MEDICAID REPORT 2012
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2011 SUMMARY

INTRODUCTION

DCFS Children's Mental Health Services (CMHS) is a Behavioral Health Community Network (BHCN) provider under Nevada Medicaid. As a BHCN under Nevada Medicaid, DCFS must adhere to all applicable requirements under the Medicaid Services Manual. Nevada Medicaid requires BHCNs to have a structured, internal monitoring and evaluation process designed to improve quality of care (MSM 403.2B6.g.). This report describes the major quality assurance activities of 2011 for DCFS CMHS. It also includes the Performance and Quality Improvement Plan for 2012-13 (Attachment A).

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 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 and Employee 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. This domain also includes employee satisfaction in the workplace and employee feedback in strategic planning.

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 3033 children served by the DCFS Children's Mental Health Services in Fiscal Year 2011 (July 1, 2010 through June 30, 2011). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 3033 children served by DCFS programs, 2266 (74.7%) received services in Clark County and 767 (25.3%) were served in Washoe County/Rural.

Community based programs (outpatient, early childhood services and wraparound services) served 85.2% of the clients statewide. The remaining 14.8% were served in residential and inpatient treatment settings.

Of all children served, 57.2% were 12 years of age or younger and 57.5% were male. Caucasian children accounted for 72.6% of all those served and African-American children 22.7%. Children of Hispanic origin came to 26.8%.

In FY11, 53.3% of the children admitted to mental health services statewide were in the custody of their parent or family, 44.4% were in Child Welfare custody, 1.8% were in the custody of their parent or family and on probation, and 0.6% were in Youth Parole custody.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY11. (Attachment B)

Consumer and Employee 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]

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 2011. 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 449 parents/caregivers and 230 youth receiving services. Spring survey results indicated a statewide average 90% parent/caregiver positive rating and an 84% 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 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 2011 report. (Attachment C).

Residential and Psychiatric Inpatient Services

DCFS residential programs, Desert Willow Treatment Center (DWTC), the Oasis On-Campus Treatment Homes (Oasis), the Adolescent Treatment Center (ATC), and Family Learning Homes (FLH) agreed to collect consumer service evaluations at time of client discharge from facilities. DCFS/PEU disseminated discharge survey instruments to DCFS residential programs. Beginning July 1, 2011 residential programs initiated the collection of parent/caregiver and youth consumer surveys at discharge. Consumer surveys will be analyzed and a report generated at the end of FY12.

Employee Satisfaction Survey

In late 2011, an employee satisfaction survey was conducted to obtain staff feedback for use in developing a strategic plan for children's mental health services. The survey instrument included domains of communication, support/resources, and overall job satisfaction that were rated on a 1 to 5 Likert scale. There were eight open-ended questions focusing on work environment values, communication expectations, barriers to success, and needed improvements. A total of 105 employees completed the survey. Survey results were used in the plan for improving children's mental health services and to increase staff morale. To assess the impact of the plan implementation, staff will be surveyed again.

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, incidents of safety holds including circumstances and outcomes, and child on child physical and/or sexual incidents. Risk measure data can serve to indicate treatment population trends and might suggest program areas in need of improvement.

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 ATC, and NNCAS FLH 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. Lessons 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 Supervisor Checklist workgroup made up of supervisors was charged with updating the Supervisor Checklist instruments. Workgroup representatives presented revised direct services and targeted case management checklists along with a business process to the Management Team. It was agreed to integrate specific items into Avatar, the DCFS Children's Mental Health management information system that would produce a supervisor checklist report. Items that are qualitative in nature will be reviewed by the supervisor. During one quarter of the fiscal year, DCFS/PEU will collect Supervisor Checklists and produce a report for clinical staff.

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 2011, DWTC served 203 children in its acute care programs and 117 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. 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 are reviewed quarterly. 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.

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 Southern 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 300 WFI interviews for 142 youth. There were 142 facilitator interviews, 103 parent/caregiver interviews and 55 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 Southern Region met wraparound national standards. A summary of the Southern WIN study can be found in the appended

Wraparound Fidelity Index (WFI-4) Summary Report September 2011 WIN South Program (Attachment G).

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 WIN 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 model 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 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 - Report to the Commission on Mental Health and Developmental Services, September 15, 2011 (Attachment H).

Additional Program Evaluation Unit Activities

Substance Abuse and Mental Health Services Administration: Mental Health Block Grant
[Plan Domain(s): I - IV]

The State of Nevada has been a long time participant in the Mental Health Services Block Grant (MHSBG) provided through the federal Substance Abuse and Mental Health Services Administration (SAMHSA). 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 represents children's mental health services in this grant.

MHSBG participation requires state accountability for funds expended and outcomes achieved. The MHSBG 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 requires that states use a 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 MHSBG by capturing, collating, analyzing and formatting and reporting children's mental health program data.

