing much really

• Weekly progress report on child. A monthly report from the doctor. • Once per month family meal at facility. • (Client) was able to run from the facility twice. She had to be moved to a higher level of care after discharge. • None • I do not like that the facility is Co-ED. It is harder for the children to focus on themselves when there are others of the same age but opposite gender. • Each child receives a big brother/big sister who understands mental illness.	• Help • More trust • A mirror in all rooms • More consistency • Consistency • More intense therapy • The staff that helps • Feed us better food • Just like the paying attention
Additional Comments	Additional Comments
• Literature to read to better understand my child's diagnosis. • When staff disciplines they should do it the same for every child so if one gets away with it the other should get the same. • Thank you so much for all of your help! • I appreciate ATC and everything they have done to help our family.	• I want a radio • Staff eat our food; fix showers; more food • Fix the shower in room 8 • We should have mirrors in our rooms • We need a large play area, And message therapy. • Better food • The food • No

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES FLH		
Parent/Caregiver N= 5 % Total Served = 22 **Youth N= 7**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	100*	71
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	100*	43
The people helping my child and family stick with us no matter what.	80	86*
I feel my child and family have someone to talk to when he/she is troubled.	100*	86*
The services my child and family receive are right for us.	100*	57
My family gets the help we want for my child.	100*	57
My family gets as much help as we need for my child.	60	71 *
TREATMENT PARTICIPATION		
I help to choose my child's services.	100*	50
I help to choose my child's treatment goals in the treatment team meeting.	100*	100*
I participate in my child's treatment.	100*	71
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	100*	86*
Staff explain my child and family's rights and confidentiality issues.	100*	71
I am learning helpful parenting skills while in services. (caregiver)	100*	n/a
I have information about my child's developmental expectations and needs. (caregiver)	100*	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	100*	57
Visitation rooms are comfortable and provide privacy with my child.	100*	60
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	100*	71
Staff respect my family's religious/spiritual beliefs.	50	80
Staff speak with me in a way that I understand.	100*	71
Staff are sensitive to my cultural and ethnic background.	100*	86 *

NORTHERN NEVADA CHILD AND ADOLESCENT SERVICES
FLH

Parent/Caregiver N= 5 % Total Served = 22 **Youth N= 7**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	0	80
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	100*	86*
Our family is aware of people and services in the community that support us.	100*	71 *
POSITIVE OUTCOMES		
My child is better at handling daily life.	60	71*
My child gets along better with family members.	80	86*
My child gets along better with friends and other people.	100*	86*
My child is doing better in school and/or work	60*	100*
My child copes in difficult situations much better.	60	71*
I am satisfied with our family life right now.	40	71*
I am better able to handle our family issues. (caregiver)	60	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• The structure and support she receives • The staff they are very open and honest. They give great advice and help in the hard times. They are all awesome. • Maintaining self control and when out of control using skills taught to regain control. • Learning to be more respectful of me	• They help me do polite things • Working with my family • Changing houses • The medication I take and the staff helping me get through things. • Making friends and/or social skills
What would improve services your child and the family received?	What would improve the services you receive?
• The insurance would be easier so my child can continue with services. Our therapist wasn't that great after two years, she didn't get anywhere. We had get hire a different therapist to get my child to open up. • I feel they are doing the best they can. Not sure what might improve it. • I can't think of anything right now. • More therapy for son • more communication with school	• People giving other people respect • They are improving very well • Less rules • I get to decide what's best for me • So far I'm satisfied with my treatment
Additional Comments	Additional Comments
• Everyone in home 2 is awesome. Thank you for everything. We love ya!!! • Thank you all for all your help. • I'm at ease to know that my child is comfortable with the staff.	• No thank you • This place is very over ruled I don't like this place

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES
OASIS

Parent/Caregiver N=2; % Total Served = 7 **Youth N= 14**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES

OASIS

Parent/Caregiver N=2; % Total Served = 7 Youth N= 14	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	100*	71
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	100*	57
The people helping my child and family stick with us no matter what.	100*	79
I feel my child and family have someone to talk to when he/she is troubled.	50	86
The services my child and family receive are right for us.	0	86*
My family gets the help we want for my child.	100*	71
My family gets as much help as we need for my child.	100*	71
TREATMENT PARTICIPATION		
I help to choose my child's services.	50	38
I help to choose my child's treatment goals in the treatment team meeting.	0	77
I participate in my child's treatment.	50	54
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	0	64
Staff explain my child and family's rights and confidentiality issues.	50	71
I am learning helpful parenting skills while in services. (caregiver)	0	n/a
I have information about my child's developmental expectations and needs. (caregiver)	0	n/a
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	50	64
Visitation rooms are comfortable and provide privacy with my child.	100*	67
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	100*	64
Staff respect my family's religious/spiritual beliefs.	100*	82
Staff speak with me in a way that I understand.	100*	71
Staff are sensitive to my cultural and ethnic background.	100*	54
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	50	79
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	50	64
Our family is aware of people and services in the community that support us.	50	67
POSITIVE OUTCOMES		
My child is better at handling daily life.	50	64
My child gets along better with family members.	100*	62
My child gets along better with friends and other people.	50	79*
My child is doing better in school and/or work	50	79 *
My child copes in difficult situations much better.	50	50
I am satisfied with our family life right now.	50	46
I am better able to handle our family issues. (caregiver)	100*	n/a

PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?

• She is much more positive is no longer harming herself. Attitude is not as severe. • programs rules and point system	• PSR (staff member) • They help me not out burst with my anger • Staff trying to help me • I don't know. Talking about problems • Nothing • Talking to my therapist • P.O. is nice to talk to me but really strict • I get all the help I need and when I need it • The most helpful thing has been the staff. All the advice and talking really made a difference.
What would improve services your child and the family received?	What would improve the services you receive?
• Reunification with my daughter and continual counseling for her and family • I don't know	• More food • If my mom would talk to me more, and if I could see my family more often • More staff respect • I don't want to be adopted. Want to go back with my real mom! • Equality • Nothing. I think that the services I receive are good. The services are helping me realize my faults. • It's all good. I'm doing a lot better now because of them
Additional Comments	Additional Comments
• Would like more involvement with her treatment and how long her facilitation could be and reunification	• I want to be left alone • I like this place • Would like to be told all rules before I get into trouble! • This place sucks really bad • I just want to thank 11 West (six staff members) for helping me throughout my time with Oasis.

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES DWTC		
Parent/Caregiver N= 21; % Total Served = 30 Youth N=40	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services are scheduled at times that are right for me and my family.	86*	75
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and family receive.	95*	75*
The people helping my child and family stick with us no matter what.	90*	71*
I feel my child and family have someone to talk to when he/she is troubled.	86*	87*
The services my child and family receive are right for us.	100*	79*
My family gets the help we want for my child.	90*	75*
My family gets as much help as we need for my child.	95*	70
TREATMENT PARTICIPATION		
I help to choose my child's services.	89*	48
I help to choose my child's treatment goals in the treatment team meeting.	90*	81*
I participate in my child's treatment.	90*	83*
TREATMENT INFORMATION		
Staff explain my child's diagnosis, medication and treatment options.	95*	80*
Staff explain my child and family's rights and confidentiality issues.	100*	82
I am learning helpful parenting skills while in services. (caregiver)	90*	n/a
I have information about my child's developmental expectations and needs. (caregiver)	90*	n/a

SOUTHERN NEVADA CHILD AND ADOLESCENT SERVICES DWTC		
Parent/Caregiver N= 21; % Total Served = 30 Youth N=40	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ENVIRONMENT AND SAFETY		
Services are provided in a safe, comfortable environment that is well cared for.	90*	75*
Visitation rooms are comfortable and provide privacy with my child.	81*	76*
CULTURAL SENSITIVITY		
Staff treat me and my family with respect.	95*	69*
Staff respect my family's religious/spiritual beliefs.	90*	89*
Staff speak with me in a way that I understand.	100*	88*
Staff are sensitive to my cultural and ethnic background.	100*	73
EDUCATION		
My child's educational needs are being met during his/her stay in the acute/ residential services.	80*	78*
SOCIAL CONNECTEDNESS		
I feel my child and family have someone to talk to when he/she is troubled.	86*	87*
Our family is aware of people and services in the community that support us.	86*	73*
POSITIVE OUTCOMES		
My child is better at handling daily life.	60	88*
My child gets along better with family members.	67*	88*
My child gets along better with friends and other people.	60*	80*
My child is doing better in school and/or work	70*	75*
My child copes in difficult situations much better.	55	82*
I am satisfied with our family life right now.	71*	63
I am better able to handle our family issues. (caregiver)	86*	n/a

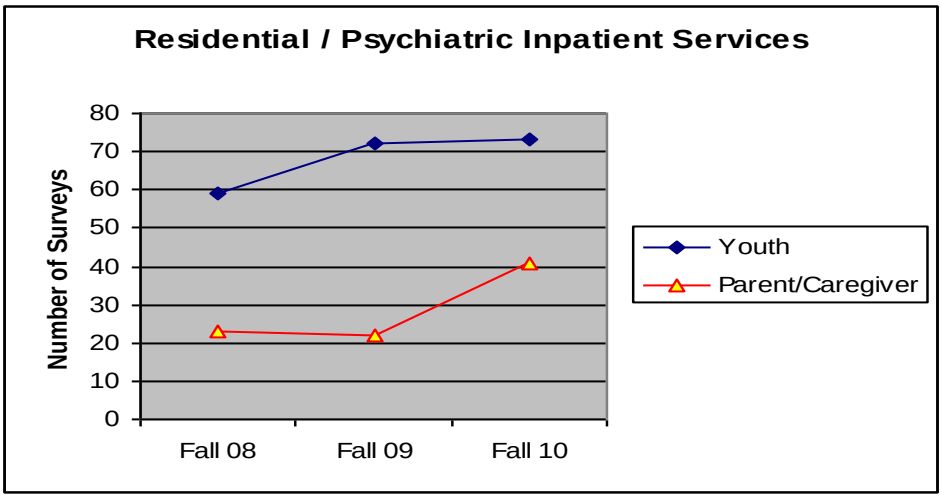
PARENT / CAREGIVER COMMENTS	YOUTH COMMENTS
What has been the most helpful thing about the services your child received?	What has been the most helpful thing about the services you receive?
• The therapist, our son needed a professional to talk to and he's gotten the best one. • Her understanding the consequences to her actions • They helped to clarify the correct diagnosis • Getting well. Getting treatment from great center. • Calmness and communication • He is safe and he will get the help he needs • She has people that she can communicate and talk to her about her problems. • She is safe • She has had structure and discipline • Helping him with anger • Information given and received • He's in a safe place to have opportunity to gain tools for a healthier future. • That he is safe • She has realized why she needs help. Awareness and cope a lot better with hearing "No". Moods have stabilized. • Structure • Counseling, therapy, meds • Medications and extended stay was well welcomed. Thank you staff. • Knowing he is in a safe place getting well needed help • Learning how to deal with her anger issues. • Support in following through with what's best for her.	• People talk to me • Getting the help I need • I think its ok, I don't have a problem so far • Therapy • Me doing positive things • That it give me to try to solve my problems. • Don't know • The food • I can cope better with things than before • None • The staff help me a lot • That I am able to have time to use my coping skills. • When I need someone to talk to • Stuff • My dads visits and caring • That staff talks to me about what I need to do • That I go on passes • I got the help I need by talking and opening up more with people • Family sessions and talking to (staff member) • I can talk to staff when I feel sad • The groups that we do • My treatment • It has pulled me out of the life I was living and made me focus on myself.

	• My self control • Having someone to talk to • When the staff talk to me and calm me down • Learning how to be more social with others • Can't pin point one thing it's all helped me. • I can control my emotions a little more • I helps me with my treatment my familys member. • I learned to not re-offend • Everything that has enhanced my life skills. (Group Sessions) • The staff talk to us whenever we have problems • Staff help me out with my offense issues. • My treatment that I receive • I have learned that I don't have to solve everything by fighting. It is only a last resort. •
What would improve services your child and the family received?	What would improve the services you receive?
• Visitation time • More counseling more often • Time together, communication, and more time with the family • More visit hours • More flexible visit hours • More family therapy. More help for him on anger management. • Nothing at this time. She's just admitted • I feel the therapist gave up on my child • No, not with DWTC staff. However, the communication with outpatient therapist - NCC to make the referral for admission of him. The outpatient therapist was unaware he needed to make the referral to get him admitted into the acute unit. • Education. Schooling. More interaction with school teachers • It would be helpful to know that there is someone to turn to once she gets out of Desert Willow in case I have problems with her. • None	• They are just fine • The staff being helpful • The way the staff act • A little more real time • Certain staff members be nicer • My attitude and more • Don't know • More watermelon (for me) • Let me journal when I'm angry • To have more activities to do during the day • Finding out my discharge date • A more comfortable bed • More passes • Seeing the therapist more often • More family sessions and longer family sessions • More staff respect • Some staff doesn't tell you what you've done to get marked down so you can work on it. • A good job • If the services were more patient with me. • My treatment here in DWTC • If the staff were less strict, more laidback, calmer. • I don't know at this moment • Patients being able engage in sports activities etc. with other people. • I think that everything is alright • Everything is fine, it's just how serious the patients need to be. • For staff to be a little bit nicer and kind • Talking more with people that I can relate with anger management. • A lot more therapy (1 to 1) • If my primary cared about me
Additional Comments	Additional Comments
• The staff are wonderful and work quickly • Education, my son needs to be challenged in the classroom. He gets bored and needs to learn new things. Other than that it's great to have him here to get help. • I only want to says thanks for all the help for my son and God bless you • The doctor was rude and treated me as if I was stupid because I questioned his choices for meds. • Appreciate services. Look forward to successful results. • Thank you for providing a safe, clean environment for my child. • The staff and facility has been wonderful in assisting me and my child. "I don't know where I'd be without the services DWTC has provided." • I am grateful he is getting help • We are very grateful for all the assistance we have received. We	• None • This has helped me in so many ways • I can't wait to go home • Thank you for all your help :) • Great program. I've learned a lot so far

see the change in her. • Staff is wonderful. Staff very open to get information from me, to have more insight to help with him. • Thank you.	

Survey participation

This current survey is the fifth statewide residential and psychiatric inpatient services survey conducted by DCFS. The following graph depicts parent/caregiver and youth participation in the three most recent surveys.



This Fall 10 survey is the second to be conducted under a new twelve month survey interval schedule. Hoping in part to encourage greater respondent participation, DCFS changed its survey intervals from six months to a full twelve months following completion of the Fall 08 survey. The present Fall 10 survey results show a 21% increase statewide over the Fall 09 survey in the combined total of youth and parent/caregiver respondents. This increase is due entirely to increased parent/caregiver participation (up 86% from last year). Youth-in-program participation rates equaled last year's results.

In last year's survey report, it was suggested that programs may want to focus on developing strategies for increasing the survey participation of adults who care for the children those programs serve. The increased

level of adult participation seen in this Fall 10 survey certainly reflects extra effort being put forth by program staff to enhance parent/caregiver survey representation

Some residential and psychiatric inpatient staff have suggested more recently that we consider changing our surveys from the current six week point-in-time format to a survey-at-discharge format. Every child and that child's parent / caregiver would be solicited to complete a survey at the time of the child's graduating their program. Staff's reasoning is that program feedback would best be articulated by a client who has had an opportunity to more fully experience the program's implementation of his/her treatment plan. This line of reasoning enjoys support in the research literature. And there is another advantage.

The worth of any survey is enhanced by the number of clients participating in it. The more respondents sharing their views, the larger is the pool of information and the more representative the sample of the total client population. Based upon the number of clients discharged from DCFS residential and psychiatric inpatient programs this past year, a survey-at-discharge format could have generated two to three times the number of participants who actually responded to the Fall10 survey. A point-in-time survey can never attain these larger survey-at-discharge numbers.

Incorporating residential and psychiatric inpatient staff suggestions, the DCFS Planning and Evaluation Unit will ask the Children's Mental Health Services Managers Group to consider the survey-at-discharge format being adopted in subsequent residential and inpatient surveying efforts. This may also be a good time to reappraise the content of our survey instrument for relevance to both acute and longer term program characteristics.

As always, the Division of Child and Family Services / Planning and Evaluation Unit extends its appreciation to all residential and psychiatric inpatient youth and parents/caregivers who participated in this survey. Our gratitude goes as well to residential and psychiatric inpatient staff statewide for their support in carrying out this quality assurance project. Thanks to all.

ATTACHMENT D

Division of Child and Family Services
OASIS
Risk Measures and Departure Conditions Report – 2010

INTRODUCTION

In partnership with the Provider Support Team, the Planning and Evaluation Unit (PEU) of the Division of Child and Family Services (DCFS) collects identified risk measures and departure conditions from specialized foster care providers for quality improvement purposes. By collecting and analyzing all risk measure data, providers can review where the risks are occurring, determine opportunities for improvement, and implement corrective action where needed.

In September 2009, most specialized foster care providers entered into contracts with DCFS, and/or Clark County Department of Family Services and/or Washoe County Department of Social Services. The contracts require providers to participate in performance and quality improvement activities through DCFS's Planning and Evaluation Unit.

This 2010 report is the third year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2010 through December 2010. OASIS submitted a timely and complete data set in 2010. OASIS is to be commended for their willingness to share this very important information.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009

and throughout 2010 the PEU, in partnership with the Provider Support Team, began to develop tools and processes to assess provider adherence to standards of practice and data reporting. These include:

- Face to face policy review meetings were conducted between PEU and contracted providers. Many of the policies reviewed in these meetings are those which address risk measures as reflected in this report (e.g., medication management, restraint, crisis triage, training curricula regarding suicide awareness, Child and Family Teams, etc.). The focus of these meetings was not only on improving practice standards but also to articulate standards regarding quality assurance activities such as data collection, data analysis and the development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide.

- The development and implementation of an internal data base for tracking data clean up issues; this endeavor has helped to minimize the limitations around missing or incomplete data which has previously impacted our interpretation and analysis of the data in past reports.

Data analysis limitations do continue as we factor in provider self reporting and our current inability to confirm the accuracy of reported incidents; however, the information provided herein is useful and can be used for program improvement initiatives to better serve Nevada's children and families.

RISK MEASURES AND DEPARTURE CONDITIONS

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance

Specialized foster care providers were asked to track and report departure conditions on children and adolescents discharged from services during the 12-month reporting period. A departure (or discharge) means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster care home and admitted to another home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

Collecting departure conditions data for analysis is a way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice:

- Treatment completion at discharge
- Restrictiveness level of next living environment
- Child and Family Team decision making

The following is the data and analysis of the four risk areas and departure conditions.

SNCAS OASIS PROGRAM INFORMATION

MEDICAID REPORT 2011
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2010 SUMMARY

This report for OASIS is the analysis of risk measures and departure conditions data collected from January 2010 though December 2010.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served for the last two reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2010	27	2010	29.09
	Range: same as capacity		Range: 19 to 33
2009	27	2009	30.33
	Range: same as capacity		Range: 27 to 35

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides. Attempted suicide was defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action.

Suicide attempts reported by OASIS for three reporting periods are noted in Table 2 below.

Table 2

SUICIDE ATTEMPTS	
Reporting Period	Number of Attempts
2010	0
2009	1
2008	4

OASIS reported no suicide attempts or completions in 2010.

Practice Guidelines and Opportunities for Improvement:

- Ensure that all provider agencies have a suicide prevention protocol, and Specialized Foster Care parents and staff are trained to implement it.
- Ensure a complete suicide history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- In collaboration with Nevada Youth Care Providers, continue to provide Specialized Foster Care providers with information about available training opportunities.

Medication Errors

Specialized foster care providers were asked to track and report medication errors. To track medication errors a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

> A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use (U.S. Pharmacopeia, 1997).

Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000). Providers are encouraged to review the definitions of a medication error to ensure that if an error is made, it is being properly documented. If errors are documented a review of errors can result in procedural improvements to minimize future errors.

Medication errors reported by OASIS for three reporting periods are noted in Table 3 below.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of Errors
2010	22
2009	11
2008	7

Clinical and Medication Error Information:

- The most frequent diagnosis was Mood Disorder, NOS.
- Type of medication error
  - 54.5% (12) omission error
  - 18.2% (4) improper dose error
  - 9.1% (2) compliance error
  - 4.5% (1) wrong dosage form
  - 13.6% (3) any medication error that does not fall into one of the predefined categories
    - Home visit error
    - Readmission error
    - "Medicaid would not cover the cost of the medication and she [the youth] was just discharged from the acute psychiatric hospital."
- Most (72.7% or 16) medication errors were with psychotropic medication.
- Medication error outcome
  - 95.5% (21) were errors that occurred that reached the client but did not cause the client harm.
  - 4.5% (1) Medication error required monitoring.