Beginning in 2011, State's are also required to report on the Mental Health National Outcome Measures (NOMS) using client-level data. Demographic, clinical, and outcomes of persons served within a 12-month period must be submitted. The first step in the process is the development of a State data crosswalk that matches State data with the National crosswalk. This is to ensure that data across all states can be combined and analyzed. Nevada successfully submitted complete client-level data sets.

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.

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. Select ECMHS staff statewide are trained as trainers to the Early Childhood Service Intensity Instrument (ECSII) and all ECMHS staff receive training on this new instrument which is the companion to the CASII for young children.

Ongoing Reports

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 2012 DCFS Performance and Quality Improvement 2011 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:

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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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Nabil Jouni, M.D. Medical Director, Southern Nevada Child and Adolescent Services, DCFS	Date
_____	_____
Darryl McClintock, M.D. Medical Director, Northern Nevada Child and Adolescent Services, DCFS	Date
_____	_____
Amber Howell, Acting Administrator Division of Child and Family Services	Date

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ATTACHMENT INDEX

ATTACHMENT A

PURPOSE

DCFS Children's Mental Health Services (CMHS) Performance and Quality Improvement Plan (PQI PLAN) is based upon a framework that focuses on developing and implementing an integrated and coordinated approach to monitoring and improving children and adolescent behavioral and mental health care. The plan is modeled after a Council of Accreditation description of what constitutes a sound PQI plan:

> A PQI plan describes how valid, reliable data will be obtained and used on a regular basis, locally and centrally, to advance monitoring of actual versus desired a) functioning of operations that influence the agency's capacity to deliver services; b) quality of service delivery; c) program results; d) client satisfaction; and e) client outcomes.
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> [Council of Accreditation. Performance and Quality Improvement, p 7. Council on ACC Standards: Public Agencies. Eighth Edition. 2006.]

The Council on Accreditation (COA) is an internationally recognized not-for-profit child and family-service and behavioral healthcare accrediting organization. COA partners with human service organizations worldwide in working to improve service delivery outcomes for the people those organizations serve. The Division of Child and Family Services CMHS has drawn upon both the content and the spirit of COA in formulating its own PQI Plan.

CMHS performance and quality improvement activities are conducted in accordance with the PQI PLAN. The CMHS PQI PLAN describes functions occurring in one or more of the plan's four primary activity areas:

SERVICE COMPLIANCE	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.
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.
SERVICE EFFICIENCY	Focus is on CMHS operational and functional efficiency as it relates to client services accessibility, availability and responsiveness.
SERVICE QUALITY	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.

Employee feedback is another component of service quality that focuses on employee satisfaction, and systemic issues such as communication in the work place, adequate resources, staff support, and training.

PLAN FUNCTIONAL DETAILS

SERVICE COMPLIANCE

PLAN GOAL	PLAN OBJECTIVE	PLAN ACTIVITIES
SC 1. Provide assistance to CMHS administrative support of internal CMHS programs and select external stakeholder groups	**SC 1.1** At Administration request provide logistic support, data reporting and other quality assurance assistance to the Nevada Commission on Mental Health and Developmental Services (Commission)	**SC 1.1.1** As directed, coordinate Commission meeting dates, materials completion and dissemination; ensure public meeting laws are complied with; facilitate member stipends and travel reimbursements in a timely manner **SC 1.1.2** Compile, analyze and report to Commission data collected regarding CMHS Seclusion and Restraint Denial of Rights. Develop strategies to decrease the use of seclusion and restraint in facilities.
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SC 1 (Cont'd)	**SC 1.2** Provide support to the Division's administrators (i.e., Administrator, Deputy Administrator, program managers and supervisors) with PQI initiatives, reports, data, and other requests.	SC 1.2.1 **Work together with the Statewide Children's Mental Health Managers to develop and implement a plan for quality assurance, quality improvement and program evaluation.** SC 1.2.2 **Work together with identified program area personnel in designing performance and quality improvement (PQI) monitoring strategies, procedures, result sharing and reporting to include the Deputy Administrator.** SC 1.2.3 **Work together with identified program area personnel in designing PQI processes for addressing selected areas found in need of remediation.** SC 1.2.4 **Work with identified program area personnel in developing agreed upon plan for**

		re-assessment of remediated areas. SC 1.2.5 **Be available to the Deputy Administrator to respond to Legislative requests for data** **SC 1.2.6** Develop annual quality assurance plans to report to Medicaid.
SC 2. CMHS programs will be in compliance with applicable federal, state and Division policy, regulation and standards of care.	**SC 2.1** Review and update/revise program policies on service delivery for compliance with standards of care	**SC 2.1.1** Program policy review and update occurs as a standard component of the CMHS Program Managers administrative group. A list of needed policies and policies requiring revision will be developed and prioritized. The PEU will gate keep the list of needed and completed policies.
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SC 3. Ensure that clients are informed of their rights and responsibilities at the onset of service contact including the right to file grievance or complaint and the right to receive a timely response toward resolution of the complaints.	**SC 3.1** Complaint/Grievance reports are reviewed and the nature of grievances summarized.	**SC 3.1.1** Programs will follow established procedures in forwarding Complaint/Grievance report information to PEU for data capture **SC 3.1.2** In accordance with Consumer Complaint Policy and Procedures, PEU develops and maintains a database for Complaint/Grievance report data **SC 3.1.3** A report summarizing Complaint/Grievance particulars will be compiled, composed and disseminated annually by PEU
SC 4. Ensure that the services to children and their families are provided in healthy and safe environments.	**SC 4.1** DCFS services are provided in locations where health and safety of the occupants is monitored by the members of the Safety and Security Committee.	**SC 4.1.1** Safety and Security Committee in each site is responsible for informing/alerting staff and clients of any safety concerns and emergency situation by telephone/e-mails so that the safety and security of the occupants are ensured. **SC 4.1.2** Physical and environmental safety concerns are reported and tracked by facility Supervisors who provide ongoing inspection of the physical plants and conduct all the necessary drills and provide competency based training for health and safety practices.

PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SC 5 DCFS CMHS meet or exceed accepted standards of practice documentation	**SC 5.1** CMHS program supervisors will stress standards of practice case documentation by using the Supervisor Checklist when supervising direct service staff	**SC 5.1.1** The Supervisor Checklist Workgroup revised the direct services and targeted case management Supervisor Checklists and developed a business process for using the checklists. **SC 5.1.2** Dichotomous checklist items will be integrated into the Avatar management information system for ease of use. Qualitative items will be reviewed by supervisors.
SC 6. Targeted case management services will adhere to wraparound process principles	**SC 6.1** Evaluate wraparound service delivery model fidelity using the Wraparound Fidelity Index (WFI) evaluation instrument	**SC 6.1.1 1.** The PEU will partner with program managers and supervisors to plan for WFI implementation. **SC 6.1.1.2** Interview service youth, parent/caregivers and Wraparound facilitators by utilizing the WFI. **SC 6.1.1.3** Analysis of data for feedback on strengths and areas needing improvement in order to increase adherence to the service delivery model. **SC 6.1.1.4** Develop a report with recommendations.
SC 7. DCFS CMHS will address client and family needs and preferences as an important component of a client and family centered treatment plan	**SC 7.1** Clients and families will have active roles in determining their initial treatment goals **SC 7.2** Clients and families will have active roles in their on-going treatment process	**SC 7.1.1** Document parent/caregiver participation in development of the client and family centered Treatment Plan **SC 7.2.1** Document parent/caregiver participation in service coordination at Child and Family Team meetings
SC 8. Provide DCFS CMHS staff with direct supervision at least monthly	**SC 8.1** Supervisors will meet with each staff member at least monthly for supervision	**SC 8.1.1** Supervisors will: review performance expectations; evaluate the status of work projects and/or clinical case loads; provide feedback to the employee regarding their performance; and, create employee developmental goals. **SC 8.1.2** Supervision meetings will be documented

SERVICE EFFECTIVENESS

PLAN GOAL	PLAN OBJECTIVE	PLAN ACTIVITIES
SE 1. Provide support to the Division's administration through	**SE 1.1** Provide annual descriptive summary for all children served in	**SE 1.1.1** Identify data elements **SE 1.1.2** Compile report elements

PQI initiatives, reports, data and other requests	preceding SFY	**SE 1.1.3** Produce summary report **SE 1.1.4** Disseminate report to CMHS managers, other stakeholders as requested
SE 2. Support Wraparound Washoe Expansion (WWE)	**SE 2.1** Develop, implement and evaluate WWE	**SE 2.1.1** Identify WWE processes and outcomes **SE 2.1.2** Develop WWE evaluation protocol **SE 2.1.3** Develop WWE data capture capability **SE 2.1.4** Develop/maintain WWE database **SE 2.1.5** Produce scheduled and ad hoc WWE reporting as required
SE 3. Support DCFS treatment home efforts toward achieving effective outcomes	**SE 3.1** Conduct DCFS treatment home outcome reviews	**SE 3.1.1** Develop and promulgate standard set of program outcome indicators **SE 3.1.2** Develop standard set tool for capturing review data **SE 3.1.3** Schedule and conduct provider reviews **SE 3.1.4** Compile and assess review data results **SE 3.1.5** The PEU will develop a tool to review the implementation of the Policy on Medication Administration and Management with DCFS treatment homes. **SE 3.1.6** Draft and report review results
SE 4. Provide performance measure data as required for the DCFS budget process	**SE 4.1** Establish an efficient method of regularly reporting on required performance measures	**SE 4.1.1** Develop a protocol for reporting on performance measure data **SE 4.1.2** Establish timelines for downloading data from Avatar, data analysis, and producing a report