Highlights:

- The number of errors reported tripled from 7 in 2008 to 22 in 2010. The increase may indicate that closer attention to documenting and reporting errors is occurring. If errors are more consistently documented and reviewed, procedural improvements can be made to minimize future errors.
- Tuesday and Wednesday had the most medication error occurrences with 21.7% (5) each.

Opportunities for Improvement:

- OASIS reported less than expected medication errors in the last three reporting periods. When one considers the potential number of both prescription and over-the-counter (OTC) medications each youth in a specialized foster care placement may be taking, oftentimes multiplied by administration several times per day multiplied again by the number of days in placement, one expects to see a higher number of errors over the course of this 12-month reporting period.
- Specialized Foster Care managers or supervisors or the agency's Quality Assurance staff should confer with the staff member involved in the error and thoroughly document how the error occurred and how its recurrence can be prevented. Medication errors are sometimes the result of system problems rather than exclusively from staff performance or environmental factors; thus error reports should be encouraged and not used for punitive purposes but to achieve correction or change. (American Society of Hospital Pharmacists, 1993)
- Clients report various reasons for refusing medications. A perceived lack of benefit or experiencing side effects is a reason given for refusal. Ensure staff/treatment parents are reporting compliance errors to the agency and that the agency is making proper notifications to treating physicians and case managers per the agency's policy. Child and Family Teams should address compliance issues to include discussing the youth's reasons for refusal, providing medication education and contracting with the youth if needed to maximize adherence to the prescribed medication regimen.
- Ensure medication logs are periodically reviewed for quality assurance by someone other than the person who administered the medication.
- Ensure staff/treatment parents receive annual medication management and administration training in order to minimize errors and provide ongoing safe administration and monitoring of clients on medication. (American Society of Hospital Pharmacists, 1993)

The PEU is available to provide technical assistance on any of these issues involving documenting, tracking and reporting medication errors, including providing clarification of medication error definitions. The PEU encourages providers to seek out technical assistance whenever there is a need for clarity about medication administration and management and/or reporting data related to medication errors.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs).

AWOL incidents reported by OASIS in the three reporting periods are noted in Table 4 below.

Table 4

AWOL INCIDENTS

MEDICAID REPORT 2011
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2010 SUMMARY

Reporting Period	Number of AWOLs
2010	7
2009	15
2008	5

The 7 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 42.9% (3) were male and 57.1% (4) were female.
- Average age was 15.43 with an age range of 14 to 16 years.
- 71.4% (5) were Caucasian, 14.3 (1) was mixed race, and 14.3% (1) was of unknown
- 100% (7) were non-Hispanic.

Clinical and AWOL Information:

- The most frequent diagnosis for the youth was Dysthymic Disorder (28.5% or 2).
- Average number of AWOL days was 6.86 days with a range of 1 to 18 days.
- 85.7% (6) of the youth had a history of AWOL.
- Type of supervision at AWOL
    - 14.3% (1) youth left from school or work
    - 85.7% (6) left from specialized foster care home during the day

- Behavior during AWOL
    - 71.4% (5) unknown
    - 14.3% (1) substance abuse
    - 14.3% (1) assaultive to other
- Outcome
    - 28.6% (2) found with family and returned to specialized foster care home.
    - 28.6% (2) other: "[both youth] went to RTC in Northern Nevada for substance abuse [treatment]"
    - 14.3% (1) youth returned voluntarily to the home within 72 hours
    - 14.3% (1) absent indefinitely
    - 14.3% (1) youth returned involuntarily to the home within 72 hours

Highlights:

- 57.1% (4) youth returned to the specialized foster care home or a respite home.
- This provider saw a significant decrease in AWOL incidents from 2009 to 2010.

Opportunities for Improvement:

- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005)
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety (Courtney et al., 2005)
    - schedule regular visitation with family members
    - promote family ties such as placement with siblings
    - nurture other positive relationships in the youth's life, such as a mentor
    - offer activities and recreational opportunities that will interest youth
    - provide personal safety training

  - inform youth of risks of and alternatives to running
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).
- Ensure that a complete runaway history of each youth is shared with providers as early in the pre-placement process as possible.
- Develop protocols regarding supervision between the school and the treatment home.

Restraint and Manual Guidance

Specialized foster care providers were asked to track and report on restraint and manual guidance used on children and adolescents. A restraint and manual guidance is a method of restricting a child's freedom of movement for his/her safety or for the safety of others. OASIS staff uses Conflict Prevention and Response Training (CPART) for the restraint method.

The number of restraint and manual guidance incidents reported by OASIS in three reporting periods is noted in Table 5 below.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	Number of Restraint / Manual Guidance
2010	207
2009	120
2008	72

The 207 incidents of restraint and manual guidance reflect the following descriptive information:

- 68% (141) were male and 32% (66) were female.
- Average age was 10.24 with an age range of 6 to 17 years.
- 24.3% (50) were Caucasian, 49% (101) were African American, 18.9% (39) were mixed, 3.9% (8) were unknown, 2.9% (6) were American Indian, and 1% (2) was Asian.
- 16.5% (34) were Hispanic.

Clinical and Restraint/Manual Guidance Information:

- The most common diagnoses were Mood Disorder NOS (39.8% or 82) followed by Bipolar Disorder NOS (22.8% or 47).
- Average length of restraint and manual guidance was 14.27 minutes, ranging from 1 to 56 minutes.
- 92.2% (190) of the youth had a history of restraint and manual guidance.
- Restraint and Manual Guidance Event

  - 51.9% (107) physically assaultive toward adult
  - 18.4% (38) youth putting self at risk of harm
  - 13.1% (23) youth running away
  - 11.2% (23) physically assaultive toward another youth
  - 5.3% (11) youth putting others at risk of harm
- Restraint and Manual Guidance Injury
  - 72.8% (150) no one injured
  - 23.8% (49) client injured
  - 2.9% (6) staff injured
  - .48% (1) peer injured

Highlights:

- There was a 72.5% increase of restraint and manual guidance incidents from 2009 to 2010. On average, there were 17.5 incidents per month in 2010 compared to 5 incidents per month in 2009.
- OASIS reported fewer injuries in 2010 (27.2 % or 56 total injuries) compared to 2009 (37.5% or 45 total injuries).
- Provider staff received restraint and manual guidance training and refresher course.

Opportunities for Improvement:

- At the time of admission, an assessment of relevant risk factors and the youth's history with restraint should be explored as this will inform the treatment planning and services provided; therefore, the provider should focus on obtaining a complete safety hold history of each child and adolescent as early in the pre-placement process as possible. (GSO, September 1999)
- Each child who is identified as having behavior management problems or a history with restraint should have an individualized behavior management plan that is evaluated on a regular basis for efficacy. (Council on Children and Families, 2007)
- Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation. (Council on Children and Families)
- Ensure debriefing occurs with those staff involved in the restraint to explore and address the events leading to the use of restraint, to explore alternatives to restraint which may have been more useful or effective, potential strategies to avoid the use of restraint, and to evaluate the physical/psychological/emotional effects on both the youth and the staff. (GAO)
- Information or data obtained during the post analysis event and debriefing processes should be used as part of the provider's and/or facility's quality assurance and performance improvement activities and should assist the program in establishing performance measurements. The purpose is:
  1. To learn whether restraint and seclusion are being used as emergency interventions;
  2. To identify rates of restraints broken down by unit and youth characteristics;
  3. To review trends in restraint use – are your program's rates increasing or decreasing?
  4. To compare rates and trends between your program and similar "benchmark" programs.
  5. To identify opportunities for improving the rate and safety of use; and,
  6. To identify staff training needs.

  Focus on collecting and aggregating these specific data on each restraint and seclusion episode on a regularly scheduled basis in order to identify frequencies, trends, and the like data analysis for continuous quality and program improvement initiatives. (Haimowitz, Urff, and Huckshorn, 2006)

- Ensure staff has effective alternative methods for handling those youth who may have a history with restraint or whose behavior plan indicates they are at risk for being restrained.
- Ensure that staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Departure Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

OASIS reported 48 discharges in the 2010 reporting period.

The 48 departures reflect the following descriptive information.

- 60.4% (29) were male and 39.6% (19) were female.
- Average age was 13.31 with an age range of 8 to 18 years.
- 54.2% (26) were Caucasian, 37.5% (18) were African American, 4.2% (2) were mixed, 2.1% (1) were Unknown, and 2.1% (1) was American Indian.
- 20.8% (10) youth were of Hispanic origin.
- Custody Status
    - 52.1% (25) were in child welfare custody
    - 33.3% (16) were in parental custody /no probation
    - 12.5% (6) were in parental custody / on probation
    - 2.1% (1) DCFS Youth Parole
- 91.7% (44) were Medicaid or SCHIP recipients
- The average length of stay at OASIS in 2010 was 161.46 days, ranging from 12 days to 438 days.

Clinical and Departure Information:

- The most frequent diagnosis at admission was Bipolar Disorder NOS (29.2% or 14 youth) followed by Mood Disorder NOS (20.8% or 10 youth).
- The most frequent diagnoses at discharge were Bipolar Disorder NOS (25% or 12 youth) and Mood Disorder NOS (22.9% or 11 youth).
- The average CASII composite score at admission was 24.55.
- The average CASII composite score at discharge was 22.34.
- Reason for departure
    - 33.3% (16) reunified with biological family
    - 29.2% (14) place in less restrictive setting
    - 14.6% (7) place in more restrictive setting
    - 10.4% (5) Youth ran away from placement (AWOL)
    - 4.2% (2) admitted to new specialized foster care home, different agency
    - 4.2% (2) adopted/adoptive home
    - 2.1% (1) admitted to new specialized foster care home, same agency
    - 2.1% (1) emancipated
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 11.17, which equals the restrictiveness score between regular foster care and individual home emergency shelter.

  - 2.1% (1) independent living by self
  - 33.3% (16) home of parents, child
  - 4.2% (2) home of relative
  - 2.1% (1) adoptive home
  - 12.5% (6) family based treatment home
  - 25% (12) group treatment home
  - 6.3% (3) group emergency shelter
  - 2.1% (1) residential treatment center
  - 6.3% (3) county detention center
  - 6.3% (3) state and private mental hospital
- 70.8% (34) youth completed treatment at discharge.
- Transition plan appropriate
  - 91.7% (44) yes
  - 8.3% (4) no
  - Explanations:

1. 2 youth were AWOL
2. 1 youth "moved to RTC without sufficient discussion with treatment team"
3. 1 youth "ran away and became intoxicated. He went to the hospital and the Judge decided his placement from there."

- Discharge plan appropriate
  - 93.8% (45) yes
  - 6.3% (3) no
  - Explanation:
    1. 1 youth "alleged physical abuse by staff".
    2. 1 youth "appeared to be stabilizing at OCTH further changes in medication may have helped mental status at OCTH".
    3. 1 youth "whereabouts unknown".
- Who recommended departure
  - 79.2% (38) child and family team
  - 8.3% (4) N/A; youth went AWOL
  - 6.3% (3) provider agency
  - 2.1% (1) Judge/hearing master
  - 2.1% (1) parole/probation officer
  - 2.1% (1) Parent

<u>Youth in Child Welfare Custody</u>
Of the 48 discharges reported by SNCAS OASIS in the 2010 reporting period, 52.1% (25) were in the custody of a public child welfare agency.

The 25 departures reflect the following descriptive information.
- 64% (16) were male and 36% (9) were female.
- Average age was 13 with an age range of 8 to 17 years.
- 44% (11) were Caucasian, 52% (13) were African American, and 4% (1) was Unknown.
- 16% (4) youth were of Hispanic origin.
- All youth were Medicaid or SCHIP recipients

- The average length of stay at OASIS in 2010 was 195.40 days, ranging from 12 days to 438 days.

Clinical and Departure Information:

- The most frequent diagnosis at admission was Bipolar Disorder NOS (32% or 8 youth) followed by Mood Disorder NOS (20% or 5 youth).
- The most frequent diagnoses at discharge were Bipolar Disorder NOS (28% or 7 youth) and Mood Disorder NOS (20% or 5 youth).
- The average CASII composite score at admission was 25.13.
- The average CASII composite score at discharge was 22.54.
- Reason for departure
    - 44% (11) place in less restrictive setting
    - 16% (4) place in more restrictive setting
    - 16% (4) Youth ran away from placement (AWOL)
    - 12% (3) reunified with biological family
    - 4% (1) admitted to new specialized foster care home, different agency
    - 4% (1) adopted/adoptive home
    - 4% (1) admitted to new specialized foster care home, same agency
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 13.60, which equals the restrictiveness score of group treatment home.
    - 4% (1) independent living by self
    - 12% (3) home of parents, child
    - 4% (1) adoptive home
    - 20% (5) family based treatment home
    - 32% (8) group treatment home
    - 12% (3) group emergency shelter
    - 4% (1) county detention center
    - 12% (3) state and private mental hospital
- 64% (16) youth completed treatment at discharge.
- Transition plan appropriate
    - 92% (24) yes
    - 8% (1) no
- Discharge plan appropriate
    - 92% (24) yes
    - 8% (1) no
- Who recommended departure
    - 76% (19) child and family team
    - 16% (4) N/A; youth went AWOL
    - 8% (2) provider agency

Overall Highlights:

- 41.6% (20) of the youth were placed in less restrictive settings upon discharge.
- In 2010, 70.8% (34 youth) completed treatment whereas in 2009, only 59% (36) completed treatment.

Children in Child Welfare Custody Highlights:

- 20% (5) of the youth were placed in less restrictive setting upon discharge.

- 92% (24) of the youth had appropriate transition and discharge plans.

Opportunities for Improvement:

- Child and Family Teams (CFT) are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. SNCAS OASIS is commended for this improvement and should continue to strive for convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.
- During the pre-placement process, a placement preparation plan should be developed by the CFT which addresses the child's emotional, psychological, developmental, and relationship connectedness needs to support placement stability.
- Focus on supporting placement stability, facilitating permanency, and minimizing the trauma of separation and loss by providing for pre-placement visitation whenever possible as this best practice helps to diminish fears and worries of the unknown, helps with the transfer of attachments, helps to initiate the grieving process, helps to empower the new caregivers/staff and, helps the youth in making commitments for the future (Falhberg, 1991).
- During the pre-placement process, an assessment of the child's previous placement history should be conducted by the CFT to determine the trauma risk factors and the provider's ability to address these factors in facilitating new attachments and relationships in the specialized foster care home.

Summary

Throughout 2010, SNCAS OASIS submitted the risk measure and departure conditions data timely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS-PEU.

This 2010 Risk Measures and Departure Conditions report reflects opportunities for improvement in the area of medication error reporting, AWOLs, supervision and child safety, placement stability and CFTs.

In partnership with the Provider Support Team, the PEU has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed policy implementation and review tools for medication management, crisis triage, and structured therapeutic environment. The PEU would encourage the provider's use of these tools to assist in developing a plan to address some of the areas identified in their 2010 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Society of Hospital Pharmacists. (1993). ASHP guidelines on preventing medication errors in hospitals. *American Journal of Hospital Pharmacy.* 50:305–14.

Bowlby, J. (1970). Attachment and loss, Volume I: Attachment. New York: Basic Press.

Child Welfare League of America. (2007). *Prevention of missing-from-care episodes.* Retrieved 10-14-09 from www.cwla.org/programs/fostercare/childmiss07.pdf

Children Missing From Care: Proceedings of Expert Panel Meeting. March 8 and 9, 2004.

Courtney, C. E., Skyles, A., Samuels, G. M., Zinn, A., Howard, E., & George, R. M. (2005) Youth who run away from substitute care (CS-114). University of Chicago, Chapin Hall Center for Children.

Committee on Restraint and Crisis Intervention Techniques Final Report to the Governor and Legislature (2007). Behavior support & management: Coordinated standards for children's systems of care. Rensselaer, NY: Council on Children and Families.

Falhberg, V. (1991). A child's journey through placement. Indianapolis: Perspective Press.

Falhberg, V. and Staff of Forest Heights Lodge (1972). Residential treatment: a tapestry of many therapies. Indianapolis: Perspectives Press.

Haimowitz, S., Urff, J., & Huckshorn, K. (1992). Restraint and seclusion: A risk management guide. New York: Author.

Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry*, 43, 54-58.

Iowa Department of Human Services Employees' Manual, Title 3, Chapter E (2006). Restraint and Seclusion Policy for Mental Health Institutions. Iowa: Author

Jewett, C. (1982). Helping children cope with separation and loss. Massachusetts: Harvard Common Press.

Nevada Children's Behavioral Health Consortium. *Guidance for creating effective child and family team meetings.*

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5.* Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

U.S. Pharmacopeia. (1997, January). *Definition of medication errors.* Retrieved April 28, 2009 from http://www.usp.org/hqi/practitionerPrograms/newsletters/qualityReview/qr571997-01-01e.html

United States General Accounting Office, GAO Report to Congress (1999). Mental health: Improper restraint or seclusion. People at risk. Washington, D.C. Author.

ATTACHMENT E

Division of Child and Family Services
Adolescent Treatment Center
Risk Measures and Departure Conditions Report - 2010

INTRODUCTION

In partnership with the Provider Support Team, the Planning and Evaluation Unit (PEU) of the Division of Child and Family Services (DCFS) collects identified risk measures and departure conditions from specialized foster care providers for quality improvement purposes. By collecting and analyzing all risk measure data, providers can review where the risks are occurring, determine opportunities for improvement, and implement corrective action where needed.

In September 2009, most specialized foster care providers entered into contracts with DCFS, and/or Clark County Department of Family Services and/or Washoe County Department of Social Services. The contracts require providers to participate in performance and quality improvement activities through DCFS's Planning and Evaluation Unit.

This 2010 report is the third year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2010 through December 2010. ATC submitted a timely and complete data set in 2010 and is to be commended for their willingness to share this very important information.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009

and throughout 2010 the PEU, in partnership with the Provider Support Team, began to develop tools and processes to assess provider adherence to standards of practice and data reporting. These include:

- Face to face policy review meetings were conducted between PEU and contracted providers. Many of the policies reviewed in these meetings are those which address risk measures as reflected in this report (e.g., medication management, restraint, crisis triage, training curricula regarding suicide awareness, Child and Family Teams, etc.). The focus of these meetings was not only on improving practice standards but also to articulate standards regarding quality assurance activities such as data collection, data analysis and the development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide.

- The development and implementation of an internal data base for tracking data clean up issues; this endeavor has helped to minimize the limitations around missing or incomplete data which has previously impacted our interpretation and analysis of the data in past reports.

Data analysis limitations do continue as we factor in provider self reporting and our current inability to confirm the accuracy of reported incidents; however, the information provided herein is useful and can be used for program improvement initiatives to better serve Nevada's children and families.

RISK MEASURES AND DEPARTURE CONDITIONS

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance

Specialized Foster Care providers were asked to also track and report departure conditions on children and adolescents discharged from services during the 12-month reporting period. Collecting departure conditions data for analysis is one way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice:

- Treatment completion at discharge
- Restrictiveness level of next living environment
- Child and Family Team decision making

The following is the data and analysis of the four risk areas and departure conditions.

ATC PROGRAM INFORMATION

This analysis is based on data collected from January 2010 though December 2010.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2010	15.25	2010	18.83
	Range: 13 to 16		Range: 17 to 22
2009	15.5	2009	18.25
	Range: 13 to 16		Range: 16 to 21

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides. Attempted suicide was defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action.

ATC reported one incident of attempted or completed suicide in 2010. The youth was a 16 year old female of American Indian race and Hispanic origin.

The youth's primary diagnosis was Posttraumatic Stress D/O. The youth attempted suicide by drinking a swallow of bleach water used for cleaning. She had a history of suicide attempts. The outcome of the youth's suicide attempt was admission into a psychiatric hospital. ATC reported a suicide protocol was used and staff involved with the attempted suicide received initial and refresher training in the facility's suicide protocol.

ATC reported zero incidents of attempted or completed suicide in 2009. In the reporting period of June 2008 through December 2008, ATC also reported zero incidents of attempted or completed suicide.

Opportunities for improvement:

- Ensure that all provider agencies have a suicide protocol, and Specialized Foster Care parents and staff are trained to implement it.
- Ensure a complete suicide history of each child and adolescent is shared with providers as early in the pre-placement process as possible.
- In collaboration with Nevada Youth Care Providers, continue to provide Specialized Foster Care providers with information about available training opportunities.

Medication Errors

Specialized foster care providers were asked to track and report medication errors. To track medication errors a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

> A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client, or consumer. Such events may be related to professional practice,

health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use (U.S. Pharmacopeia, 1997).

Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000). Providers are encouraged to review the definitions of a medication error to ensure that if an error is made, it is being properly documented. If errors are documented a review of errors can result in procedural improvements to minimize future errors.

Medication errors reported by ATC are noted in Table 2.