SERVICE EFFICIENCY

PLAN GOAL	PLAN OBJECTIVE	PLAN ACTIVITIES
SEF 1. Provide and maintain a DCFS CMHS planning and evaluation capacity via the Planning and Evaluation Unit (PEU)	**SEF 1.1** Develop/maintain a PEU annual work plan that addresses, supports the PQI PLAN	**SEF 1.1.1** Draft a PEU annual work plan for each SFY **SEF 1.1.2** Track/modify the PEU annual work plan during regular PEU meetings
SEF 2. Provide an information	**SEF 2.1** Ensure that the Avatar	**SEF 2.1.1** Track and report on

system that accurately captures, maintains and reports client clinical, financial, demographic and other service related information	database contains accurate, complete and timely information	client cases open>= 6 months and >= 90 days with no activity **SEF 2.1.2** Establish a data clean-up committee and related data clean-up process
SEF 3. Support on-going CMHS staff professional competency and development	**SEF 3.1** DCFS practitioners will be proficient when using CMHS standardized assessment tools	**SEF 3.1.1** CMHS direct service staff are trained in all standardized assessment tools used by CMHS
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SEF 4. Monitor adequacy of major or systemic factors affecting DCFS capacity to deliver quality CMHS services	**SEF 4.1** Desert Willow Treatment Center (DWTC) will maintain its Joint Commission certification	**SEF 4.1.1** DWTC will abide by all Joint Commission regulations and requirements in the conduct of its day to day operations **SEF 4.1.2** DWTC will prepare for and successfully pass its annual Joint Commission recertification assessment
SEF 5 Recommend actions that serve to improve standards of care, enhance service delivery and improve service outcomes	**SEF 5.1** Conduct quality assurance activities in collaboration with CMHS Program Supervisors **SEF 5.2** CMHS supervisors will work with direct service staff to support and enhance service productivity	**SEF 5.1.1** Periodically coordinate with supervisors a time period during which they submit their Supervisor Checklists to PEU **SEF 5.1.2** Enter checklist data into supervisor checklist database **SEF 5.1.3** Perform comparative / other data analysis **SEF 5.1.4** Report results to supervisors **SEF 5.2.1** Supervisors use available Avatar reports for collaborating with staff on ways to maintain/enhance their levels of service
SEF 6 New clients applying to CMHS will receive those services in a timely manner	**SEF 6.1** Programs will maintain wait lists that track the date of new client intake/referral contact and the first face to face contact with practitioner	**SEF 6.1.1** Program wait lists will be kept current and reported regularly to the State Mental Health Commission **SEF 6.1.2** Program wait lists will be available for budget planning purposes
SEF 7 Ensure that treatment interventions reflect treatment plans that are fluid, flexible and appropriate to the needs of the individual child	**SEF 7.1** Review active cases open for more that 24 months to ensure that case documentation is complete and indicates movement	**SEF 7.1.1** Download for review Avatar report for cases open longer than 24 months **SEF 7.1.2** Group report data into 2-3 years, 4-5 years, and 6 years or more **SEF 7.1.3** Provide a detailed monthly report to CMHS managers on each child and his/her

		practitioner for each group by program area
SEF 8 Client and family needs and expectations will be addressed during the course of service	**SEF 8.1** Client and family needs and expectations are to be addressed during treatment plan development **SEF 8.2** Client and family needs and expectations are addressed throughout treatment plan implementation	**SEF 8.1.1** Client needs and expectations are to be solicited during the CFT, included during treatment plan development and documented in CFT meeting notes **SEF 8.2.1** Client needs and expectations are addressed periodically and as they change and will be documented at 90 day reviews

SERVICE QUALITY

PLAN GOAL	PLAN OBJECTIVE	PLAN ACTIVITIES
SQ 1 CMHS clients and their families will have opportunity to provide feedback regarding the quality of services they've received	**SQ 1.1** CMHS will conduct annual client satisfaction surveys for its community based mental health services	**SQ 1.1.1** Implement survey in accordance with protocol **SQ 1.1.2** Collect, compile and analyze survey data results **SQ 1.1.3** Make results available to all service providers, program managers, stakeholders and service recipients **SQ 1.1.4** Incorporate survey results as required for federal block grant reporting
	SQ 1.2 CMHS will conduct client satisfaction surveys at discharge for its psychiatric inpatient and residential treatment mental health services	**SQ 1.2.1** Implement survey in accordance with protocol **SQ 1.2.2** Collect, compile and analyze survey data results **SQ 1.2.3** Make results available to all service providers, program managers, stakeholders and service recipients. **SQ 1.2.4** Incorporate survey results as required for federal block grant reporting
SQ 2 CMHS Staff will provide feedback regarding their employment experience and the impact service delivery has on client outcomes	**SQ 2.1.** Staff Satisfaction Survey will provide an opportunity to gather feedback from the service providers' perspective on what works and what does not work in service delivery.	**SQ 2.1.1** CMHS conducts annual staff satisfaction survey to obtain feedback regarding workplace strengths and challenges.