Table 2

MEDICATION ERRORS	
Reporting Period	**Number of Errors**
2010	0
2009	1
June 2008 – Dec 2008	0

Opportunities for improvement:

As noted in Table 2, ATC has consistently reported less than expected medication errors. When one considers the potential number of both prescription and over-the-counter (OTC) medications each youth in a specialized foster care placement may be taking, oftentimes multiplied by administration several times per day multiplied again by the number of days in placement, one expects to see a higher number of errors over the course of this 12-month reporting period.

The administration and dispensing of all prescription and OTC medications are to be tracked and errors reported in the Medication Errors workbook. In multiple discussions with providers about the issue of tracking and reporting medication errors, it has been determined that some providers have a misunderstanding of what constitutes a medication for this reporting purpose. For example, several providers thought they were to report only psychotropic medication errors while others thought they were to report only on prescription medication errors. Many providers did not understand the requirement to report all medication errors, whether they are prescription or OTC medications. This misunderstanding resulted in an identified under-reporting of medication errors overall for some providers.

Other common mistakes in tracking and reporting medication errors which the PEU has identified in discussions with providers include:

1. the youth refusing to take the medication
2. dispensing a medication at the wrong time of day or failing to dispense a medication as prescribed or directed
3. sending medications with the youth on home passes and confirming on the youth's return to the specialized foster care home that the medication was not dispensed by the family or other responsible adult
4. inability to fill the prescription and dispense the medication because the prior authorization has not yet been approved or consents had not been obtained or provided timely by the legal guardian/custodian

- Ensure staff/treatment parents receive annual medication management and administration training in order to minimize errors and provide ongoing safe administration and monitoring of clients on medication (ASHP, 1993).

Given the less than expected medication errors reported by ATC, the PEU would encourage the provider to explore whether these sorts of common mistakes in documenting, tracking and reporting medication errors are occurring at the facility and, if a determination is made these mistakes are occurring, ATC should focus on implementing program improvement and corrective action to ensure this mistakes are ameliorated.

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The PEU is available to provide technical assistance on any of these issues involving documenting, tracking and reporting medication errors, including providing clarification of medication error definitions. The PEU encourages providers to seek out technical assistance whenever there is a need for clarity about medication administration and management and/or reporting data related to medication errors.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs). AWOL incidents reported by ATC are noted in Table 3.

Table 3

AWOL INCIDENTS	
Reporting Period	**Number of AWOLs**
2010	4
2009	8
June 2008 – Dec 2008	0

As noted in Table 3, ATC has seen a 50% decrease in this reporting period in the number of AWOL incidents as compared to the 2009 data.

The four incidents of child and adolescent absence of more than 24 hours in this 2010 reporting period reflect the following descriptive information:

- 50% (2) were male and 50% (2) were female
- Average age was 16 with an age range of 15 to 17 years
- 100% (4) were Caucasian
- 100% (4) were of non-Hispanic origin

Clinical and AWOL information:

- The most frequent diagnosis was Mood D/O, NOS (50%) followed by Oppositional Defiant D/O and Posttraumatic Stress D/O
- Average length of absence was 3.75 days with a range of 2 to 5 days. In the 2009 reporting period, the average length of absence was 10.38 days with a range of 2 to 16 days.
- 50% (2) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
  - 100% (4) left from specialized foster care home at night – staff awake
- Behavior during AWOL

  - 50% (2) substance abuse
  - 50% (2) unknown
- AWOL Time
  - 50% (2) went AWOL at 10:35 PM
  - 50% (2) went AWOL at 7:30 PM
- Outcome
  - 50% (2) absent indefinitely – did not return to specialized foster care home
  - 25% (1) returned through juvenile detention
  - 25% (1) Other: arrested and detained at Jan Evans

Highlights:

- 50% of the youth who ran away had a history of AWOL.
- ATC experienced a decline in AWOLs from the last reporting period notwithstanding an increase in youth served in the current reporting period.

Opportunities for improvement:

- Focus on AWOL prevention at night. In the 2009 reporting period 50% of AWOLs occurred with night staff awake. In the current reporting period, 100% of AWOLS occurred with night staff awake.
- Focus on developing protocols regarding supervision in the home; 100% of the AWOLs occurred when staff was awake.
- Develop a protocol for children and adolescents who threaten to run away. The protocol would include the creation of a plan that provides appropriate alternatives to the runaway behavior.
- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005)
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety
  - schedule regular visitation with family members
  - promote family ties such as placement with siblings
  - nurture other positive relationships in the youth's life, such as a mentor
  - offer activities and recreational opportunities that will interest youth
  - provide personal safety training
  - inform youth of risks of and alternatives to running (Courtney et al., 2005).
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).

Restraint and Manual Guidance

Specialized foster care providers were asked to track and report on restraint and manual guidance used on children and adolescents. A restraint is a method of restricting a child's freedom of movement for his/her safety or for the safety of others.

The model of restraint employed at ATC is Conflict Prevention and Response (CPAR). ATC reported all staff present during the restraint/manual guidance received both initial and refresher restraint training.

The number of restraint incidents reported by ATC is noted in Table 4.

Table 4

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	**Number of Restraints/Manual Guidance**
2010	6
2009	3
June 2008 – Dec 2008	4

The 6 reports of restraint/manual guidance reflect the following descriptive information:

- 100% (6) were female.
- Average age was 12.2 with an age range of 12 to 13 years.
- 100% (6) were Caucasian.
- 100% (6) were of non-Hispanic origin
- 83.3% (5) of the restraints/manual guidance occurred in the month of September, 2010.

Clinical and Restraint/Manual Guidance Information:

- 83.3% (5) youth had a diagnosis of Posttraumatic Stress Disorder, 16.7% (1) youth had a diagnosis of Reactive Attachment D/O.
- 66.7% (4) youth had a restraint used on them previously.
- Average length of restraints was 7 minutes, ranging from 3 to 14 minutes. In the 2009 reporting period, the average length of restraints was 16.7 minutes, ranging from 15 minute to 20 minutes.
- Restraint Event
  - 83.3% (5) physically assaultive toward an adult
  - 16.7% (1) putting self at risk of harm
- Restraint Time
  - 50.1% (3) between the hours of 1:00 PM and 4:00 PM
  - 33.4% (2) between the hours of 7:30 PM and 9:30 PM
  - 16.7 % (1) restraint occurred at 11:00 AM.
- 83.8% (5) type of supervision prior to use of restraint/manual guidance was group – 2 or 3
- Injury report
  - 100% (6) No one injured

Highlights:

- All of the restraints were used with female youth. It appears that 5 of the restraints occurred for one youth in the month of September, 2010.
- No youth or staff was injured as a result of restraints used during the current reporting period.

Opportunities for improvement:

- At the time of admission, an assessment of relevant risk factors and the youth's history with restraint should be explored as this will inform the treatment planning and services provided; therefore, the provider should focus on obtaining a complete safety hold history of each child and adolescent as early in the pre-placement process as possible (GAO, September 1999).
- Each child who is identified as having behavior management problems or a history with restraint should have an individualized behavior management plan that is evaluated on a regular basis for efficacy (Council on Children and Families, 2007).
- Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation (Council on Children and Families).
- Ensure debriefing occurs with those staff involved in the restraint to explore and address the events leading to the use of restraint, to explore alternatives to restraint which may have been more useful or effective, potential strategies to avoid the use of restraint, and to evaluate the physical/psychological/emotional effects on both the youth and the staff (GAO).
- Information or data obtained during the post analysis event and debriefing processes should be used as part of the provider's and/or facility's quality assurance and performance improvement activities and should assist the program in establishing performance measurements. The purpose is:
    1. To learn whether restraint and seclusion are being used as emergency interventions;
    2. To identify rates of restraints broken down by unit and youth characteristics;
    3. To review trends in restraint use – are your program's rates increasing or decreasing?
    4. To compare rates and trends between your program and similar "benchmark" programs.
    5. To identify opportunities for improving the rate and safety of use; and,
    6. To identify staff training needs. (Iowa Department of HHS, 2006)

  Focus on collecting and aggregating these specific data on each restraint and seclusion episode on a regularly scheduled basis in order to identify frequencies, trends, and the like data analysis for continuous quality and program improvement initiatives (Haimowitz, Urff, and Huckshorn, 2006) .
- Ensure staff has effective alternative methods for handling those youth who may have a history with restraint or whose behavior plan indicates they are at risk for being restrained.
- Ensure ATC staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Departure Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

ATC reported forty-six (46) discharges in the 2010 reporting period.

The 46 departures reflect the following descriptive information.

- Average age was 15.4 with an age range of 12 to 17 years.
- 56.5% (21) youth were female, 43.5% (20) youth were male.
- Race
  - 82.6% (38) Caucasian
  - 10.9% (5) Black/African-American
  - 4.4% (2) American Indian
  - 2.2% (1) mixed race.
- 17.4% (8) youth were of Hispanic origin.
- Custody Status
  - 41.3% (19) parental custody and on probation
  - 39.1% (18) child welfare custody
  - 19.6% (9) parental custody with no juvenile probation involvement
- 95.7% (44) of the discharged youth were on Medicaid. During the 2009 reporting period, ATC reported 81% of the discharged youth were on Medicaid.
- The average length of stay for youth discharged from ATC in 2010 was 116 days, ranging from 3 days to 209 days.

Clinical and departure information:

- The 3 most frequent diagnoses at admission
  - 26.1% (12) Posttraumatic Stress Disorder
  - 8.7% (4) Major Depressive Disorder, Recurrent, Unspecified
  - 6.5% (3) Mood Disorder, NOS
- The most frequent diagnosis at discharge was Posttraumatic Stress D/O (26.1% or 12 youth).
- The average CASII composite score at admission was 23.9, with a range from 20 to 29.
- The average CASII composite score at discharge was 21.2.
- Reason for departure
  - 37% (17) placed in a less restrictive environment
  - 35% (16) reunified with biological family
  - 15.2% (7) placed in a more restrictive environment
  - 7% (3) AWOL
  - 2.2% (1) new specialized foster home, different agency
  - 2.2% (1) emancipated
  - 2.2% (1) relative placement
- Setting in which child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 11.3, which equals the restrictiveness score of specialized foster care. The average ROLES score in the 2009 reporting period was 10.8 which equals the restrictiveness score of specialized foster care.
  - 32.6% (15) group treatment home
  - 26.1% (12) home of birth/adoptive parents, for a child
  - 13% (6) county detention center
  - 8.7% (4) home of birth/adoptive parents, for an 18 year old
  - 6.5% (3) residential treatment center
  - 4.4% (2) regular foster care
  - 2.2% (1) independent living
  - 2.2% (1) home of a relative
  - 2.2% (1) family based treatment home
  - 2.2% (1) youth correction center

- 65.2% (30) youth had completed treatment at discharge. In the 2009 reporting period, 71.4% youth had completed treatment.
- Who recommended discharge
  - 87% (40) of the discharges were recommended by Child and Family Teams.
  - 4.3% (2) N/A; youth went AWOL
  - 4.3% (1) probation/parole officer
  - 2.2% (1) child welfare case manager
  - 2.2% (1) parent
- Transition plan appropriate
  - 97.8% (45) yes
  - 2.2% (1) no.
    - Explanation: Was pulled out AMA by parent
- Discharge plan appropriate
  - 95.7% (44) yes
  - 4.4% (2) no.
    - Explanation: Youth was being successful at ATC and was struggling at previous group home. ATC was open to continuing treatment, legal guardian pushed for transition when group home accepted him clinically.

Youth in Child Welfare Custody

Of the 46 discharges reported by ATC in the 2010 reporting period, 39.1% (18) were in the custody of a public child welfare agency.

These 18 departures for youth in the custody of a public child welfare agency reflect the following descriptive information:

66.78% (12) were female, 33.3% (6) were male.

- Average age was 15.33 with an age range of 12 to 17 years.
- Race
  - 83.3% (15) were Caucasian
  - 5.6% (1) were Black/African American
  - 5.6% (1) were American Indian
  - 5.6% (1) were of mix race.
- 100% (18) of youth were in child welfare custody
- 100% (18) were Medicaid or SCHIP recipients.
- The average length of stay at ATC in 2010 for youth in the custody of a public child welfare agency was 109.6 days, ranging from11 days to 205 days.

Clinical and departure information for youth in the custody of a public child welfare agency:

- The 3 most frequent diagnoses at admission
  - 33.3% (6) Posttraumatic Stress D/O
  - 16.7% (3) Major Depressive D/O
  - 5.6% (1) Reactive Attachment D/O
- The 3 most frequent diagnoses at discharge
  - 33.3% (6) Posttraumatic Stress D/O
  - 11.1% (2) Dysthymic D/O
  - 11.1% 92) Major Depressive D/O
- The average CASII composite score at admission was 24.1.
- The average CASII composite score at discharge was 20.9.
- Reason for departure

  - 50% (9) placed in a less restrictive setting
  - 22.2% (4) placed in a more restrictive setting
  - 16.7% (3) reunified with biological family
  - 5.6% (1) relative placement
  - 5.6% (1) youth ran away from placement (AWOL)
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 12.9, which equals the restrictiveness score of a family based treatment home.
  - 16.7% (3) home of birth/adoptive parents, for a child
  - 5.6% (1) home of a relative
  - 11.1% (2) regular foster care
  - 5.6% (1) family based treatment home
  - 33.3% (6) group treatment home
  - 16.7% (3) residential treatment center
  - 11.1% (2) county detention center
- 66.7% (12) completed treatment.
- Who recommended departure
  - 88.9% (16) child and family team
  - 5.6% (1) N/A; youth went AWOL
  - 5.6% (1) child welfare case manager
- Transition plan appropriate
  - 100% (18) yes
- Discharge plan appropriate
  - 94.4% (17) yes
  - 5.6% (1) no.

Overall Highlights:

- The use of Child and Family Teams to recommend discharge increased by almost 11% over the 2009 reporting period. 87% of the discharges were recommended by Child and Family Teams in this reporting period. In the 2009 reporting period, 76.2% of the discharges were recommended by a CFT.
- Youths completing treatment at discharge was down slightly more than 6% from the 2009 reporting period.
- Upon discharge, 78.3 % of the youth were going to a less restrictive environment; this was down slightly from 81% in the 2009 reporting period.
- Upon discharge, 37% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).

Children in Child Welfare Custody Highlights:

Upon discharge, 72.3% of youth returned to a less restrictive environment.

Upon discharge, 22.3% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives)

66.7% of youth completed treatment at the time of discharge.

88.9% of the discharges were recommended by Child and Family Teams.

Opportunities for improvement:

- During the pre-placement process, a placement preparation plan should be developed by the Child and Family Team which addresses the child's emotional, psychological, developmental, and relationship connectedness needs to support placement stability.
- Focus on supporting placement stability, facilitating permanency, and minimizing the trauma of separation and loss by providing for pre-placement visitation whenever possible as this best practice helps to diminish fears and worries of the unknown, helps with the transfer of attachments, helps to initiate the grieving process, helps to empower the new caregivers/staff and, helps the youth in making commitments for the future (Falhberg, 1991).
- During the pre-placement process, an assessment of the child's previous placement history should be conducted by the Child and Family Team to determine the trauma risk factors and the provider's ability to address these factors in facilitating new attachments and relationships in the specialized foster care home.
- Child and Family Teams are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Summary

ATC submitted all of its 2010 risk measures and departure conditions timely and, for the most part, completely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2010 Risk Measures and Departure Conditions report reflects substantial opportunities for improvement in the areas of medication errors, restraint and manual guidance, AWOLs, child safety, placement stability and permanency, well-being, and Child and Family Teams.

In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed policy implementation and review tools for medication management, crisis triage, and structured therapeutic environment. The PEU would encourage the provider's used of these tools to assist in developing their own program improvement planning to address some of the areas identified in their 2010 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Society of Hospital Pharmacists. (1993). ASHP guidelines on preventing medication errors in hospitals. *American Journal of Hospital Pharmacy.* 50:305–14.

Bowlby, J. (1970). Attachment and loss, Volume I: Attachment. New York: Basic Press.

Child Welfare League of America. (2007). *Prevention of missing-from-care episodes.* Retrieved 10-14-09 from www.cwla.org/programs/fostercare/childmiss07.pdf

Children Missing From Care: Proceedings of Expert Panel Meeting. March 8 and 9, 2004.

Courtney, C. E., Skyles, A., Samuels, G. M., Zinn, A., Howard, E., & George, R. M. (2005) Youth who run away from substitute care (CS-114). University of Chicago, Chapin Hall Center for Children.

Committee on Restraint and Crisis Intervention Techniques Final Report to the Governor and Legislature (2007). Behavior support & management: Coordinated standards for children's systems of care. Rensselaer, NY: Council on Children and Families.

Falhberg, V. (1991). A child's journey through placement. Indianapolis: Perspective Press.

Falhberg, V. and Staff of Forest Heights Lodge (1972). Residential treatment: a tapestry of many therapies. Indianapolis: Perspectives Press.

Haimowitz, S., Urff, J., & Huckshorn, K. (1992). Restraint and seclusion: A risk management guide. New York: Author.

Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry*, 43, 54-58.

Iowa Department of Human Services Employees' Manual, Title 3, Chapter E (2006). Restraint and Seclusion Policy for Mental Health Institutions. Iowa: Author

Jewett, C. (1982). Helping children cope with separation and loss. Massachusetts: Harvard Common Press.

Nevada Children's Behavioral Health Consortium. *Guidance for creating effective child and family team meetings.*

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5.* Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

U.S. Pharmacopeia. (1997, January). *Definition of medication errors.* Retrieved April 28, 2009 from http://www.usp.org/hqi/practitionerPrograms/newsletters/qualityReview/qr571997-01-01e.html

United States General Accounting Office, GAO Report to Congress (1999). Mental health: Improper restraint or seclusion. People at risk. Washington, D.C. Author.

ATTACHMENT F

Division of Child and Family Services
Family Learning Homes
Risk Measures and Departure Conditions Report - 2010

INTRODUCTION

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This 2010 report is the third year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2010 through December 2010. FLH submitted a timely and complete data set in 2010 and is to be commended for their willingness to share this very important information.

All of the risk measure and departure conditions data is self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported.

Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2010 the PEU, in partnership with the Provider Support Team, began to develop tools and processes to assess provider adherence to standards of practice and data reporting. These include:

- Face to face policy review meetings were conducted between PEU and contracted providers. Many of the policies reviewed in these meetings are those which address risk measures as reflected in this report (e.g., medication management, restraint, crisis triage, training curricula regarding suicide awareness, Child and Family Teams, etc.). The focus of these meetings was not only on improving practice standards but also to articulate standards regarding quality assurance activities such as data collection, data analysis and the development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide.

- The development and implementation of an internal data base for tracking data clean up issues; this endeavor has helped to minimize the limitations around missing or incomplete data which has previously impacted our interpretation and analysis of the data in past reports.

Data analysis limitations do continue as we factor in provider self reporting and our current inability to confirm the accuracy of reported incidents; however, the information provided herein is useful and can be used for program improvement initiatives to better serve Nevada's children and families.

RISK MEASURES AND DEPARTURE CONDITIONS

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance

Specialized Foster Care providers were asked to also track and report departure conditions on children and adolescents discharged from services during the 12-month reporting period. Collecting departure conditions data for analysis is one way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice:

- Treatment completion at discharge
- Restrictiveness level of next living environment
- Child and Family Team decision making

The following is the data and analysis of the four risk areas and departure conditions.

FLH PROGRAM INFORMATION

This analysis is based on data collected from January 2010 though December 2010.

Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served for the 2009 and 2010 reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2010	16.83	2010	20.42
	Range: 12 to 21		Range: 16 to 24
2009	16.2	2009	17.5
	Range: 10 to 20		13 to 22

Suicide

Specialized foster care providers were asked to track and report incidents of attempted and completed suicides.

Attempted suicide was defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself but was rescued or thwarted, or changed his or her mind after taking initial action.

FLH reported zero incidents of suicide attempts during this reporting period as well as the prior period of 2009. In the reporting period of June 2008 through December 2008, FLH reported one incident of attempted suicide.

Medication Errors

Specialized foster care providers were asked to track and report medication errors. To track medication errors a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

> A medication error is any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional, client, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use (U.S. Pharmacopeia, 1997).

Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000). Providers are encouraged to review the definitions of a medication error to ensure that if an error is made, it is being properly documented. If errors are documented a review of errors can result in procedural improvements to minimize future errors.

Medication errors reported by FLH in the 3 reporting periods are reflected in Table 2.

Table 2

MEDICATION ERRORS	
Reporting Period	**Number of Errors**
2010	3
2009	3
June 2008 – Dec 2008	2

The 3 incidents of medication errors reflect the following descriptive and clinical medication error information:

- One youth had a diagnosis of ADHD, the second youth had a diagnosis of Dysthymic Disorder, and the third youth had a diagnosis of Major Depressive D/O.
- Medication Error Type
  - 66.7% (2) omission error
  - 33.3% (1) unauthorized drug administration
- Two of the medication errors were with psychotropic medication, one was with non-psychotropic medication.