ATTACHMENT B

Division of Child and Family Services

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2011

CONTENTS

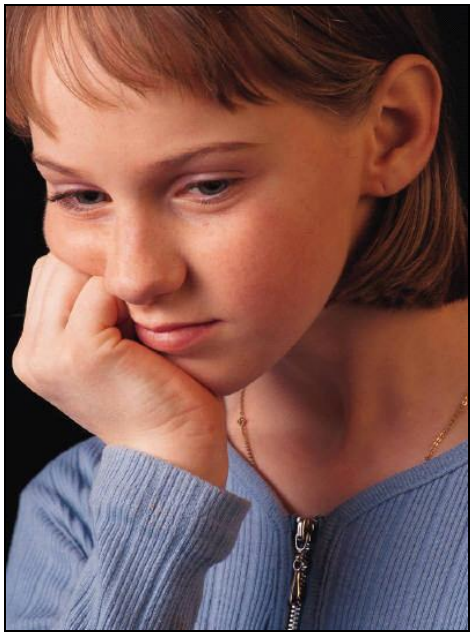
INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2011, from July 1, 2010 through June 30, 2011. The FY 2011 Descriptive Summary provides an expanded analysis of DCFS programs. This FY 2011 report examines served client data statewide and by program area. Children served are those who received a service sometime during the fiscal year.

This descriptive report summarizes demographic and clinical information on the 3033 children served by mental health services across the State of Nevada in DCFS Children's Mental Health Services. 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)	



CHILDREN'S MENTAL HEALTH

Number of Children Served

Statewide	NNCAS	SNCAS
3033	767	2266

Admissions

Statewide	NNCAS	SNCAS
1331	290	1041

Discharges

Statewide	NNCAS	SNCAS
1705	402	1303

SURVEY COMMENT FROM A SATISFIED PARENT

I felt the workers genuinely cared about us and wanted us to succeed.

CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

The average age of children served Statewide was 11.0, NNCAS was 11.8, and SNCAS was 10.7.

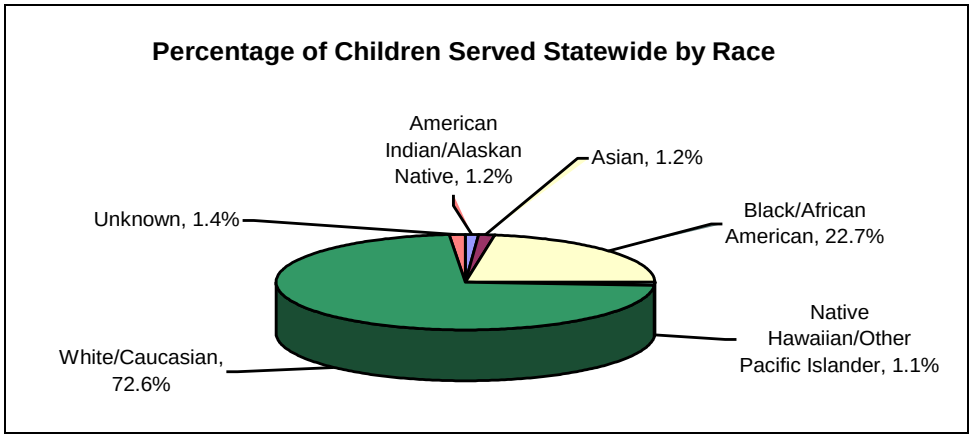
Age Group	Statewide	NNCAS	SNCAS
0–5 years old	736 (24.3%)	124 (16.2%)	612 (27.0%)
6–12 years old	998 (32.9%)	285 (37.2%)	713 (31.5%)
13–17 years old	1100 (36.3%)	299 (39.0%)	801 (35.3%)
18+ years old	199 (6.6%)	59 (7.7%)	140 (6.2%)

Gender

	Statewide	NNCAS	SNCAS
Male	1744 (57.5%)	455 (59.3%)	1289 (56.9%)
Female	1289 (42.5%)	312 (40.7%)	977 (43.1%)

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	36 (1.2%)	20 (2.6%)	16 (0.7%)
Asian	35 (1.2%)	4 (0.5%)	31 (1.4%)
Black/African American	688 (22.7)	54 (7.0%)	634 (28.0%)
Native Hawaiian/Other Pacific Islander	32 (1.1%)	7 (0.9%)	25 (1.1%)
White/Caucasian	2201 (72.6%)	667 (87.0%)	1534 (67.7%)
Unknown	41 (1.4%)	15 (2.0%)	26 (1.1%)
Ethnicity	**Statewide**	**NNCAS**	**SNCAS**
Hispanic Origin	812 (26.8%)	154 (20.1%)	658 (29.0%)



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	20 (2.6%)	2.1%	16 (0.7%)	0.7%
Asian	4 (0.5%)	4.4%	31 (1.4%)	6.8%
Black/African American	54 (7.0%)	2.6%	634 (28.0%)	11.6%
Native Hawaiian/Other Pacific Islander	7 (0.9%)	0.8%	25 (1.1%)	0.8%
White/Caucasian	667 (87.0%)	67.6%	1534 (67.7%)	51.3%
Unknown	15 (2.0%)	-	26 (1.1%)	-
Ethnicity	**NNCAS**		**SNCAS**	
Hispanic Origin	154 (20.1%)	35.6%	658 (29.0%)	42.1%