- Medication error outcome
  - 100% (3) an error occurred that reached the patient but did not cause patient harm.

Med error day
33.3% (1) Thursday
33.3% (1) Sunday
33.3% (1) Friday

- Med error time
  - 33.3% (1) 8:00 PM
  - 33.3% (1) 8:45 AM
  - 33.3% (1) 4:10 PM
- FLH reported all staff involved in the medication errors had initial medication administration training as well as refresher training.

Opportunities for improvement:

- Workplace distraction is a leading factor contributing to omission medication errors. Some errors of omission occur due to environmental factors such as noise, many youth in the immediate vicinity and frequent interruptions. Quality assurance reviews of errors should include observing medication administration in order to make environmental and procedural improvements to prevent future errors (ASHP, 1993).
- Ensure the use of medication logs in each child's treatment home agency record and that each log is reviewed for quality assurance by someone other than the person who administered the medication (ASHP).
- For 3 successive reporting periods as noted in Table 2, FLH has consistently reported less than expected medication errors. When one considers the potential number of both prescription and over-the-counter (OTC) medications each youth in a specialized foster care placement may be taking, oftentimes multiplied by administration several times per day multiplied again by the

number of days in placement, one expects to see a higher number of errors over the course of this 12-month reporting period

The administration and dispensing of all prescription and OTC medications are to be tracked and errors reported in the Medication Errors workbook. In multiple discussions with providers about the issue of tracking and reporting medication errors, it has been determined that some providers have a misunderstanding of what constitutes a medication for this reporting purpose. For example, several providers thought they were to report only psychotropic medication errors while others thought they were to report only on prescription medication errors. Many providers did not understand the requirement to report all medication errors, whether they are prescription or OTC medications. This misunderstanding resulted in an identified under-reporting of medication errors overall for some providers.

Other common mistakes in tracking and reporting medication errors which the PEU has identified in discussions with providers include:

1. the youth refusing to take the medication
2. dispensing a medication at the wrong time of day or failing to dispense a medication as prescribed or directed
3. sending medications with the youth on home passes and confirming on the youth's return to the specialized foster care home, the medication was not dispensed by the family or other responsible adult
4. inability to fill the prescription and dispense the medication because the prior authorization has not yet been approved or consents had not been obtained or provided timely by the legal guardian/custodian

- By reviewing the circumstances surrounding an error, providers may be able to identify procedural changes needed to minimize further errors. A common contributing factor to medication errors is distractions (U.S. Pharmacopeia, 2000). The person responsible for the medication error can be informed of the error and receive education or training. A positive action is to ask the person responsible for the medication error to identify how he or she would correct the error in the future.

Given the less than expected medication errors reported by FLH, the PEU would encourage FLH staff to explore whether these sorts of common mistakes in documenting, tracking and reporting medication errors are occurring at the facility and, if a determination is made these mistakes are occurring, FLH should focus on implementing program improvement and corrective action to ensure this mistakes are ameliorated.

The PEU is available to provide technical assistance on any of these issues involving tracking and reporting medication errors, including providing clarification of medication error definitions. The PEU encourages providers to seek out technical assistance whenever there is a need for clarity about medication administration and management and/or reporting data related to medication errors.

AWOL

Specialized foster care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs). AWOL incidents reported by FLH in the 3 reporting periods are reflected in Table 3.

Table 3

AWOL INCIDENTS	
Reporting Period	**Number of AWOLs**
2010	7
2009	8
Sept. 2008 – Feb 2009	3

The 7 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 85.7% (6) were male, 14.3% (1) was female.
- Average age was 14.43 with an age range of 13 to 17 years.
- 100% (8) were Caucasian.

Clinical and AWOL information:

- The most common diagnosis for those youth who went AWOL was Bipolar D/O (85.8% or 6 youth)
- Average length of absence was 2.6 days with a range of 1 to 7 days.
- 100% (7) of the youth absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
  - 85.7% (6) left home during the day
  - 14.3% (1) left from treatment home at night – staff awake
  -
- Behavior during AWOL
  - 100% (7) unknown

AWOL Time

28.6% (2) occurred between the hours of 5:00 PM and 9:00 PM
52.2% (4) occurred between the hours of 2:30 PM and 3: 30 PM
14.3% (1) occurred at 10:15 PM

AWOL Day

- 57.1% (4) Monday
- 14.3% (1) Tuesday
- 14.3% (1) Sunday
- 14.3% (1) Friday

AWOL Outcome

- 28.6% (2) returned involuntarily within 72 hours
- 28.6% (2) returned through juvenile detention or law enforcement
- 14.3% (1) absent indefinitely – did not return to treatment home
- 14.3% (1) returned voluntarily to treatment home within 72 hours
- 14.3% (1) other: Returned voluntarily to the specialized foster home 5 days after going AWOL.

Highlights:

- 100% of the children and adolescents who ran away had a history of AWOL.
- 28.6% of AWOL children and adolescents voluntarily returned to the treatment
- Over one-half of the AWOLs occurred on Mondays during the afternoon when children are typically returning to the home after school.

Opportunities for improvement:

- Focus on AWOL prevention when staff is awake; all of AWOLs in 2010 occurred when staff was awake and in the home. In the 2009 reporting period 50% of the AWOLs occurred during the time staff was present and awake for supervision.
- Consider examining the routine in the home as children are transitioning from school to home in the afternoons to determine whether there are strategies that might help minimize the stresses for youth and staff during these times; e.g., Is staffing in the home adequate at that time of the day to provide both supervision and individualized attention to children who may have transition challenges? Is the routine in the home flexible enough to accommodate youth who may need extra attention at the end of a stressful school day and/or bus ride home?, Does the routine allow for adequate debriefing with each youth about their day in general or concerns they need to address or resolve about their school day or perhaps about a visitation that occurred the prior weekend?, etc.
- Focus on developing protocols regarding supervision in the home; 100% (7) of the AWOLs occurred when staff was present in the home, awake and presumably available for supervision and intervention.
- Develop a protocol for children and adolescents who threaten to run away or who have a history of AWOL behavior. The protocol would include the creation of a plan that provides appropriate alternatives to the runaway behavior.
- Develop a crisis plan at admission for children that have a known history of AWOL.
- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005)
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety
  - schedule regular visitation with family members
  - promote family ties such as placement with siblings
  - nurture other positive relationships in the youth's life, such as a mentor
  - offer activities and recreational opportunities that will interest youth
  - provide personal safety training
  - inform youth of risks of and alternatives to running (Courtney et al., 2005).
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).

Restraint and Manual Guidance

Specialized foster care providers were asked to track and report on restraint and manual guidance used on children and adolescents. A restraint is a method of restricting a child's freedom of movement for his/her safety or for the safety of others.

The model of restraint employed at FLH is Conflict Prevention and Response (CPAR). FLH reported all staff present during the restraint/manual guidance received both initial restraint/manual guidance training and 83.3% (5) staff received refresher training.

The number of restraint/manual guidance incidents reported by FLH in the 3 reporting periods is noted in Table 4.

Table 4

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	**Number of Restraints/Manual Guidance Incidents**
2010	6
2009	7
June 2008 – Dec 2008	2

The 6 reports of the use of restraints/manual guidance reflect the following descriptive information:

- 83.3% (5) were female and 16.7% (1) were male.
- Average age was 8.2 with an age range of 5 to 12 years.
- 66.7% (4) were Caucasian, 33.3% (2) were of mixed race.
- None of the youth were of Hispanic origin.

Clinical and Restraint/Manual Guidance Information:

- The most frequent diagnosis was Posttraumatic Stress Disorder (66.7% or 4).
- 50% (3) of children had a restraint used on them previously.
- Average length of restraint was 19 minutes, ranging from 3 minutes to 75 minutes.
- Precipitating restraint event
  - 33.3% (2) physically assaultive toward an adult
  - 33.3% (2) physically assaultive toward another youth
  - 33.4% (3) Other
    - Explanation:
      1. Difficult morning; noncompliance with staff instructions to complete chores. Parent came for a visit and asked client to complete her reading homework. Client became assaultive.
      2. Telephone conversation with mother prior to incident however, phone call was non-remarkable for negative or upsetting content.
- Type of supervision prior to use of restraint/manual guidance
  - 66.7% (4) Group – 4 or more
  - 33.3% (2) Group of 2 or more
- Restraint injury
  - 83.3% (5) no one was injured
  - 16.7% (1) staff injured
- Restraint Time
  - 50.1% (3) occurred between the hours of 6:00 PM and 10:00 PM
  - 33.4% (2) occurred between the hours of 3:00 PM and 5:00 PM
  - 16.7% (1) occurred between the hours of 9:00 AM and 10:00 AM
- Restraint Month
  - 33.3% (2) September

- 33.3% (2) April
- 33.3% (2) May

Opportunities for improvement:

- At the time of admission, an assessment of relevant risk factors and the youth's history with restraint should be explored as this will inform the treatment planning and services provided; therefore, the provider should focus on obtaining a complete restraint/manual guidance history of each child and adolescent as early in the pre-placement process as possible. (GAO, September 1999)
- Each child who is identified as having behavior management problems or a history with restraint should have an individualized behavior management plan that is evaluated on a regular basis for efficacy (Council on Children and Families, 2007).
- Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation. (Council on Children and Families)
- Ensure debriefing occurs with those staff involved in the restraint to explore and address the events leading to the use of restraint, to explore alternatives to restraint which may have been more useful or effective, potential strategies to avoid the use of restraint, and to evaluate the physical/psychological/emotional effects on both the youth and the staff. (GAO)
- Information or data obtained during the post analysis event and debriefing processes should be used as part of the provider's and/or facility's quality assurance and performance improvement activities and should assist the program in establishing performance measurements. The purpose is:
    1. To learn whether restraint and seclusion are being used as emergency interventions;
    2. To identify rates of restraints broken down by unit and youth characteristics;
    3. To review trends in restraint use – are your program's rates increasing or decreasing?
    4. To compare rates and trends between your program and similar "benchmark" programs.
    5. To identify opportunities for improving the rate and safety of use; and,
    6. To identify staff training needs. (Iowa Department of HHS, 2006)

  Focus on collecting and aggregating these specific data on each restraint and seclusion episode on a regularly scheduled basis in order to identify frequencies, trends, and the like data analysis for continuous quality and program improvement initiatives. (Haimowitz, Urff, and Huckshorn, 2006)
- Ensure staff has effective alternative methods for handling those youth who may have a history with restraint or whose behavior plan indicates they are at risk for being restrained.
- Ensure FLH staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Departure Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster home and admitted to another specialized foster home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period.

FLH reported thirty-five (41) discharges in this reporting period. In the 2009 reporting period FLH reported thirty-five (35) discharges. In the September 2008 through December 2008, FLH reported 4 discharges.

The 41 departures reflect the following descriptive information.

- 51.3% (21) were male, 48.8% (20) were female.
- Average age was 12.3 with an age range of 6 to 17 years.
- Race
  - 92.7% (38) Caucasian
  - 4.9% (2) Black/African American
  - 2.4% (1) Native Hawaiian/Pacific Islander.
- 9.8% (4) of youth were of Hispanic origin.
- 31.7% (13) of youth were in child welfare custody, 34.1% (14) of youth were in parental custody and on probation, and 34.1% (14) of youth were in parental custody and no juvenile probation involvement.
- 95.1% (39) were Medicaid or SCHIP recipients.
- The average length of stay for youth discharged from FLH in 2010 was 155.4 days, ranging from 7 days to 319 days.

Clinical and departure information:

- The 3 most frequent diagnosis at admission
  - 41.5% (17) Posttraumatic Stress D/O
  - 7.3% (3) Bipolar D/O, NOS
  - 7.3% (3) Mood D/O, NOS
- The 3 most frequent diagnosis at discharge
  - 41.5% (17) Posttraumatic Stress D/O
  - 7.3% (3) Bipolar D/O, NOS
  - 7.3% (3) Mood D/O, NOS
- The average CASII composite score at admission was 23.3.
- The average CASII composite score at discharge was 22.4.
- Reason for departure
  - 48.8% (20) reunified with biological family
  - 17.1% (7) placed in a more restrictive setting
  - 12.2% (5) admitted to new specialized foster care home, different agency
  - 7.3% (3) relative placement
  - 4.9% (2) emancipated
  - 4.9% (2) youth ran away from placement (AWOL)
  - 2.4% (1) adopted/adoptive placement
  - 2.4% (1) placed in a less restrictive setting
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 8.6, which equals the restrictiveness score of supervised independent living. In the 2009 and 2008 reporting periods, the ROLES reported resulted in an average score of 7.6, which equals the restrictiveness score of the home of a family friend, and 7.5, which equals the restrictiveness score of an adoptive home, respectively.
  - 2.4% (1) home of birth/adoptive parents, for an 18-year old
  - 48.8% (20) home of birth/adoptive parents, for a child
  - 9.8% (4) home of a relative
  - 2.4% (1) adoptive home
  - 2.4% (1) regular foster care
  - 14.6% (6) family based treatment home

  - 4.9% (2) group treatment home
  - 7.3% (3) residential treatment center
  - 4.9% (2) county detention center
  - 2.4% (1) state and private mental hospital
- 61% (25) completed treatment.
- Who recommended departure
  - 78% (32) child and family team
  - 14.6% (6) parent
  - 4.9% (2) N/A; youth went AWOL
  - 2.4% (1) provider agency
- Transition plan appropriate
  - 82.9% (34) yes
  - 16.8% (7) no.
    - Explanation:
      1. (2) Youth went AWOL
      2. Client was discharged AMA as parents elected to admit youth to an out of state RTC that specializes in RAD. They informed the youth without informing staff and the youth rebelled in program as she was scared about going out of state.
      3. Client was discharged AMA per parent's request.
      4. Father removed client AMA due to alleged child abuse report that was filed and police became involved to investigate the allegation. Parents had a voluntary with the public county child welfare agency and were angry with the social worker re: investigation of abuse report
      5. Mother AMA discharged client as they missed each other and she believed client living out of the home was detrimental.
      6. Mother discharged client AMA as she was tired of having to drive to FLH for client crisis and parent training/therapy.
- Discharge plan appropriate
  - 80.5% (33) yes
  - 19.5% (8) no
    - Explanation:

      Believed client had enough skills to return to the family home. Parents were not in agreement.

      (2) Youth went AWOL.

      Client was discharged AMA as parents elected to admit youth to an out of state RTC that specializes in RAD (which is not her primary diagnosis).

      Client was discharged AMA per parent's request.

      Father removed client AMA due to alleged child abuse report that was filed and police became involved to investigate the allegation. Parents had a voluntary with the public county child welfare agency and were angry with the social worker re: investigation of abuse report

      FLH and Dr. McClintock recommended client remain in specialized foster care level of treatment as recommended by West Hills Hospital prior to client admitting to FLH.

      Mother discharged client AMA as she was tired of having to drive to FLH for client crisis and parent training/therapy.

<u>Youth in Child Welfare Custody</u>

Of the 41 discharges reported by FLH in the 2010 reporting period, 31.7% (13) were in the custody of a public child welfare agency.

These 13 departures for youth in the custody of a public child welfare agency reflect the following descriptive information:

53.8% (7) were female, 46.2% (6) were male.

- Average age was 11.1 with an age range of 7 to 17 years.
- Race
  - 76.9% (10) Caucasian
  - 15.4% (2) Black/African American
  - 7.7% (1) Native Hawaiian/Pacific Islander.
- 100% (13) were Medicaid or SCHIP recipients.
- The average length of stay at FLH in 2010 for youth in the custody of a public child welfare agency was 159.2 days, ranging from 7 days to 312 days.

Clinical and departure information for youth in the custody of a public child welfare agency:

- The 2 most frequent diagnosis at admission
  - 53.8% (7) Posttraumatic Stress D/O
  - 15.4% (2) Bipolar D/O, NOS
- The 2 most frequent diagnosis at discharge
  - 53.8% (7) Posttraumatic Stress D/O
  - 15.4% (2) Bipolar D/O, NOS
- The average CASII composite score at admission was 23.3.
- The average CASII composite score at discharge was 23.
- Reason for departure
  - 30.8% (4) admitted to new specialized foster care home, different agency
  - 15.4% (2) placed in a more restrictive setting
  - 15.4% (2) relative placement
  - 15.4% (2) youth ran away from placement (AWOL)
  - 7.7% (1) adopted/adoptive placement
  - 7.7% (1) placed in a less restrictive setting
  - 7.7% (1) reunified with biological family
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 12.7, which equals the restrictiveness score of a family based treatment home.
  - 7.7% (1) home of birth/adoptive parents, for an 18-year old
  - 15.4% (2) home of a relative
  - 7.7% (1) adoptive home
  - 7.7% (1) regular foster care
  - 38.5% (5) family based treatment home
  - 7.7% (1) residential treatment center
  - 7.7% (1) county detention center
  - 7.7% (1) state and private mental hospital
- 53.8% (7) completed treatment.
- Who recommended departure
  - 76.9% (10) child and family team
  - 15.4% (2) N/A; youth went AWOL
  - 7.7% (1) provider agency

- Transition plan appropriate
  - 84.6% (11) yes
  - 15.4% (2) no
    - Explanation: Both youth went AWOL.
- Discharge plan appropriate
  - 84.6% (11) yes
  - 15.4% (2) no.
    - Explanation: Both youth went AWOL.

Overall Highlights:

- Upon discharge, 60.9% of youth returned to a less restrictive environment. In the 2009 reporting period, 65.8% of youth returned to a less restrictive environment, with over half returning to live with family members. In the September 2008 through December 2008 reporting period, 50% of the youth were going to a less restrictive environment.
- Upon discharge, 63.4% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- 61% of the youth completed treatment at discharge. In the 2009 reporting period, over half of the youth completed treatment. In the September 2008 through December 2008 reporting period, 50% of the youth discharged completed treatment.
- 75% of the discharges were recommended by Child and Family Teams. In the 2009 reporting period, slightly more than 75% of the discharges were recommended by Child and Family Teams. In the September 2008 through December 2008 reporting period, 50% of the discharges were recommended by the child and family team.

Children in Child Welfare Custody Highlights:

Upon discharge, 38.5% of youth returned to a less restrictive environment.
Upon discharge, 30.8% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives)
53.8% of youth completed treatment at the time of discharge.
76% of the discharges were recommended by Child and Family Teams.

Opportunities for improvement:

- During the pre-placement process, a placement preparation plan should be developed by the Child and Family Team which addresses the child's emotional, psychological, developmental, and relationship connectedness needs to support placement stability.
- Focus on supporting placement stability, facilitating permanency, and minimizing the trauma of separation and loss by providing for pre-placement visitation whenever possible as this best practice helps to diminish fears and worries of the unknown, helps with the transfer of attachments, helps to initiate the grieving process, helps to empower the new caregivers/staff and, helps the youth in making commitments for the future (Falhberg, 1991).
- During the pre-placement process, an assessment of the child's previous placement history should be conducted by the Child and Family Team (CFT) to determine the trauma risk factors and the provider's ability to address these factors in facilitating new attachments and relationships in the specialized foster care home.
- Child and Family Teams are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Summary

FLH submitted all of its 2010 risk measures and departure conditions timely and, for the most part, completely and accurately. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2010 Risk Measures and Departure Conditions report reflects substantial opportunities for improvement in the areas of medication errors, AWOLs, restraint and manual guidance, child safety, placement stability and permanency, well-being, and Child and Family Teams.

In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed policy implementation and review tools for medication management, crisis triage, and structured therapeutic environment. The PEU would encourage the provider's used of these tools to assist in developing their own program improvement planning to address some of the areas identified in their 2010 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Society of Hospital Pharmacists. (1993). ASHP guidelines on preventing medication errors in hospitals. *American Journal of Hospital Pharmacy.* 50:305–14.

Bowlby, J. (1970). Attachment and loss, Volume I: Attachment. New York: Basic Press.

Child Welfare League of America. (2007). *Prevention of missing-from-care episodes.* Retrieved 10-14-09 from www.cwla.org/programs/fostercare/childmiss07.pdf

Children Missing From Care: Proceedings of Expert Panel Meeting. March 8 and 9, 2004.

Courtney, C. E., Skyles, A., Samuels, G. M., Zinn, A., Howard, E., & George, R. M. (2005) Youth who run away from substitute care (CS-114). University of Chicago, Chapin Hall Center for Children.

Committee on Restraint and Crisis Intervention Techniques Final Report to the Governor and Legislature (2007). Behavior support & management: Coordinated standards for children's systems of care. Rensselaer, NY: Council on Children and Families.

Falhberg, V. (1991). A child's journey through placement. Indianapolis: Perspective Press.

Falhberg, V. and Staff of Forest Heights Lodge (1972). Residential treatment: a tapestry of many therapies. Indianapolis: Perspectives Press.

Haimowitz, S., Urff, J., & Huckshorn, K. (1992). Restraint and seclusion: A risk management guide. New York: Author.

Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry*, 43, 54-58.

Iowa Department of Human Services Employees' Manual, Title 3, Chapter E (2006). Restraint and Seclusion Policy for Mental Health Institutions. Iowa: Author

Jewett, C. (1982). Helping children cope with separation and loss. Massachusetts: Harvard Common Press.

Nevada Children's Behavioral Health Consortium. *Guidance for creating effective child and family team meetings*.

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5.* Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

U.S. Pharmacopeia. (1997, January). *Definition of medication errors.* Retrieved April 28, 2009 from http://www.usp.org/hqi/practitionerPrograms/newsletters/qualityReview/qr571997-01-01e.html

United States General Accounting Office, GAO Report to Congress (1999). Mental health: Improper restraint or seclusion. People at risk. Washington, D.C. Author.

ATTACHMENT G

DCFS Children's Mental Health Services Supervisor File Review

The Supervisor File Review was implemented by the DCFS Children's Mental Health Management Team in the fourth quarter of FY 2010. The purpose of this project is to review documentation in client files and evaluate the rate of compliance to service standards and required documentation indicators. Accurate and timely documentation of services provided to children and families are a critical component of quality assurance for service delivery.

Until recently, documentation compliance file reviews were conducted using one checklist tool that incorporated both direct and targeted case management services documentation standards. The new tools make it possible for supervisors to review both direct services and/or targeted case management services depending on the program files they choose to address. Periodic client file reviews assist in the quality assurance of services and enhance the service delivery process by providing feedback to practitioners on their compliance with established service standards and documentation requirements.

Method

File Selection: Supervisors selected client files that were actively receiving services or had recently been discharged.

Tools: The two Supervisor File Review Checklist tools, developed according to DCFS legal, ethical, and mental health service standards and approved by service program managers, are utilized for quality assurance of service delivery.

The Direct Service Delivery Clinical Supervisor Checklist consists of 40 items and assists in the evaluation of the following documentation standards.

- Client Rights/Privacy
- Children's Uniform Mental Health Assessment (CUMHA)
- Discharge Planning at Admission
- Treatment Plan/Rehabilitation Plan
- Monitoring of Treatment: Progress Notes/Billing Codes
- Monitoring of Treatment: 90 Day Reviews
- Monitoring of Treatment: 30 Day Rehab Service Report
- Monitoring of Treatment: Discharge Summary

The Targeted Case Management Supervisor Checklist consists of 41 items and assists in the evaluation of the following targeted case management documentation standards:

- Client Rights/Privacy
- Medical Necessity
- Targeted Case Management Assessment
- Targeted Case Management Care Coordination Plan (CCP)
- Monitoring of Care Coordination: Progress Notes and Billing Codes
- Monitoring of Care Coordination: 90 Day Reviews
- Monitoring of Care Coordination: Discharge/Transition Summary

Supervisor Checklist Rating: Each item on the supervisor checklist is an indicator consistent with a standard of care that addresses documentation requirements. Supervisors endorse either a "YES" or a "NO" response for each indicator on the tool, acknowledging the presence or absence of the documentation indicators in the client file.

Data Collection: The Supervisor File Review was initiated on April 1, 2010 and continued through the end of July 2010. Files were reviewed electronically and in hard copy to determine the presence or absence of items. Supervisors either mailed or faxed their completed tools to the Planning and Evaluation Unit for data entry and analysis. The number of completed checklists and the number of participating supervisors by program from each region is illustrated in Table 1.

Table 1

PROGRAM	SNCAS		NNCAS		TOTAL
	# of Supervisors	# of Tools	# of Supervisors	# of Tools	
CCS/Outpatient Direct Clinical	4	36	2	17	53
CCS/Outpatient TCM	2	9	2	6	15
ECMHS Direct Clinical	3	10	1	12	22

ECMHS TCM	2	7	1	4	11
WIN	5	64	2	20	84
ATC Direct Clinical			1	18	18
Total	--	126	--	77	203

Eighteen supervisors, 6 at NNCAS and 12 at SNCAS, participated in the Supervisor File Review Project. A total of 203 file reviews, 93 direct clinical services checklists and 110 targeted case management checklists were completed.

Data Analysis: Rate of compliance to service documentation standards is summarized for supervisor checklist tools, and results are presented for participating DCFS Children's Mental Health programs.

Areas of Strength are identified as indicators with 85% compliance rate or higher; Satisfactory Areas are identified as indicators with 70%-84% compliance rate; Areas that Need Improvement are indictors identified as less that 70% compliance rate with the documentation standards consistent with DCFS Children's Mental Health service delivery processes.

Results

Supervisor Checklist Results: Table 2 and Table 3 show Direct Service Delivery Clinical Supervisor Checklist results and Targeted Case Management Supervisor Checklist results respectively. Ratings less than 70% are highlighted as areas that need improvement. Ratings of "NR" indicate that the item was not rated. Ratings of "NA" indicate that the item was not applicable.

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Table 2

Direct Service Delivery Clinical Supervisor Checklist Results

	STANDARD	NNCAS OPS No. of Supervisors:2 No. of Files: 17	NNCAS ECMHS No. of Supervisors: 1 No. of Files: 12	NNCAS ATC No. of Supervisors: 1 No. of Files:18	SNCAS CCS No. of Supervisors: 4 No. of Files: 36	SNCAS ECMHS No. of Supervisors:3 No. of Files: 10
	Clients Rights/Privacy	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
1.	Informed Consent/Client Rights signed and dated on or before the first session.	**94**	**100**	**89**	**100**	**30**
2.	HIPAA acknowledgement signed and dated on or before the first session	**70**	**100**	**89**	**100**	**30**
3.	Release of Information completed properly by addressing the source and the nature of information needed with expiration of 1 year or less, signed and initialed.	**82**	**100**	**67**	**83**	**20**
4.	DCFS Freedom of Choice form signed and dated at the time of or following the clinical assessment.	**88**	**100**	**94**	**78**	**20**
	Children's Uniform Mental Health Assessment	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
5.	Children's Uniform Mental Health Assessment is completed at the first session to include minimally the diagnosis, level of intensity, SED determination in order to treat the child	**76**	**83**	**72**	**94**	**90**
6.	Children's Uniform Mental Health Assessment is entered into Avatar within 10 working days of the first session	**41**	**58**	**83**	**30**	**80**
	Discharge Planning at admission	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
7.	The anticipated duration of the overall services.	**29**	**11**	**83**	**47**	**10**
8.	Discharge criteria	**47**	**11**	**89**	**78**	**40**
9.	Required aftercare/transition services	**0**	**0**	**61**	**11**	**0**
10.	Identified agency(ies) or independent providers to provide the aftercare services.	**6**	**0**	**33**	**19**	**0**
11.	A plan for assisting the client and family in selecting and accessing these services	**17**	**0**	**50**	**14**	**0**
	Treatment Plan/Rehabilitation Plan	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
12.	Each child has an initial treatment/rehab plan completed during the assessment session.	**88**	**67**	**94**	**97**	**80**
13.	Each child has a full clinical treatment/rehab plan completed within 30 days of the initial session, entered into Avatar and approved by supervisor within 45 days from intake	**23**	**8**	**100**	**64**	**70**

	STANDARD	NNCAS OPS	NNCAS ECMHS	NNCAS ATC	SNCAS CCS	SNCAS ECMHS
14.	Treatment/rehab goals and objectives are expressed in the words of the child (when developmentally appropriate) and the family.	**41**	**50**	**100**	**75**	**70**
15.	Family/Caregiver is involved in developing the treatment/rehab plan as evidenced by their signature on the plan.	**59**	**92**	**94**	**42**	**40**
16.	Child/adolescent is involved in developing the treatment/rehab plan (when developmentally appropriate) that is individualized to the child's needs.	**88**	**NA**	**89**	**64**	**NA**
17.	Treatment/rehab plan is reviewed and authorized by QMHP in Avatar.	**35**	**42**	**50**	**83**	**70**
18.	Include on the treatment/rehab plan the child's name & 11-digit Medicaid billing number	**65**	**60**	**22**	**69**	**40**
19.	Strengths & Needs of the child and his/her family	**100**	**83**	**83**	**75**	**70**
20.	Intensity of Needs determination	**94**	**92**	**78**	**61**	**60**
21.	Goals are specific, measurable (observable), achievable, realistic, and time-limited (SMART)	**70**	**92**	**100**	**72**	**80**
22.	Discharge/transition criteria for each treatment goal are reflected in the treatment/rehab plan.	**53**	**75**	**78**	**64**	**60**
23.	Specific treatment goal/objective includes the frequency, amount, scope, duration and the anticipated provider of service	**59**	**92**	**94**	**50**	**10**
24.	Coordinating QMHP signs the treatment/rehab plan	**23**	**42**	**44**	**61**	**70**
	Monitoring of Care Coordination Progress Notes and Billing Codes	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
25.	Progress notes that follow a standardized format (DAP) document the data, assessment and plan necessary for treatment and service care coordination that includes the amount, cope, duration and name of the service provider.	**88**	**92**	**100**	**83**	**100**
26.	Progress notes relate to the treatment/rehab plan goals and objectives and document progress or lack thereof in the DAP format	**88**	**92**	**100**	**80**	**90**
27.	Progress notes are documented in Avatar within 72 hours of service delivery	**47**	**33**	**100**	**42**	**80**
	Monitoring of Treatment 90-Day review	**% of Compliance** 9 files	**% of Compliance** 5 files	**% of Compliance** 15 files	**% of Compliance** 27 files	**% of Compliance** 8 files
28.	90 day review summarizes treatment/rehab goals and objectives and progress made (or lack of progress) in	**78**	**60**	**87**	**70**	**50**

	STANDARD	NNCAS OPS	NNCAS ECMHS	NNCAS ATC	SNCAS CCS	SNCAS ECMHS
	therapy; addresses revised goals and objectives of the treatment.					
29.	90 day review includes updated assessment; CASII/NECSET/ECSII, CAFAS/PECFAS, diagnostic changes etc.	**78**	**80**	**73**	**63**	**75**
30.	Involvement of the family/caregiver in 90 day reviews.	**89**	**60**	**67**	**55**	**62**
31.	Education status information and juvenile justice involvement information if child is school age	**NR**	**NA**	**53**	**33**	**NA**
	Monitoring of Care Coordination 90-Day progress report for rehab services only	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
32.	Rehab Service provider sends 30 day progress report to the coordinating QMHP	**NR**	**NR**	**28**	**3**	**NR**
	Discharge/Transition Summary	**% of Compliance** 5 files	**% of Compliance** 3 files	**% of Compliance** 4 files	**% of Compliance** 13 files	**% of Compliance** 5 files
33.	Discharge Summary completed within 30 days when planned; 45 days when unplanned; and 7 days when transferred, following discharge.	**60**	**67**	**100**	**61**	**20**
34.	Date of last service contact.	**60**	**67**	**100**	**38**	**40**
35.	Diagnosis at admission and discharge.	**100**	**100**	**100**	**85**	**60**
36.	Reason for transition/discharge stated clearly	**100**	**100**	**100**	**100**	**80**
37.	Current level of functioning description and measurement CASII/NECSET/ECSII.	**80**	**100**	**100**	**77**	**80**
38.	Summary of effectiveness of treatment modalities, progress toward treatment/rehab goals and objectives as documented in the treatment/rehab plan.	**100**	**100**	**100**	**92**	**60**
39.	Recommendations for further services and how child has been transitioned to these services.	**100**	**67**	**75**	**100**	**40**
40.	Education status information and juvenile justice involvement information if child is school age	**NR**	**NA**	**25**	**54**	**40**

Table 3

Targeted Case Management Supervisor Checklist Results

	STANDARD	WIN South No. of Supervisors: 5 No. of Files: 64	WIN North No. of Supervisors: 2 No. of Files: 20	OPS No. of Supervisors: 2 No. of Files: 6	CCS No. of Supervisors: 2 No. of Files: 9	NNCAS ECMHS No. of Supervisors: 1 No. of Files: 4	SNCAS ECMHS No. of Supervisors: 2 No. of Files: 7
	Clients Rights/Privacy	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
1.	Informed Consent/Client Rights signed and dated on or before the first session.	**87**	**90**	**100**	**100**	**100**	**NR**
2.	HIPAA Acknowledgement signed and dated on or before the first session	**89**	**100**	**67**	**100**	**100**	**NR**
3.	Release of Information completed properly by addressing the source and the nature of information needed with expiration of 1 year or less, signed and initialed.	**81**	**100**	**83**	**89**	**100**	**NR**
4.	DCFS Freedom of Choice form signed and dated after completion of the clinical assessment recommending targeted case management.	**56**	**95**	**100**	**100**	**100**	**NR**
	Medical Necessity	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
5.	Children's Uniform Mental Health Assessment is complete and recommends TCM. Level of intensity measure meets level of service needs for TCM. SED determination is completed	**80**	**65**	**50**	**67**	**50**	**100**

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	STANDARD	WIN South	WIN North	OPS	CCS	NNCAS ECMHS	SNCAS ECMHS
	Targeted Case Management Assessment	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
6.	Targeted Case Management Assessment is completed and entered into Avatar within 10 working days of the initial targeted case management contact.	**66**	**25**	**33**	**67**	**25**	**86**
7.	Strengths, Needs and Cultural Discovery includes strengths and needs related to the culture of the family. It is reviewed by the family before the initial 30 day Child and Family Team meeting. (When the case manager is not a clinician)	**72**	**90**	**50**	**22**	**25**	**NR**
8.	Medical, social, educational, emotional and other support services including housing and transportation needs are addressed.	**88**	**100**	**50**	**78**	**33**	**100**
	Targeted Case Management Care Coordination Plan	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**	**% of Compliance**
9.	The initial Care Coordination Plan is completed and signed within 30 days of admission and before initiating services.	**72**	**85**	**67**	**89**	**50**	**50**
10.	Care Coordination Plan is developed at the Child and Family Team meeting.	**91**	**100**	**33**	**78**	**50**	**100**
11.	The child/family's needs and care coordination recommendations are addressed through the life domains.	**95**	**95**	**50**	**78**	**33**	**100**
12.	Care Coordination Plan is reviewed and updated in Child and Family Team meetings.	**91**	**100**	**17**	**55**	**0**	**86**
13.	Confidentiality Form that identifies and is signed by all participants is attached to the Care Coordination Plan.	**69**	**100**	**33**	**22**	**75**	**NA**

	STANDARD	WIN South	WIN North	OPS	CCS	NNCAS ECMHS	SNCAS ECMHS
14.	Care Coordination Plan reflects a planned action for addressing and meeting the identified needs of the child/family.	**92**	**100**	**50**	**78**	**33**	**100**
15.	Care Coordination Plan is individualized to reflect the child's age, gender, ethnic background, primary language in the home, life experience, culture, etc.	**64**	**85**	**50**	**78**	**33**	**100**
16.	Care Coordination Plan goals are expressed in the words of the child (when developmentally appropriate) and the family.	**75**	**100**	**33**	**78**	**0**	**86**
17.	Children, when developmentally appropriate are involved in developing the Care Coordination Plan.	**86**	**95**	**50**	**67**	**NA**	**100**
18.	Family/Caregiver is involved in developing the Care Coordination Plan as evidenced by their signature on the plan.	**86**	**95**	**67**	**33**	**75**	**33**
19.	Care Coordination Plan goals, objectives and actions address the medical, social, educational, emotional, and other needs.	**92**	**85**	**67**	**78**	**33**	**86**
20.	Care Coordination Plan addresses specific services and treatments that include the amount, scope, duration, and names of the service providers.	**63**	**95**	**50**	**78**	**33**	**16**
21.	Anticipated aftercare/transition plan	**30**	**70**	**33**	**28**	**33**	**0**
22.	Crisis Plan	**78**	**5**	**33**	**44**	**0**	**0**

	STANDARD	WIN South	WIN North	OPS	CCS	NNCAS ECMHS	SNCAS ECMHS
	Monitoring of Care Coordination Progress Notes and Billing Codes	% of Compliance	% of Compliance	% of Compliance	% of Compliance	% of Compliance	% of Compliance
23.	Progress notes that follow a standardized format (DAP) document the data, assessment and plan necessary for service care coordination that includes the name of the individual receiving services, the dates of service, time- line for providing services and reassess-ment, and the name of the service provider.	91	100	100	78	67	100
24.	Progress notes relate to the Care Coordination Plan goals and objectives and document progress or lack thereof as evidenced by attaching CCP goals to notes	69	55	83	44	0	57
25.	Progress note documents the nature, content and units of case management services received.	91	100	100	89	67	100
26.	Progress notes are documented in Avatar within 72 hours of service. WIN also enters notes in UNITY by the following Friday after services are provided.	25	85	33	55	25	57
27.	The need for and occurrences of coordination with case managers of other programs	98	100	67	55	100	NA
	Monitoring of Care Coordination 90-Day Review	% of Compliance 63 files	% of Compliance 17 files	% of Compliance 2 files	% of Compliance 5 files	% of Compliance 0 files	% of Compliance 6 files
28.	Whether the goals specified in the Care Coordination Plan have been achieved.	77	100	50	60	NA	100

	STANDARD	WIN South	WIN North	OPS	CCS	NNCAS ECMHS	SNCAS ECMHS
29.	90 day written review for each child that includes all the objectives/goals of the Care Coordination Plan that addresses all the relevant life domains of the child and family and progress or lack of in the CCP.	**75**	**94**	**0**	**60**	**NA**	**67**
30.	Review explains updated/revised Care Coordination Plan goals, objectives, and anticipated time of goal achievement/progress and discharge/transition plan.	**66**	**94**	**0**	**60**	**NA**	**100**
31.	Review includes updated assessment and medical necessity data; CASII/ NECSET/ECSII/CAFAS/PECFAS.	**76**	**87**	**0**	**60**	**NA**	**100**
32.	Education status information and juvenile justice involvement information if child is school age	**66**	**71**	**NA**	**40**	**NA**	**NA**
	Discharge/Transition Summary	**% of Compliance** 17 files	**% of Compliance** 3 files	**% of Compliance** 0 files	**% of Compliance** 2 files	**% of Compliance** 0 files	**% of Compliance** 3 files
33.	Discharge Summary completed within 30 days when planned; 45 days when unplanned; and 7 days when transferred, following discharge.	**82**	**100**	**NA**	**100**	**NA**	**67**
34.	Date of last service contact.	**82**	**100**	**NA**	**100**	**NA**	**33**
35.	Diagnosis at admission and discharge.	**53**	**100**	**NA**	**100**	**NA**	**100**
36.	Reason for transition/discharge stated clearly	**94**	**67**	**NA**	**100**	**NA**	**100**
37.	Implementation steps toward transition/discharge addressed.	**76**	**100**	**NA**	**100**	**NA**	**67**
38.	Current level of functioning description and measurement- CAFAS/PECFAS CASII/NECSET/ECSII.	**82**	**100**	**NA**	**100**	**NA**	**100**

	STANDARD	WIN South	WIN North	OPS	CCS	NNCAS ECMHS	SNCAS ECMHS
39	Summary of effectiveness of services, progress or lack of towards service goals as documented in the Care Coordination Plan.	**70**	**100**	**NA**	**100**	**NA**	**100**
40.	Recommendations for further services and how child has been transitioned to these services.	**82**	**100**	**NA**	**100**	**NA**	**67**
41.	Education status information and juvenile justice involvement information if child is school age	**70**	**100**	**NA**	**50**	**NA**	**NA**

Northern Nevada Child and Adolescent Services (NNCAS)

NNCAS Outpatient - Direct Service Delivery Clinical Supervisor Checklist Results

Two supervisors completed seventeen Supervisor Checklists. Results show 54% compliance rate with documentation standards. Thirteen indicators are rated in the area of strength and seven indicators are rated as satisfactory.