Custody Status at Admission

	Statewide	NNCAS	SNCAS
Parent/Family	1616 (53.3%)	418 (54.5%)	1198 (52.9%)
Child Welfare	1346 (44.4%)	327 (42.6%)	1019 (45.0%)
DCFS Youth Parole	17 (0.6%)	2 (0.3%)	15 (0.7%)
Parental Custody on Probation	54 (1.8%)	20 (2.6%)	34 (1.5%)

Severe Emotional Disturbance Status at Admission

Statewide	NNCAS	SNCAS
2569 (84.7%)	704 (91.8%)	1865 (82.3%)

[1] U.S. Census Bureau, "Race, Hispanic or Latino, Age, and Housing Occupancy: 2010 - 2010 Census Redistricting Data (Public Law 94-171) Summary File." Retrieved on November 10, 2011 from http://factfinder2.census.gov

Demographics by Program

Community-Based Services

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

Number of Children Served

Statewide	OPS	CCS
1322	365	957

Age

The average age of children served Statewide was 14.2, OPS was 14.5, and CCS was 14.1.

Age Group	Statewide	OPS	CCS
0–5 years old	1 (0.1%)	0 (0.0%)	1 (0.1%)
6–12 years old	451 (34.1%)	107 (29.3%)	344 (35.9%)
13–17 years old	742 (56.1%)	223 (61.1%)	519 (54.2%)
18+ years old	128 (9.7%)	35 (9.6%)	93 (9.7%)

Gender

	Statewide	OPS	CCS
Male	771 (58.3%)	216 (59.2%)	555 (58.0%)
Female	551 (41.7%)	149 (40.8%)	402 (42.0%)

Race and Ethnicity

Race	Statewide	OPS	CCS
American Indian/Alaskan Native	12 (0.9%)	4 (1.1%)	8 (0.8%)
Asian	16 (1.2%)	2 (0.5%)	14 (1.5%)
Black/African American	224 (16.9%)	31 (8.5%)	193 (20.2%)
Native Hawaiian/Other Pacific Islander	21 (1.6%)	4 (1.1%)	17 (1.8%)
White/Caucasian	1043 (78.9%)	323 (88.5%)	720 (75.2%)
Unknown	6 (0.5%)	1 (0.3%)	5 (0.5%)
Ethnicity	**Statewide**	**OPS**	**CCS**
Hispanic Origin	398 (30.1%)	72 (19.7%)	326 (34.1%)

Custody Status at Admission

	Statewide	OPS	CCS
Parent/Family	1016 (76.9%)	289 (79.2%)	727 (76.0%)
Child Welfare	273 (20.7%)	55 (15.1%)	218 (22.8%)
DCFS Youth Parole	5 (0.4%)	2 (0.5%)	3 (0.3%)
Parental Custody on Probation	28 (2.1%)	19 (5.2%)	9 (0.9%)

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

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
969	225	744

Age

The average age of children served by ECMHS Statewide was 5.2, ECMHS (NNCAS) was 6.2, and ECMHS (SNCAS) was 4.9.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	653 (67.4%)	111 (49.3%)	542 (72.8%)
6–12 years old	316 (32.6%)	114 (50.7%)	202 (27.2%)

Gender

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	576 (59.4%)	142 (63.1%)	434 (58.3%)
Female	393 (40.6%)	83 (36.9%)	310 (41.7%)

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	9 (0.9%)	7 (3.1%)	2 (0.3%)
Asian	9 (0.9%)	1 (0.4%)	8 (1.1%)
Black/African American	255 (26.3%)	12 (5.3%)	243 (32.7%)
Native Hawaiian/Other Pacific Islander	6 (0.6%)	2 (0.9%)	4 (0.5%)
White/Caucasian	683 (70.5%)	203 (90.2%)	480 (64.5%)
Unknown	7 (0.7%)	0 (0.0%)	7 (0.9%)
Ethnicity	**Statewide**	**ECMHS (NNCAS)**	**ECMHS (SNCAS)**
Hispanic Origin	261 (26.9%)	52 (23.1%)	209 (28.1%)

Custody Status at Admission

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	374 (38.6%)	95 (42.2%)	279 (37.5%)
Child Welfare	595 (61.4%)	130 (57.8%)	465 (62.5%)

SURVEY COMMENT FROM A SATISFIED YOUTH

They made me think twice about my choices.

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
612	114	107	391

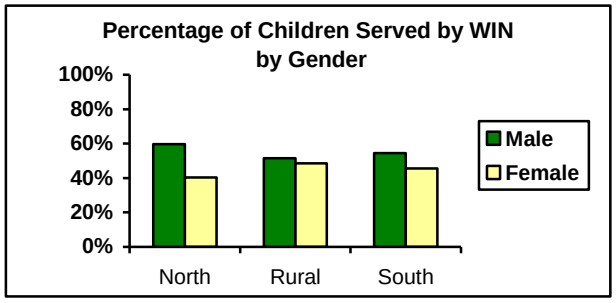
Age

The average age of children served Statewide was 13.2, North was 14.2, Rural was 11.7, and South was 13.4.

Age Group	Statewide	North	Rural	South
0–5 years old	16 (2.6%)	2 (1.8%)	12 (11.2%)	2 (0.5%)
6–12 years old	263 (43.0%)	37 (32.5%)	51 (47.7%)	175 (44.8%)
13–17 years old	263 (43.0%)	53 (46.5%)	34 (31.8%)	176 (45.0%)
18+ years old	70 (11.4%)	22 (19.3%)	10 (9.3%)	38 (9.7%)

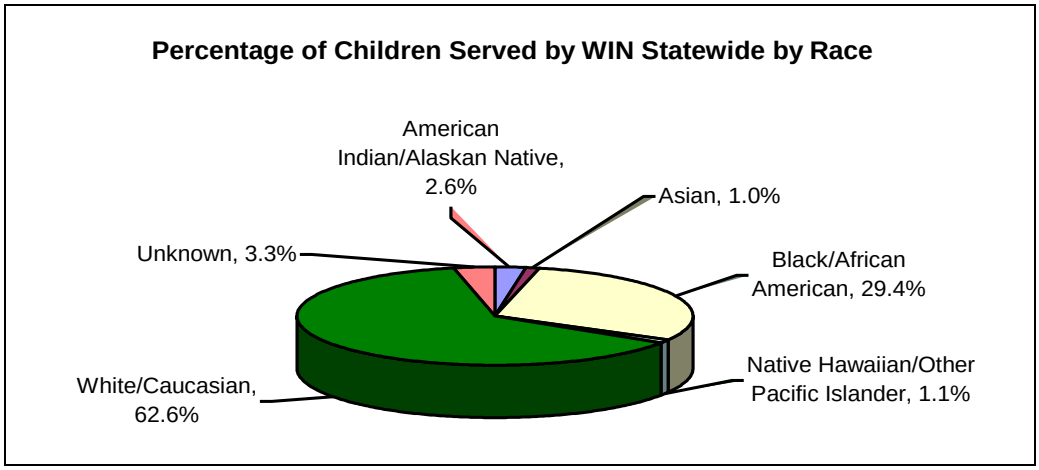
Gender

	Statewide	North	Rural	South
Male	336 (54.9%)	68 (59.6%)	55 (51.4%)	213 (54.5%)
Female	276 (45.1%)	46 (40.4%)	52 (48.6%)	178 (45.5%)



Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	16 (2.6%)	5 (4.4%)	6 (5.6%)	5 (1.3%)
Asian	6 (1.0%)	0 (0.0%)	1 (0.9%)	5 (1.3%)
Black/African American	180 (29.4%)	14 (12.3%)	3 (2.8%)	163 (41.7%)
Native Hawaiian/Other Pacific Islander	7 (1.1%)	0 (0.0%)	1 (0.9%)	6 (1.5%)
White/Caucasian	383 (62.6%)	90 (78.9%)	87 (81.3%)	206 (52.7%)
Unknown	20 (3.3%)	5 (4.4%)	9 (8.4%)	6 (1.5%)
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	110 (18.0%)	26 (22.8%)	13 (12.1%)	71 (18.2%)



Custody Status at Admission

	Statewide	North	Rural	South
Parent/Family	80 (13.1%)	31 (25.0%)	22 (22.7%)	27 (6.9%)
Child Welfare	530 (86.6%)	92 (74.2%)	75 (77.3%)	363 (92.8%)
DCFS Youth Parole	1 (0.2%)	0 (0.0%)	0 (0.0%)	1 (0.3%)
Parental Custody on Probation	1 (0.2%)	1 (0.8%)	0 (0.0%)	0 (0.0%)

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
186	56	64	76

The total count statewide is unduplicated, but the count by program may include clients also admitted to the other treatment homes.

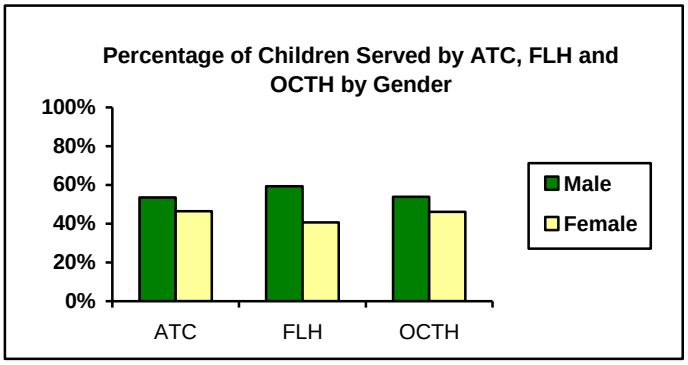
Age

The average age of children served Statewide was 14.1, ATC was 16.0, FLH was 12.9, and OCTH was 14.0.