Areas of strengths and satisfactory compliance with documentation standards**:**

a) Client Rights/Privacy

b) CUMHA

- CUMHA assessment is completed at the first session

c) Treatment Plan

- Completed during the assessment session
- Child/Adolescent involved in developing the individualized treatment plan
- Strengths and needs of the child and family identified
- Intensity of needs determination
- Treatment goals are specific, measurable, achievable, realistic, and time-limited

d) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes follow standardized format (DAP with amount, scope, duration and name of service provider)
- Progress notes relate to treatment goals and objectives

e) Monitoring of Treatment - 90 Day Review

- Summarized treatment goals/objectives and progress (or lack of) made and addresses revised goals/objectives of the treatment
- Updated assessment for CASII/CAFAS; change in diagnosis
- Family/caregiver involved in 90 day review process

f) Discharge/Transition Summary

- Diagnosis at admission and discharge
- Reason for discharge/transition stated clearly
- Current level of functioning and measurement
- Summary of effectiveness of treatment modalities; goals/objectives documented in treatment plan
- Recommendation for further services and how the child has been transitioned to such services

Areas for improvement towards compliance with documentation standards**:**

a) CUMHA

- CUMHA is entered into Avatar within 10 working days of the first session

b) Discharge Planning at Admission

c) Treatment Plan

- A full clinical treatment plan is completed within 30 days of the initial session, entered into Avatar, and approved by the supervisor within 45 days
- Goals and objectives expressed in the language of the family/child
- Family involved in the treatment plan development verified by signature
- Reviewed and authorized/approval signature of QMHP in Avatar
- Medicaid billing number on the treatment/rehab plan
- Discharge/transition criteria for each goal/objective is reflected in the plan

- Goals/objectives includes frequency, amount, scope, duration and the name of the anticipated provider of services
- Coordinating QMHP signs the treatment/rehab plan

d) Monitoring of Care Coordination – Progress Notes and Billing Codes

- Progress notes are documented in Avatar within 72 hours of service delivery

e) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact

NNCAS Outpatient Services - Targeted Case Management Supervisor Checklist Results

Two supervisors completed six TCM Supervisor Checklist tools. Results show that overall documentation compliance rate is directly impacted by the reportedly missing Targeted Case Management Care Coordination Plans (Fourteen indicators of the tool).

Areas of strength and satisfactory compliance with documentation standards:

a) Client Rights/Privacy

- Informed consent/client rights signed and dated on or before the first session
- Release of information completed properly by addressing the source and nature of information needed with expiration of 1 year or less, signed and initialed
- Freedom of Choice form signed and dated

b) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes follow a standard format (DAP)
- Goals and objectives are relevant to and attached to progress notes
- Progress notes document the nature, content and units of case management services received

Areas for improvement toward compliance with documentation standards:

a) Clients Rights/Privacy

- HIPAA acknowledgement signed and dated

b) Medical Necessity

c) Targeted Case Management Assessment

d) Targeted Case Management Care Coordination Plan

e) Monitoring Care Coordination - Progress Notes and Billing Codes

- Progress notes are documented in Avatar within 72 hours of service
- The need for and occurrences of coordination with case managers of other programs

f) Monitoring of Care Coordination - 90 Day Reviews

- Whether the goals specified in the CCP have been achieved
- Includes all the objectives/goals of CCP relevant to life domains of the child/family and the progress (or lack of) made
- Addresses updated/revised CCP goals/objectives and anticipated time of achievement
- Addresses updated assessment and medical necessity data

NNCAS Early Childhood Mental Health Services - Direct Service Delivery Clinical Supervisor Checklist Results

One supervisor completed 12 file reviews. The results show 50% compliance with documentation standards. Fourteen indicators are rated in the area of strength and four indicators are rated as satisfactory.

The following indicators were not rated as they were reported as "Not Applicable" for the following reasons:

- Children are too young to participate in treatment planning
- Children are not of school age for Education/Juvenile Justice involvement information (90 Day Review and Discharge Summary indicator)
- No rehab service report submitted to QMHP

Areas of Strength and Satisfactory Compliance with Documentation Standards:

a) Clients Rights/Privacy

b) CUMHA

- CUMHA completed at the first session

c) Treatment Plan

- Family/Caregiver is involved in developing the treatment plan as evidenced by their signature
- Strengths and needs of the child /family
- Intensity of Needs determination
- Goals are specific, measurable, achievable, time limited
- Discharge/transition criteria for each treatment goal are reflected in the plan
- Specific treatment objective/goals includes frequency, amount, scope duration and anticipated provider of services

d) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes follow standardized format (DAP) that includes amount, scope, duration and name of provider
- Progress notes relate to treatment/rehab plan goals/objectives and document progress (or lack of) in the DAP format

e) Monitoring of Care Coordination - 90 Day reviews

- Includes updated assessment

f) Discharge/Transition Summary

- Diagnosis at admission and discharge
- Reason for transition/discharge stated clearly
- Current level of functioning description and measurement
- Summary of effectiveness of treatment; progress toward treatment goals as documented in treatment plan

Areas for improvement towards compliance with documentation standards:

a) CUMHA

- CUMHA is entered into Avatar within 10 working days

b) Discharge Planning at Admission

c) Treatment/Rehabilitation Plan

- Initial treatment/rehab plan completed during the assessment session
- A full clinical treatment/rehab plan is completed within 30 days of the initial session

- Treatment goals/objectives expressed in the words of the family
- Review, authorization and signature of plans by QMHP
- Child's name and Medicaid number is on the plan
- Coordinating QMHP signs the plan

d) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes are documented in Avatar within 72 hours of service delivery

e) Monitoring of Treatment - 90 Day Review

- 90 day review summarizes goals and objectives and progress made (or lack of) in therapy
- Family/caregiver participation in 90 day review development

f) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Recommendations for further services and how child has been transitioned to services

NNCAS Early Childhood Mental Health - Targeted Case Management Supervisor Checklist Results

One supervisor completed four Targeted Case Management File reviews.

Areas of Strength and Satisfactory Compliance with Documentation Standards:
a) Client Rights/Privacy
b) Targeted Case Management Care Coordination Plan

- Confidentiality Form signed and attached to CCP
- Family/Caregiver involved in developing the CCP

c) Monitoring of Care Coordination – Progress Notes and Billing Codes

- Need for and occurrences of coordination with case managers of other programs

Areas for improvement towards compliance with documentation standards:
a) Medical Necessity
b) Targeted Case Management Assessment
c) Targeted Case Management Care Coordination Plan

- Initial CCP is completed and signed within 30 days of admission
- CCP is developed at the Child and Family Team meeting
- CCP is reviewed and updated in Child and Family Team meetings
- Child/family's needs are care coordination recommendations are addressed through the life domains
- CCP reflects a planned action for addressing and meeting the identified needs of the child/family
- CCP is individualized
- CCP goals are expressed in the words of the family
- CCP goals, objectives and actions address the medical, social, educational, emotional, and other needs
- CCP addresses specific services and treatments that include the amount, scope, duration, and names of the service providers
- Anticipated aftercare/transition plan
- Crisis plan

d) Monitoring of Care Coordination- Progress Notes and Billing Codes

- Progress notes follow a standardized format (DAP) document the data, assessment, and plan for service care coordination

- Progress notes relate to CCP goals and objectives
- Progress note document the nature, content, and units of case management services received
- Progress notes are entered in Avatar within 72 hours of service

NNCAS WIN – Targeted Case Management Supervisor Checklist Results

Two supervisors, one supervisor from NNCAS WIN and one supervisor from Rural WIN, completed 20 Targeted Case Management file reviews. Results show an 88% compliance rate with targeted case management documentation standards. Thirty-four indicators are rated in the area of strength and two indicators are rated as satisfactory.

The NNCAS WIN program had the highest rate of compliance with documentation standards on Targeted Case Management Supervisor Checklist tool results across all DCFS targeted case management services statewide.

Areas of Strength and Satisfactory Compliance with Documentation Standards:
a) Clients Rights/Privacy
b) Targeted Case Management Assessment
- Strengths, Needs and Cultural Discovery
- Medical, social, educational, emotional and other support services including housing and transportation needs are addressed

c) Targeted Case Management Care Coordination Plan
d) Monitoring of Care Coordination-Progress notes and Billing Codes
- Progress notes that follow a standardized format (DAP) document the data, assessment, and plan necessary for service care coordination
- Progress note document the nature, content, and units of case management services received
- Progress notes are documented in Avatar within 72 hours of service
- Need for and occurrences of coordination with case managers of other programs

e) Monitoring of Care Coordination - 90 Day Review
f) Discharge/Transition Summary
- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Diagnosis at admission and discharge
- Implementation steps toward transition/discharge addressed
- Current level of functioning
- Summary of effectiveness of services, progress or lack of
- Recommendations for further services and how child has been transitioned to these services
- Education and juvenile justice information

Areas for improvement toward compliance with Documentation Standards:
a) Medical Necessity
b) Targeted Case Management Assessment
- Assessment is completed and entered into Avatar within 10 working days

c) Targeted Case Management Care Coordination Plan
- Crisis Plan

d) Monitoring of Care Coordination - Progress Notes and Billing Codes
- Progress notes relate to CCP goals and objectives that are attached to notes

e) Discharge/Transition Summary

- Reason for transition/discharge stated in summary

NNCAS Adolescent Treatment Center (ATC) – Direct Service Delivery Clinical Supervisor Checklist Results

One supervisor completed 18 Direct Service Delivery Clinical Supervisor Checklist. Results show a 72% compliance rate with documentation standards. Twenty-one indicators are rated in the area of strength and eight indicators are rated as satisfactory.

NNCAS ATC results show the highest rate of compliance achieved with the documentation standards measured by Direct Service Delivery Clinical Supervisor Checklist tool across all DCFS Children's Mental Health Direct Services statewide.

Areas of strength and satisfactory compliance with documentation standards

a) Client Rights/Privacy

- Informed consent/client rights are signed and dated
- HIPAA acknowledgement signed and dated
- Freedom of Choice form signed and dated

b) CUMHA

c) Discharge Planning at Admission

- Anticipated duration of the overall services
- Discharge criteria

d) Treatment Plan/Rehabilitation Plan

- Initial treatment plan completed during the assessment session
- Full clinical treatment plan completed within 30 days, entered into Avatar and approved by supervisor within 45 days from intake
- Goals/objectives are expressed in the words of the child/family
- Family/caregiver involved in developing the treatment/rehab plan
- Child/adolescent involved in developing the treatment/rehab plan
- Strengths and Needs of the child and family
- Intensity of Needs determination
- Goals are specific, measurable, achievable, realistic and time-limited
- Discharge/transition criteria are reflected for each treatment goal
- Treatment goals/objectives include frequency, amount, scope, duration and the anticipated provider of service

e) Monitoring of Care Coordination - Progress Notes and Billing Codes

f) Monitoring of Treatment - 90 Day Review

- 90 day review summarize treatment/rehab goals and progress made (or lack of) and address revised goals/objectives
- 90 day reviews include updated assessment

g) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Diagnosis at admission and discharge
- Reason for transition/discharge stated clearly

- Current level of functioning description and measurement
- Summary of effectiveness of treatment; progress towards treatment goals/objectives as documented in treatment plan
- Recommendations for further services and how child has been transitioned to these services

Areas for improvement toward compliance with the documentation standards:
a) Client Rights/Privacy
- Release of information completed properly and signed

b) Discharge Planning at Admission
- Required aftercare/transition services
- Agencies and independent providers identified for aftercare services
- Plan for assisting client/family in selecting and accessing the aftercare services

c) Treatment Plan/Rehabilitation Plan
- Treatment /rehab plan reviewed and signed by QMHP in Avatar
- Name and Medicaid billing number on the treatment/rehab plan
- Coordinating QMHP signs the treatment/rehab plan

d) Monitoring of Treatment - 90 Day Reviews
- Family/caregiver involved in 90 day reviews
- Education and juvenile justice involvement

e) Monitoring of Care Coordination - 90 Day Progress Report for Rehab Services Only
- Rehab Service provider sends 30 day progress report to the coordinating QMHP

f) Discharge/Transition Summary
- Education and juvenile justice information

Southern Nevada Child and Adolescent Services (SNCAS)

SNCAS Children's Clinical Services - Direct Service Delivery Clinical Supervisor Checklist Results

Four supervisors completed 36 Direct Service Delivery Clinical Supervisor Checklists. Results show a 47% compliance rate with the documentation standards. Eight indicators are rated in the area of strength and 11 indicators are rated as satisfactory.

Areas of strength and satisfactory compliance with documentation standards:
a) Client Rights/Privacy
b) CUMHA
- CUMHA completed at the first session

c) Discharge Planning at Admission
- Discharge Criteria

d) Treatment Plan/Rehabilitation Plan
- Initial treatment/rehab plan completed during the assessment session
- Goals/objectives are expressed in the words of the child/family
- Treatment/rehab plan is reviewed and authorized by QMHP in Avatar
- Strengths and needs of the child and family
- Goals are specific, measurable and achievable and time limited

e) Monitoring of Care Coordination - Progress Notes and Billing Codes
- Progress notes follow a standardized format (DAP)
- Progress notes relate to treatment/rehab goals and objectives

f) Monitoring of Treatment - 90 Day review
- 90 day summarizes treatment/rehab goals/objectives and the progress made (or lack of) in therapy

g) Discharge/Transition Summary
- Diagnosis at admission and discharge
- Reason for discharge/transition stated clearly
- Current level of functioning description and measurement
- Summary of effectiveness of treatment; progress made toward treatment goals documented in treatment plan
- Recommendations for further services and how has the child transitioned to the recommended services

Areas for improvement toward compliance with documentation standards:

a) CUMHA
- CUMHA is entered into Avatar within 10 working days

b) Discharge Planning at Admission
- Anticipated duration of the overall services
- Required aftercare/transition services
- Identified agencies or providers for aftercare services
- A plan for assisting client/family in accessing these services

c) Treatment Plan/Rehabilitation Plan
- Full clinical treatment/rehab plan completed within 30 days of initial session
- Family/caregiver involved in developing the in treatment/rehab plan as evidenced by signature
- Child/adolescent is involved in developing the treatment plan
- Child's name and Medicaid number on treatment plan
- Intensity of needs determination
- Discharge/transition criteria for each treatment goal of the treatment plan
- Treatment goals/objectives include frequency, amount, scope, duration and the anticipated provider of service
- Coordinating QMHP signs the treatment/rehab plan

d) Monitoring of Care Coordination - Progress Notes and Billing Codes
- Progress notes are documented in Avatar within 72 hours of service delivery

e) Monitoring of Treatment -90 Day Review
- 90 day review includes updated assessment
- Family/caregiver involvement
- Education and juvenile justice information

f) Monitoring of Care Coordination – 90 Day Progress Report for Rehab Services Only
- Rehab Service provider sends 30 day progress review to the coordinating QMHP

g) Discharge/Transition Summary
- Discharge summary completed within 30 days when planned
- Date of last service contact
- Education and juvenile justice information

SNCAS Children's Clinical Services - Targeted Case Management Supervisor Checklist Results

Two supervisors completed 9 file reviews for Targeted Case Management Services. Results show a 56% compliance rate with documentation standards. Fourteen indicators are rated in the area of strength and nine indicators are rated as satisfactory.

Areas of strength and satisfactory compliance with documentation standards:

a) Clients Rights/Privacy

b) Targeted Case Management Assessment

- Medical, social, educational, emotional and other support services and needs are addressed

c) Targeted Case Management CCP

- Initial CCP is completed and signed within 30 days of admission
- CCP developed at CFT meeting
- Child/family needs are addressed through life domains
- CCP reflects a planned action for addressing and meeting identified needs
- CCP is individualized
- CCP goals are expressed in the word of the child/family
- CCP goals/objectives address medical, social, educational, emotional needs
- CCP addresses services that include amount, scope, duration and names of service providers

d) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes follow a standardized format (DAP)
- Progress notes document the nature, content and units of case management services received

e) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Diagnosis at admission and discharge
- Reason for transition/discharge stated clearly
- Implementation steps toward transition/discharge addressed
- Current level of functioning description and measurement
- Summary of effectiveness of services; progress (lack of) towards CCP goals
- Recommendations for further services and how the child has been transitioned to these services

Areas for improvement toward compliance with documentation standards:

a) Medical Necessity

b) Targeted Case Management Assessment

- Assessment is completed and entered into Avatar within 10 working days
- Strengths/Needs/Cultural discovery reviewed by family before Child and Family Team meeting

c) Targeted Case Management Care Coordination Plan

- CCP is reviewed and updated in Child and Family Team meetings
- Confidentiality form is signed by all participants and attached to CCP
- Child is involved in developing CCP
- Family/caregiver involved in developing CCP
- Anticipated aftercare/transition plan
- Crisis Plan

d) Monitoring Care Coordination - Progress Notes and Billing Codes

- Progress notes relate to CCP goals and objectives

- Progress notes are documented in Avatar within 72 hours of service
- Need for and occurrences of coordination with case managers of other programs

e) Monitoring of Care Coordination - 90 Day Review
f) Discharge/Transition Summary

- Education and juvenile justice information

SNCAS Early Childhood Mental Health Services - Direct Service Delivery Clinical Supervisor Checklist Results

Three supervisors completed Direct Service Delivery Supervisor Checklist on 10 client files. The supervisors primarily reviewed electronic files since they did not have access to hard copy files. Most of the Client Rights/Privacy indictors were not rated.

Direct Service Delivery Supervisor Checklist results show a 50% compliance rate with documentation standards. Three indicators are rated in the area of strength and twelve indicators are rated as satisfactory.

Areas of strength and satisfactory compliance with documentation standards:
a) CUMHA
b) Treatment Plan/Rehabilitation Plan

- Child has an initial treatment/rehab plan completed during the assessment session
- A full clinical treatment/rehab plan completed within 30 days of initial session
- Treatment/rehab goals/objectives are expressed in the words of family
- Treatment/rehab plan is reviewed and authorized by QMHP in Avatar
- Strengths and needs of the child/family are addressed
- Goals are specific, measurable, achievable, realistic, and time limited
- Coordinating QMHP signs the treatment/rehab plan

c) Monitoring of Care Coordination - Progress Notes and Billing Codes
d) Monitoring of Treatment -90 Day Review

- 90 day review includes updated assessment

e) Discharge/Transition Summary

- Reason for Discharge/transition stated clearly
- Current level of functioning description and measurement

Areas for improvement toward compliance with documentation standards:
a) Clients Rights/Privacy
b) Discharge Planning at Admission
c) Treatment Plan/Rehabilitation Plan

- Family/caregiver is involved in developing the treatment/rehab plan as evidenced by signature
- Intensity of need determination
- Discharge/transition criteria of each treatment goal reflected in treatment plan
- Child's name and Medicaid number
- Treatment goals/objectives include frequency, amount, scope, duration, and name of anticipated provider of services

d) Monitoring of Treatment - 90 Day Review

- 90 day review summarizes treatment goals/objectives and progress made (or lack of)
- Family involvement in developing 90 day reviews.

e) Discharge/Transition Summary
- Discharge summary completed within 30 days when planned
- Date of last service contact
- Diagnosis and admission at discharge
- Summary of effectiveness of treatment goals and objectives as documented in treatment plan
- Recommendations for further services and how child has been transitioned to these services

SNCAS Early Childhood Mental Health Services- Targeted Case Management Supervisor Checklist Results

Two supervisors completed 7 Targeted Case Management Supervisor Checklists. The supervisors primarily reviewed electronic files.

The following indicators were not rated:
- Client Rights/Privacy indicators - client hard files were not available.
- Strengths needs discovery as it relates to the culture of the family

The following indicators were not applicable:
- Confidentiality forms by all participants for CCP
- Coordination with case managers of other programs
- Education and juvenile justice information - clients not old enough

Targeted Case Management Supervisor Checklist results show a 62% compliance rate with documentation standards when calculated on the 32 standards rated.

Areas of strength and satisfactory compliance with documentation standards:
a) Medical Necessity
b) Targeted Case Management Assessment
- Assessment is completed and entered into Avatar within 10 working days
- Medical, social, educational, emotional and other support services are addressed

c) Targeted Case Management CCP
- CCP developed at Child and Family Team meeting
- Child/family needs and care coordination are addressed through life domains
- CCP is reviewed and updated in Child and Family Team meetings
- CCP reflects planned action for addressing needs of the child/family
- CCP is individualized
- CCP goals are expressed in the words of the child/family
- Children, when developmentally appropriate are involved in developing the CCP
- Family/caregiver is involved in developing the CCP
- CCP goals/objectives address medical, social, educational, emotional, and other needs

d) Monitoring of Care Coordination - Progress Notes and Billing Codes
- Progress notes follow standardized format (DAP)
- Progress notes document the nature content and units of case management services received

e) Monitoring Care Coordination - 90 Day Review
- Whether the goals specified in the CCP have been achieved

- Explains updated/revised CCP goals /objectives
- Review includes updated assessment and medical necessity data

f) Discharge/Transition Summary

- Diagnosis at admission and discharge
- Reason for transition/discharge stated clearly
- Current level of functioning description and measurement
- Summary of effectiveness of services as documented in CCP

Areas for improvement toward compliance with documentation standards:

a) Targeted Case Management CCP

- Initial CCP is completed and signed within 30 days of admission
- Family/caregiver is involved in developing the CCP as evidenced by their signature
- CCP addresses specific services that include the amount, scope, duration, and names of service providers
- Anticipated aftercare/transition plan
- Crisis Plan

b) Monitoring Care Coordination - Progress Notes and Billing Codes

- Progress notes relate to CCP goals and objectives
- Progress notes are documented in Avatar within 72 hours of service

c) Monitoring of Care Coordination - 90 Day Review

- Addresses all CCP objectives/goals relevant to life domains of the child and family and report progress (or lack of) made

d) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Implementation steps toward transition/discharge are addressed
- Recommendations for further services and how child has been transitioned to these services

SNCAS WIN – Targeted Case Management Supervisor Checklist Results

Five WIN supervisors completed 64 Targeted Case Management Supervisor Checklists. SNCAS WIN Targeted Case Management Supervisor Checklist results show a 73% compliance rate with the documentation standards. Fourteen indicators are rated in the area of strength and sixteen indicators are rated as satisfactory.

Areas of strength and satisfactory compliance with documentation standards are:

a) Client Rights/Privacy

- Informed consent/client rights signed and dated
- HIPAA acknowledgement signed and dated
- Release of information completed

b) Medical Necessity

c) Targeted Case Management Assessment

- Strengths, Needs and Cultural Discovery
- Medical, social, educational, emotional and other needs are addressed

d) Targeted Case Management CCP

- Initial CCP completed and signed within 30 days of admission

- CCP is developed at Child and Family Team meeting
- Child/family's needs are addressed through life domains
- CCP is reviewed and updated in Child and Family Team meetings
- CCP reflects planned action to meet the needs of the child/family
- CCP goals are expressed in the words of the child and family
- Child is involved in developing the CCP
- Family/caregiver is involved in developing the CCP
- CCP goals/objectives and actions address medical, social, educational, emotional, and other needs
- Crisis Plan

e) Monitoring of Care Coordination - Progress Notes and Billing Codes

- Progress notes follow standardized format (DAP)
- Progress notes document the nature, content and units of case management services received
- Need for and occurrences of coordination with case managers of other programs

f) Monitoring of Care Coordination - 90 Day Review

- Whether goals in CCP have been achieved
- Review includes all objectives/goals of CCP that addresses all life domains and progress (or lack of)
- Review includes updated assessment and medical necessity data

g) Discharge/Transition Summary

- Discharge Summary completed within 30 days when planned
- Date of last service contact
- Reason for transition/discharge stated clearly
- Implementation steps towards transition/discharge addressed
- Current level of functioning description and measurement
- Summary of effectiveness of services; progress towards CCP goals or lack of
- Recommendations for further services and how the child has been transition to these services
- Education and juvenile justice information

Areas for improvement toward compliance with documentation standards:

a) Client Rights/Privacy

- Freedom of Choice Form signed and dated

b) Targeted Case Management Assessment

- Completed and entered into Avatar within 10 working days

c) Targeted Case Management CCP

- Confidentiality form signed by all participants and attached to CCP
- CCP is individualized
- CCP addresses specific services with amount, scope, duration, and names of service providers
- Anticipated aftercare/transition plan

d) Monitoring Care Coordination - Progress Notes and Billing Codes

- Progress notes relate to CCP goals and objectives and goals are attached to notes
- Progress notes are documented in Avatar within 72 hours of service

e) Monitoring of Care Coordination- 90 Day Review

- Review explains updated/revised CCP goals and objectives and the anticipated time of goal achievement
- Education and juvenile justice information

f) Discharge Summary

- Diagnosis at admission and discharge

Summary and Discussion

The purpose of the Supervisor File Review is to ensure that documentation in DCFS Children's Mental Health Services client files adheres to standards of care and documentation requirements. SNCAS supervisors participated in this project with 126 file reviews with 46 Direct Service Clinical Supervisor Checklists and 80 Targeted Case Management Supervisor Checklists. NNCAS supervisors submitted 77 file reviews with 47 Direct Services Clinical Supervisor Checklists and 30 Targeted Case Management Supervisor Checklists. Since file selection was not randomized, caution is necessary in the interpretation of the findings across programs.

Supervisor Checklist Administration Challenges

Some supervisors relied solely on electronic files to complete their file reviews while others reviewed the electronic and hard files.
Some indicators were not rated. In reviewing the notes on the comment section the following reasons were given:

Not all children served are Medicaid recipients
Not all children served are of school age
Not all children served require a rehab report
Early Childhood Mental Health Services does not require intensity of need determination to qualify for case management

Supervisors frequently expressed difficulty in trying to locate some of the checklist indicators in client files. They were confronted with old forms that were not updated and reports in draft form that could not be approved and signed by the QMHP.

It is recommended that the Supervisor Checklist administration process be standardized following the resolution of supervisors' concerns. Standardized administration of the tool would lead to more accurate, efficient and thorough assessment of client file documentation.

The Direct Service Delivery Clinical Supervisor Checklist indicators that require attention in documentation compliance with DCFS standards of care are as follows.

- Discharge Planning at Admission: Several supervisors provided their input on this documentation standard. Some recommended that while discharge planning at admission is a requirement of the initial assessment process, the CUMHA does not seem to provide space for this information. Therefore a request for the revision of CUMHA is made to include Discharge Planning at Admission.
- Other supervisors indicated that the treatment plan addresses Discharge Planning at Admission (see Direct Service Delivery Clinical Supervisor Checklist item #22).
-

It is recommended that supervisors address both the implementation and documentation of the Discharge Planning at Admission process consistent with DCFS standards.

- Timely documentation and signatures in Avatar: Across all programs there is concern with timely documentation and the required signatures needed on certain reports.

- Education Information and Juvenile Justice Involvement: These indicators, frequently missing in 90 day reviews and in discharge summaries, are relatively new fields in Avatar and may not be consistently utilized by practitioners. However, the most recent data clean up effort will undoubtedly have a positive impact on ensuring the documentation of this indicator.
- Rehab Service Provider 30 Day Progress report submitted to QMHP: This indicator was frequently not rated.

Although developing Treatment Plans, 90 Day Review Reports, and Discharge/Transition Summaries are regularly addressed in the course of service implementation, it is recommended that review of the policies on documentation standards may assist in resolving the challenges some practitioners' experience.

The Targeted Case Management Supervisor Checklist indicators that require attention in documentation compliance with DCFS standards of care are as follows.

- Medical Necessity**:** This indicator, addressed in CUMHA, may have created difficulty for supervisors when reviewing client files with assessments prior to CUMHA implementation.
- Targeted Case Management - Strengths and Needs Assessment: With high compliance in the WIN program, this indicator shows documentation compliance rating below the standard of care for the outpatient programs. Some program supervisors left this item blank. This may indicate that the assessment of the child/youth and their family strengths and needs are incorporated in other assessments rather than the customary assessment form the WIN program utilizes.
- Targeted Case Management CCP: This documentation standard has 12 indicators that need to be addressed in the CCP. Frequently CCP was missing in programs that had an overall rating below standard for documentation compliance.

Indicators that require close attention across programs toward higher compliance rate in the CCP are:

- Anticipated aftercare/transition plan
- Confidentiality Form signed and attached to Targeted Case Management CCP
- Crisis Plan
- Timely Documentation in Avatar

It is likely that some of the clients of Outpatient Services/Children's Clinical Services and Early Childhood Mental Health Services may simultaneously be receiving both direct and targeted case management services. Maintaining documentation standards of both services could be challenging for the practitioners unless collaboration on documentation expectations and periodic review of files is conducted to ensure accurate documentation in a timely manner. Case managers may also rely on the primary practitioners to complete certain document requirements (e.g. education/juvenile justice information) and may overlook the missing indicators.

It is recommended that when clients are simultaneously receiving both direct and targeted case management services, guidelines for documentation standards are highlighted for practitioners.

Both NNCAS and SNCAS WIN Targeted Case Management Supervisor Checklist results show a high rate of compliance with documentation standards. This may be due to WIN service delivery standards that are consistently observed in the implementation of wraparound principals that inherently guide the targeted case management process.

Finally, it would be essential for supervisors to provide feedback to the Planning and Evaluation Unit on their experience of the implementation of the checklists. Any improvement on the revision of the tools, to increase their utility and clarity, should not be considered without program supervisors input. Item analysis of both Direct Service Clinical Supervisor Checklist and Targeted Case Management Supervisor Checklist suggests that revisions based on supervisor recommendations may also reduce the difficulties in the location of certain documentation indicators in client files.

The Planning and Evaluation Unit extends its appreciation to all supervisors who participated in this project and thank them for making this investigation possible.

ATTACHMENT H

Wraparound Fidelity Index (WFI-4) Summary Report

June, 2010

WIN North and Rural Programs

Purpose of the Study

- The Wraparound Fidelity Index (WFI) assesses the degree of adherence to the principles and core activities of wraparound service delivery model.
- This study evaluated the adherence of the WIN program in Northern and Rural Nevada to the wraparound model using the WFI.

Methodology – Measurement

- The WFI-4 is an interview tool designed to solicit feedback about the services and supports received by parents/caregivers and youth.
- Youth (11 years and older) who are receiving wraparound, their parents/caregivers and their wraparound facilitators are asked to participate in the interview.
- If a youth is under age 11, only their parent/caregiver and wraparound facilitator are interviewed.
- The parent/caregiver and wraparound facilitator WFI has 40 questions.
- The youth WFI has 32 items with specific questions that ask about the youth's involvement in their wraparound process.
- The WFI is organized by the four phases of the wraparound process: Engagement, Planning, Implementation, and Transition.
- The WFI is administered by telephone or face-to-face interviews.
- The WFI rating system is yes = 2, sometimes/somewhat = 1, and no = 0.

Methodology – Procedure

- WFI interviews are conducted by trained staff members who demonstrate competency in the interview process prior to the administration of the tool. This training is necessary to master the interview process and establish reliability by rating six interview vignettes.

- Seven supervisors (5 WIN and 2 PEU) were trained in the administration of the WFI and completed the reliability test. WFI interviews began in December 2009 and concluded in March 2010.

Methodology – Subject Selection

- 80 youth were randomly selected (36 from Reno and 44 from Rural Region) from the active client list report in Avatar.

- Youth were selected who met the following criteria: 1) they had been receiving services for at least 90 days, and 2) their facilitator had at least 6 months experience with the wraparound model.

Methodology – Data Collection

- WFI interviews were collected and data were entered into a database maintained by the Wraparound Evaluation and Research Team.
- There were a total of 193 WFI interviews for 79 youth.
  - The number of facilitator interviews was 79.
  - The number of parent/caregiver interviews was 72.
  - The number of youth interviews was 42.

Methodology – Data Analysis

The findings of the WFI study are presented in several ways:

- Youth information and demographics
- Overall fidelity score
- WFI fidelity scores by facilitator, parent/caregiver, and youth
- WFI fidelity scores by phase
- WFI fidelity scores for WIN north and rural
- Identified areas of high fidelity and areas needing improvement

WFI scores are compared to the scores in the national database of the Wraparound Initiative (2004). This database provides national means and fidelity standards to assist WIN program staff and stakeholders in interpreting the results at their respective sites.

Results – Youth Information and Demographics

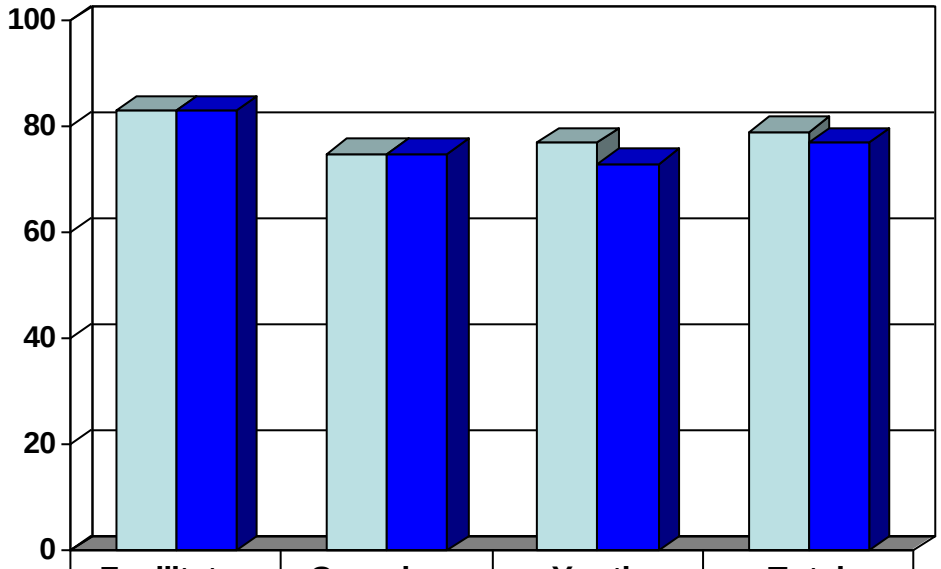
GENDER	Male	44 (55%)
	Female	35 (44%)
RACE	White/Caucasian	63 (79%)
	Black/African-American	2 (2%)
	American Indian/Alaskan Native	1 (1%)
	Mixed Race	13 (16%)
ETHNICITY	Hispanic origin	21 (26.6%)
AGE	Mean	12.7
ENROLLED IN SCHOOL (LAST 30 DAYS)		74 (93%)
CAREGIVER RELATIONSHIP TO YOUTH		
	Parent	16 (20%)
	Adoptive parent	3 (3%)
	Foster parent	44 (55%)
	Aunt or uncle	5 (6%)
	Grandparent	9 (11%)
	Other	2 (2%)

LEGAL CUSTODY		
	Ward of the state or county	60 (75%)
	Two parents	5 (6%)
	Birth mother only	2 (2%)
	Birth father only	2 (2%)
	Adoptive parent(s)	3 (3%)
	Aunt and/or uncle	3 (3%)
	Grandparent(s)	2 (2%)
	Other	2 (2%)
PLAN TO REUNITE WITH BIRTH PARENTS		26 (38%)
MONTHS IN WRAPAROUND	Mean:	13.7

Results – Percentage of Youth, Family, and Informal Supports in Child and Family Team

Youth	67 (84%)
Birth mother	39 (49%)
Birth father	15 (18%)
Adoptive parent	4 (5%)
Sibling	27 (34%)
Friend of parent/caregiver	7 (8%)
Friend of youth	4 (5%)
Grandparent	21 (26%)
Other family member	13 (16%)
Family support partner or advocate	14 (17%)

Results – Overall Fidelity



	Facilitator	Caregiver	Youth	Total
Yours	83	75	77	79
Nat'l. Mean	83	75	73	77

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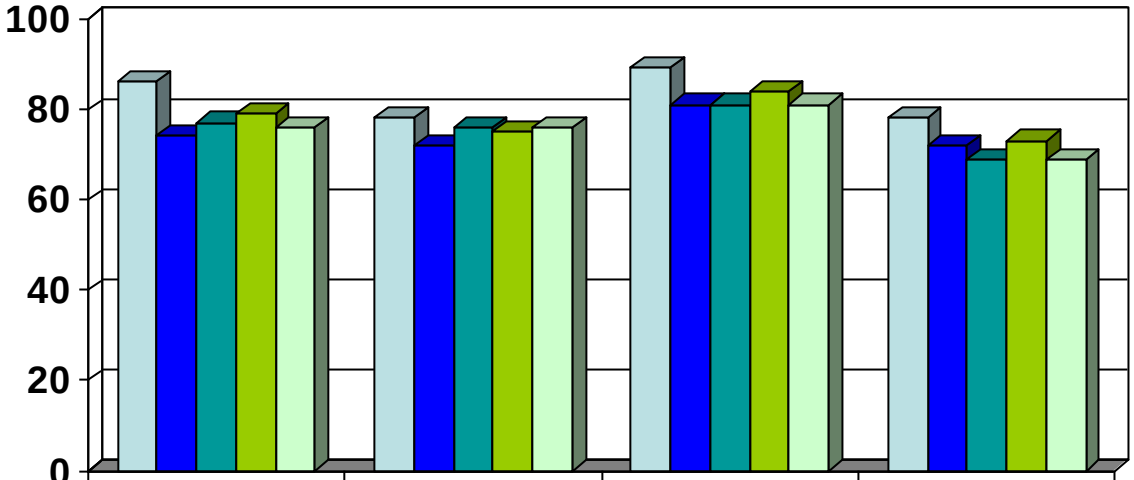
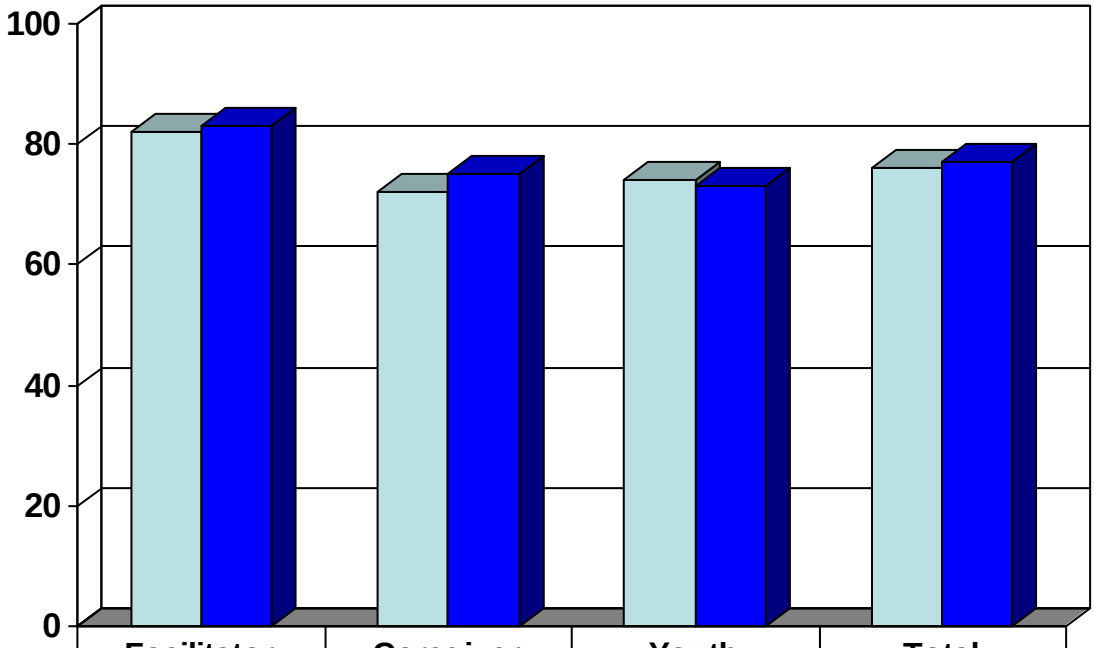
Results – Fidelity Scores by Phase and Group



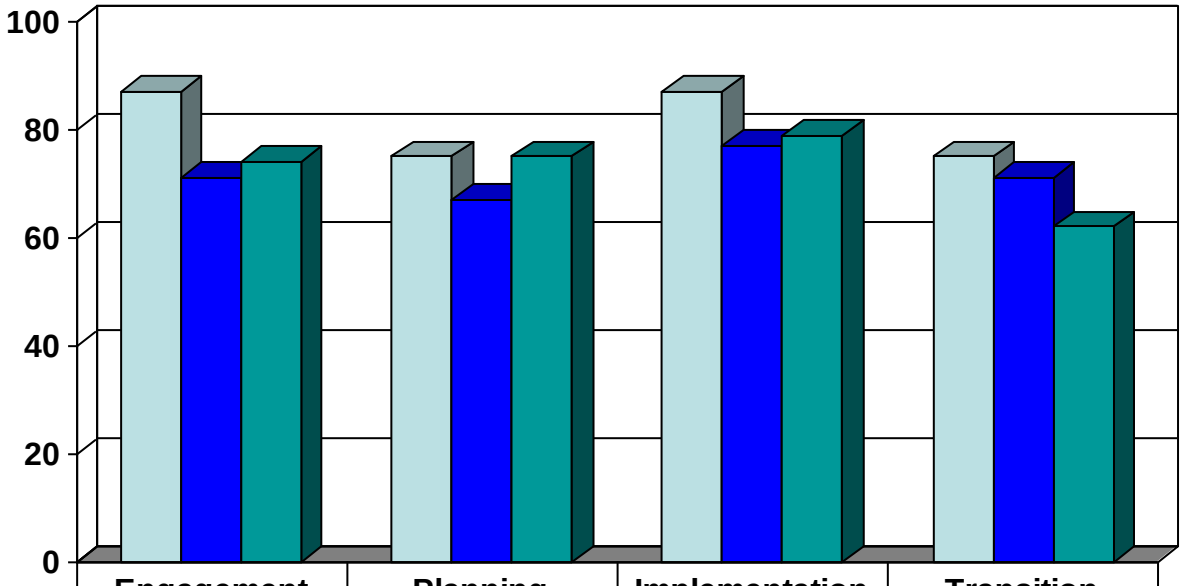
	Engagement	Planning	Implementation	Transition
Facilitator	86	78	89	78
Caregiver	74	72	81	72
Youth	77	76	81	69
Total	79	75	84	73
Nat'l. Mean	76	76	81	69

Results – Rural Overall Fidelity



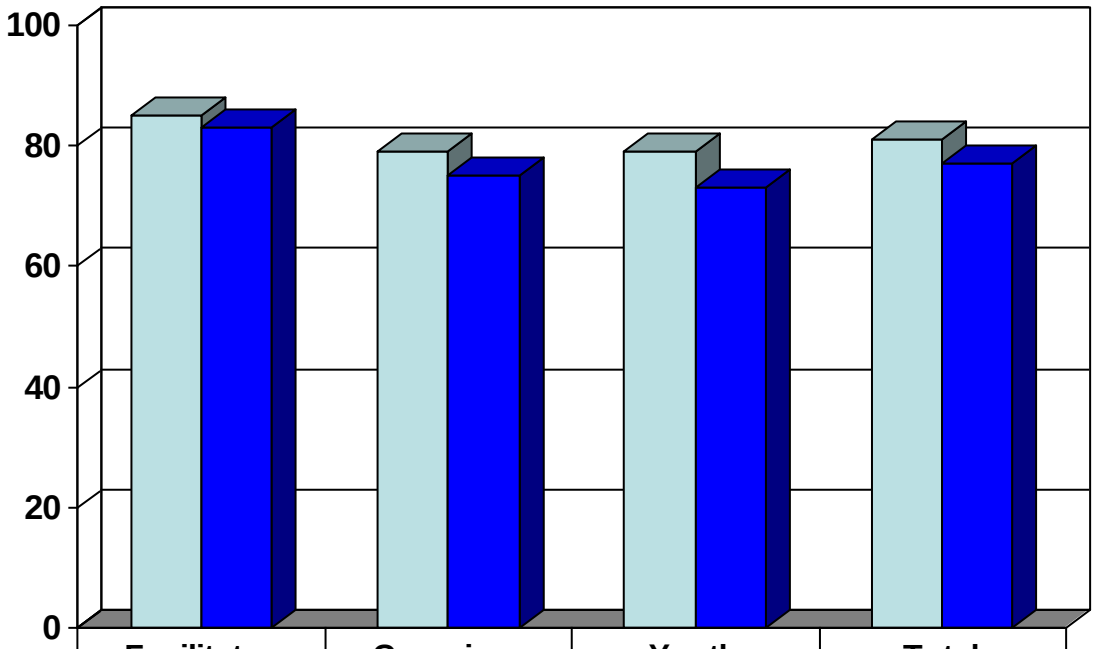
	Facilitator	Caregiver	Youth	Total
Rural	82	72	74	76
Nat'l. Mean	83	75	73	77

Results – Rural Fidelity Scores by Phase and Group



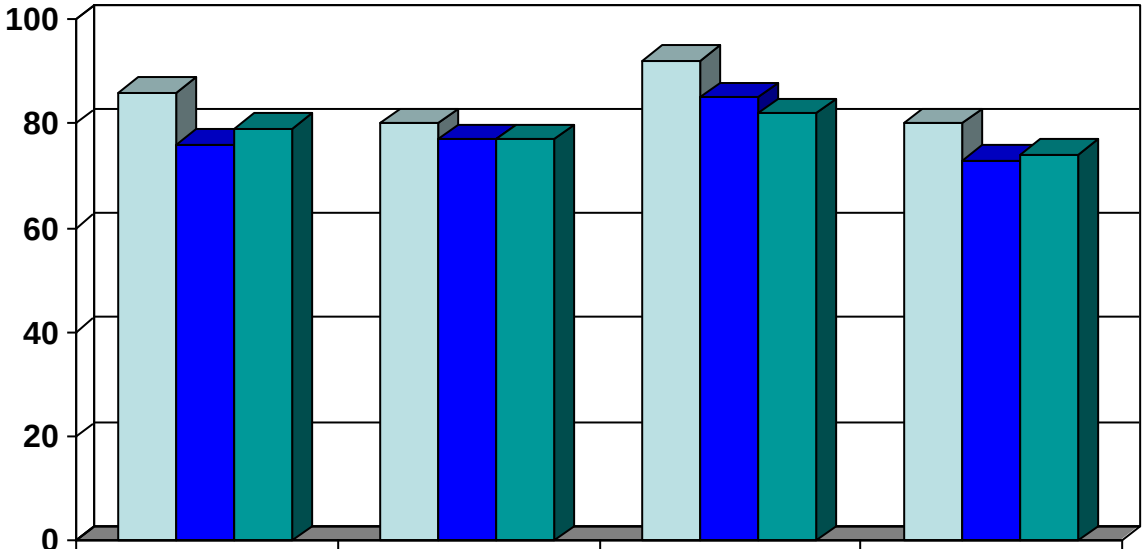
	Engagement	Planning	Implementation	Transition
Facilitator	87	75	87	75
Caregiver	71	67	77	71
Youth	74	75	79	62

Results – North Overall Fidelity



	Facilitator	Caregiver	Youth	Total
North	85	79	79	81
Nat'l. Mean	83	75	73	77

Results – North Fidelity Scores by Phase and Group



	Engagement	Planning	Implementation	Transition
Facilitator	86	80	92	80
Caregiver	76	77	85	73
Youth	79	77	82	74

WFI Items: Engagement Phase

Item	Facilitator N=79	Nat'l. Mean	Caregiver N=72	Nat'l. Mean
1.1 When you first met with the family, were they given ample time to talk about their strengths, beliefs & traditions? At the first team meeting, were these strengths, beliefs, and traditions shared with all team members?	1.85	1.88	1.71	1.65
1.2 Before the first team meeting, did you fully explain the wraparound (WA) process and the choices the family could make?	1.94	1.83	1.71	1.68
1.3 At the beginning of the WA process, was the family given an opportunity to tell you what things have worked in the past for the child and family?	1.75	1.86	1.68	1.75
1.4 Did the family members select the people who would be on their WA team?	1.65	1.49	0.72	0.86
1.5 Is it difficult to get team members to attend team meetings when they are needed?	1.59	1.37	1.61	1.57
1.6 Before the first WA team meeting, did you go through a process of identifying what leads to crises or dangerous situations for the child and family?	1.60	1.77	1.38	1.52

WFI Items: Planning Phase

Item	Facilitator N=79	Nat'l. Mean	Caregiver N=72	Nat'l. Mean
2.1 Did the family plan and its team create a written plan of care (or WA plan, child and family plan) that describes how the team will meet the child's and family's needs? Do they have a copy of the plan?	**2.00** *Strength*	1.81	1.88	1.64
2.2 Did the team develop any kind of written statement about what the future will look like for the child and family, or what the team will achieve for the child and family?	1.42	1.61	**1.19** *Improve-ment*	1.56
2.3 Can you summarize the services, supports, and strategies that are in the family's WA plan?	0.49	0.69	0.58	0.61
2.4 Are the supports and services in the WA plan connected to the strengths and abilities of the child and family?	1.92	1.89	1.79	1.74
2.5 Does the WA plan include strategies for helping the child get involved in her or his community?	1.25	1.53	1.23	1.24
2.6 Are there members of the WA team who do not have a role in implementing the plan?	1.87	1.71	1.76	1.67
2.7 Does the team brainstorm many strategies to address the family's needs before selecting one?	1.92	1.90	1.78	1.73
2.8 Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?	**1.08** *Improve -ment*	1.82	**1.02** *Improve -ment*	1.43
2.9 Do you feel confident that, in the event of a major crises, the team can keep the child or youth in the community?	1.82	1.62	1.69	1.50
2.10 Would you say that people other than the family have higher priority than the family in designing their WA plan?	1.47	1.58	1.36	1.53
2.11 During the planning process, did the team take enough time to understand the family's values and beliefs? Is the WA plan in tune with the family's values and beliefs?	1.81	1.88	1.57	1.73

WFI Items: Implementation Phase

Item	Facilitator N=79	Nat'l. Mean	Caregiver N=72	Nat'l. Mean
3.1 Are important decisions ever made about the child or family when they are not there?	1.77	1.73	1.53	1.64
3.2 When the WA team has a good idea for a support or services for the child, can it find the resources or figure out some way to make it happen?	1.84	1.81	1.85	1.70
3.3 Does the WA team get the child involved with activities she or he likes and does well?	1.47	1.50	1.04	1.20
3.4 Does the team find ways to increase the support the family gets from its friends and family members?	1.59	1.50	1.44	1.22
3.5 Do the members of the team hold each other responsible for doing their part of the WA plan?	1.95	1.86	1.78	1.70
3.6 Is there a friend or advocate of the child or family who actively participates on the WA team?	1.29	0.97	0.94	0.95
3.7 Does the team come up with new ideas for the WA plan whenever the family's needs change? Does the team come up with new ideas for the WA plan whenever something is not working?	**2.00** *Strength*	1.95	1.76	1.74
3.8 Are the services and supports in the WA plan difficult for the family to access?	1.75	1.63	1.61	1.54
3.9 Does the team assign specific tasks to all members at the end of each meeting? Does the team review each member's follow-through on their tasks at the next meeting?	1.86	1.80	1.80	1.59
3.10 Do members of the team always use language the family can understand?	1.95	1.93	1.86	1.93
3.11 Does the team create a positive atmosphere around successes and accomplishments at each team meeting?	**1.99** *Strength*	1.93	1.81	1.86
3.12 Does the team go out of its way to make sure all team members – including friends, family, and natural supports – present ideas and participate in decision making?	1.91	1.84	1.69	1.67
3.13 Do you think the WA process could be discontinued before the family is ready for it to end?	**1.86** *Strength*	1.50	1.64	1.35

WFI Items: Implementation Phase (cont.)

Item	Facilitator N=79	Nat'l. Mean	Caregiver N=72	Nat'l. Mean
3.14 Do all the members of the team demonstrate respect for the family?	1.85	1.90	1.79	1.88
3.15 Does the child or youth have the opportunity to communicate his or her own ideas when the time comes to make decisions?	1.77	1.86	1.77	1.71

WFI Items: Transition Phase

Item	Facilitator N=79	Nat'l. Mean	Caregiver N=72	Nat'l. Mean
4.1 Has the team discussed a plan for how the WA process will end? Does the team have a plan for when this will occur?	**0.61** *Improve-ment*	1.11	0.59	0.68
4.2 Has the WA process helped the child develop friendships with other youth who will have a positive influence on him or her?	1.58	1.34	1.24	1.20
4.3 Has the WA process helped the child solve her or his own problems?	1.56	1.52	1.41	1.30
4.4 Has the team helped the child or youth prepare for major transitions by making plans to deal with these changes?	1.81	1.74	1.57	1.35
4.5 After formal WA has ended, do you think that the process will be able to be "restarted" if the youth or family needs it?	1.81	1.75	1.75	1.61
4.6 Has the WA process helped the family develop or strengthen relationships that will support them when WA is finished?	1.78	1.65	1.71	1.49
4.7 Do you feel like the child and family will be able to succeed without the formal WA process?	1.37	1.31	1.56	1.22
4.8 Will some members of the team be there to support the family when formal WA is finished?	1.92	1.68	1.70	1.65

WFI Items: Engagement Phase

Item	Youth N=42	Nat'l. Mean
1.1 When you first met your WA facilitator, were you given time to talk about things you are good at and things you like to do?	1.95	1.84
1.2 Before your first team meeting, did your WA facilitator fully explain how the WA process would work?	1.74	1.68
1.3 At the beginning of the WA process, did you have a chance to tell your WA facilitator what things have worked in the past to help you and family?	1.74	1.52
1.4 Did you help pick the people who would be on your WA team?	**1.12** *Strength*	0.66
1.5 Do you have a friend or advocate who participates actively on your WA team?	1.14	0.99
1.6 Would you have different people on your team if you could?	1.50	1.20

WFI Items: Planning Phase

Item	Youth N=42	Nat'l. Mean
2.1 Did you help create a written plan that describes how the team will meet your family's needs? Do you have a copy of the plan?	**1.67** *Strength*	1.22
2.2 During meetings, does your team brainstorm many ideas to meet your needs before picking one?	1.86	1.74
2.3 Does the team know what you like and the things that you do well?	1.86	1.80
2.4 Does your WA plan include things that get you involved with activities in your community?	1.40	1.21
2.5 When your team was making its plan, did you and your family have many chances to talk about what you like and what you believe in?	1.79	1.59
2.6 Does your WA plan include mostly professional services?	0.82	0.74
2.7 If things go wrong or there is a crisis, is there a plan that says what everyone must do?	1.08	1.37
2.8 Do you and your family get the help that you need?	1.71	1.75

WFI Items: Implementation Phase

Item	Youth N=42	Nat'l. Mean
3.1 Are important decisions made about you or your family when you are not there?	1.24	1.19
3.2 When your WA team has a good idea, can it figure out some way to make it happen?	1.81	1.73
3.3 Does your WA team get you involved with activities you like and do well?	1.07	1.20
3.4 Do people on the team help you do things with your friends and family?	1.64	1.47
3.5 When things are not going right, does the team help you talk with friends and other people you like to talk to?	1.50	1.49
3.6 Does your team come up with new ideas for your WA plan whenever something is not working?	1.74	1.77
3.7 Are the places you go to for services hard to reach because they are far away?	1.40	1.55
3.8 Do members of your team always use language you can understand?	1.69	1.77
3.9 Do your WA team meetings make you feel good about your successes and accomplishments?	1.81	1.70
3.10 Does everyone on your team talk and give their ideas during your WA team meeting?	1.81	1.90
3.11 Do you think you could get "kicked out" of WA before you or your family is ready for it to end?	1.64	1.49
3.12 Do all the members of your team show respect for you and your family?	1.76	1.87
3.13 Do you have a chance to give your ideas during the WA team meetings?	1.95	1.77

WFI Items: Transition Phase

Item	Youth N=42	Nat'l. Mean
4.1 Has your team discussed a plan for how the WA process will end? Does your team have a plan for when this will occur?	0.57	0.66
4.2 Has the WA process helped you and your family to develop relationships with people who will support you when WA is finished?	1.67	1.46
4.3 Has the WA process helped you become friends with other youth in the community?	1.31	1.25
4.4 Has your team helped you prepare for major changes?	1.60	1.53
4.5 Will people on your team be there to help you when WA is finished?	1.71	1.72

ATTACHMENT I

Seclusion and Restraint Emergency Procedures for Children and Youth
Denial of Rights

This report summarizes seclusion and restraint emergency procedures information for DCFS residential programs and private facilities from 451 Denial of Rights forms. Data are taken from forms submitted from August 2009 to September 2010.

Results

The following is the number of denial of rights reports by facility.

Public Facilities	Number of Reports	Private Facilities	Number of Reports
Adolescent Treatment Center	1 (.2%)	Monte Vista Hospital	46 (10.2%)
DWTC Adolescent Acute	12 (2.7%)	Spring Mountain Treatment Center	87 (19.3%)
DWTC RTC 1	23 (5.1%)	West Hills Hospital	6 (1.3%)
DWTC RTC 2	29 (6.4%)	Willow Springs Treatment Center	176 (39%)
DWTC SATP	1 (.2%)		
Family Learning Home 1	2 (.4%)		
Oasis West 11	8 (1.8%)		
Oasis East 12	10 (2.2%)		
Oasis West 12	26 (5.8%)		
Oasis 13	16 (3.5%)		
Oasis 14	8 (1.8%)		
Total	**136 (30%)**		**315 (70%)**

Demographic Information
Average age: 11.9 ranging from age 6 to 17
Average height: 60 inches ranging from 42 to 89
Average weight: 113.9 pounds ranging from 37 to 282

Gender	
Male	335 (74.3%)
Female	110 (24.4%)
Missing	6 (1.3%)

Race	
American Indian/Alaskan Native	8 (1.8%)
Black/African American	178 (39.5%)
Asian	1 (.2%)
White/Caucasian	216 (47.9%)
Other	32 (7.1%)
Missing	16 (3.5%)

Ethnicity	
Hispanic Origin	50 (11.1%)

Custody Status	
Parent/Family	316 (70.1%)
Child Welfare	108 (23.9%)
DCFS Youth Parole	7 (1.6%)
Missing	20 (4.4%)

Children and Adolescents ages 9-17	Number Reported	Children under age 9	Number Reported
Restrained for up to 2 hours	152 (33.7%)	Restrained for up to 1 hour	50 (11.1%)
Secluded for up to 2 hours	51 (11.3%)	Secluded for up to 1 hour	18 (4.0%)
Secluded and Restrained for up to 2 hours	114 (25.3%)	Secluded and Restrained for up to 1 hour	11 (2.4%)
Total	317 (70.3%)	**Total**	79 (17.5%)

Was the seclusion or restraint discussed with the physician? Yes = 360 (79.8%)

Was the seclusion: Locked = 194 (43%)
Unlocked = 44 (9.8%)

Average total time in seclusion: 39.36 minutes ranging from 1 to 130.

What type of mechanical restraint was used?

Type of Restraint	Number of Reports
Cuff/Belt	0
Legs	0
Wrists	2
4-Point	4
5-Point	5
Mitts	0
Geri Chair	0
Mechanical Other	1
Total	12

Average total time in mechanical restraint: 35.55 minutes ranging from 5 to 55.

What type of physical restraint was used?

Type of Physical Restraint	Number of Reports
Escort	179
Standing	65
Seated	17
Supine	7
Prone	102
Other Hold Implemented	108
Total	478

Respondents described several restraint models such as Conflict Prevention and Response Training (CPART or CPAR), Crisis Prevention Institute (CPI), and David Mandt System (Mandt). Sometimes the number of persons involved in the hold was described (e.g., 2 person, 3 person or 4 person). The position of the hold was also frequently described (e.g., patient control position, team control position, or prone position).

Average total time in a physical restraint: 7.64 minutes ranging from 1 to 56

What are the behavioral descriptors of events?

Behaviors	Number of Events
Bites	48
Cuts	12
Hits	189
Imminent harm to others	325
Imminent harm to self	176
Kicks	213
Physical fighting	147
Punches	167
Pushes	154
Scratches	52
Spits	39
Threatening gestures	233
Throwing objects at another	108

Was the patient medically compromised? Yes = 30 (6.7%)

What type of medical problem does the patient have?

Medical Problems	Number of Problems
Known History of Cardiac or Respiratory Disease	11
Morbid Obesity	7
Seizure Precautions	1
Pregnancy	0
Recent Vomiting	0
Spinal Injury	0
Other*	15

*Other included asthma, history of heart murmur, deaf, detached retina, legally blind, leucopenia, lymphocytosis, possible sexual abuse, possible sleep apnea, recent bilateral great toenail procedure, severely underweight

Was there injury to the patient during the procedure? Yes = 55 (12.2%)

What was the staff intervention prior to the restraint or seclusion of the patient?

Type of Intervention	Number of Interventions
Ventilation of feelings	290 (64.3%)
Verbal reassurance	251 (55.7%)
Verbal redirection	398 (88.2%)
Timeout	276 (61.2%)
Environmental change	211 (46.8%)
Praise/empathy statement	109 (24.2%)

1:1 Interaction with staff	351 (77.8%)
Coupling statements	69 (15.3%)
Limit setting	327 (72.5%)
Rationale/reality statements	159 (35.3%)
Reduction in stimuli	203 (35.3%)

Did the patient have a Personal Safety Plan? Yes = 394 (87.4%)

Was the plan followed? Yes = 346 (76.7%)

Was there a debriefing? Yes = 439 (97.3%)

Was the parent/guardian/custodian notified? Yes = 435 (96.5%)

Behavior Management Team Review:

Was the seclusion and restraint intervention necessary? Yes = 259 (57.4%)

Did the intervention have the appropriate documentation? Yes = 166 (36.8%)

Was the seclusion and restraint intervention justified? Yes = 161 (35.7%)

Discussion

Limitations

The information summarized in this report must be viewed with caution for the following reasons:

- Private providers submit this information voluntarily. There is no assurance that we receive all Seclusion and Restraint forms completed by private facilities.

- Seclusion and Restraint forms are not received on a scheduled timeframe. For example, all forms for April 2010 may not have been received in order to be entered into the database. Therefore, only a portion of the April 2010 Seclusion and Restraint forms may be represented in the sample.

- Seclusion and Restraint forms provide a count of incidents of seclusion and restraint. One youth can have multiple incidents.

- There is consistently a lot of missing information on Seclusion and Restraint forms. Information on forms is often inaccurate.

Recommendations

To decrease the number of inaccuracies, the form would need to be designed to better capture the experiences of using seclusions and restraints. The form could also be designed to help reduce user error.

To make the results more meaningful, DCFS will attempt to verify the number of Seclusion and Restraint forms submitted by using seclusion and restraint counts obtained from each program and facility. For example, the number of seclusions and restraints DWTC conducted in April 2010 is compared with the count of seclusions and restraints that are in the database for April 2010. Once the count of seclusions and restraints is verified, then we can begin tracking month-to-month changes to monitor trends.