Age Group	Statewide	ATC	FLH	OCTH
0–5 years old	1 (0.5%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
6–12 years old	55 (29.6%)	0 (0.0%)	30 (46.9%)	25 (32.9%)
13–17 years old	118 (63.4%)	49 (87.5%)	30 (46.9%)	48 (63.2%)
18+ years old	12 (6.5%)	7 (12.5%)	3 (4.7%)	3 (3.9%)

Gender

	Statewide	ATC	FLH	OCTH
Male	105 (56.5%)	30 (53.6%)	38 (59.4%)	41 (53.9%)
Female	81 (43.5%)	26 (46.4%)	26 (40.6%)	35 (46.1%)



Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	2 (1.1%)	0 (0.0%)	0 (0.0%)	2 (2.6%)
Asian	1 (0.5%)	0 (0.0%)	0 (0.0%)	1 (1.3%)
Black/African American	38 (20.4%)	6 (10.7%)	5 (7.8%)	29 (38.2%)
Native Hawaiian/Other Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
White/Caucasian	144 (77.4%)	50 (89.3%)	59 (92.2%)	43 (56.6%)
Unknown	1 (0.5%)	0 (0.0%)	0 (0.0%)	1 (1.3%)
Ethnicity	**Statewide**	**ATC**	**FLH**	**OCTH**
Hispanic Origin	41 (22.0%)	15 (26.8%)	11 (17.2%)	16 (21.1%)

Custody Status at Admission

	Statewide	ATC	FLH	OCTH
Parent/Family	104 (53.1%)	28 (50.0%)	50 (78.1%)	26 (34.2%)
Child Welfare	73 (37.2%)	14 (25.0%)	12 (18.8%)	47 (61.8%)
DCFS Youth Parole	1 (0.5%)	0 (0.0%)	0 (0.0%)	1 (1.3%)
Parental Custody on Probation	18 (9.2%)	14 (25.0%)	2 (3.1%)	2 (2.6%)

SURVEY COMMENT FROM A SATISFIED PARENT

The therapist gives us solutions and tools to use when we need help.

Residential Facility and Psychiatric Hospital

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

Number of Children Served

Acute	RTC
203	117

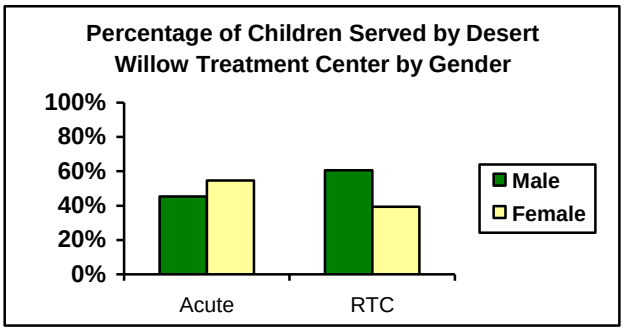
Age

The average age of children served by Desert Willow Acute was 15.2 and it was 15.8 for the Desert Willow Residential Treatment Center.

Age Group	Acute	RTC
6–12 years old	31 (15.3%)	5 (4.3%)
13–17 years old	155 (76.4%)	99 (84.6%)
18+ years old	17 (8.4%)	13 (11.1%)

Gender

	Acute	RTC
Male	92 (45.3%)	71 (60.7%)
Female	111 (54.7%)	46 (39.3%)



Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	0 (0.0%)	2 (1.7%)
Asian	5 (2.5%)	3 (2.6%)
Black/African American	31 (15.3%)	21 (17.9%)
Native Hawaiian/Other Pacific Islander	6 (3.0%)	3 (2.6%)
White/Caucasian	157 (77.3%)	85 (72.6%)
Unknown	4 (2.0%)	3 (2.6%)
Ethnicity	**Acute**	**RTC**
Hispanic Origin	70 (34.5%)	24 (20.5%)

Custody Status at Admission

	Acute	RTC
Parent/Family	192 (94.6%)	78 (66.7%)
Child Welfare	10 (4.9%)	5 (4.3%)
DCFS Youth Parole	0 (0.0%)	11 (9.4%)
Parental Custody on Probation	1 (0.5%)	23 (19.7%)

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 six problems identified below (and listed in order of prevalence) accounted for 36% of all problems reported.

- Child Neglect Victim (12.3%)
- Adjustment Problems (5.8%)
- Depression (5.7%)
- Suicide Attempt – Threat (4.9%)
- Physical Aggression (3.7%)
- ADHD (3.6%)

Child neglect was the most prevalent presenting problem in FY2011, surpassing adjustment problems this year. Depression has remained in the top five for the third year. In addition, suicide attempt/threat surpassed physical aggression. Joining the list was ADHD.

Diagnosis

In FY 2011 over 36 percent 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 NOS	Neglect of Child	Disruptive Behavior Disorder NOS
Neglect of Child	Anxiety Disorder NOS	Neglect of Child
Anxiety Disorder NOS	Disruptive Behavior Disorder NOS	Anxiety Disorder NOS
Adjustment Disorder	Adjustment Disorder	Adjustment Disorder
Deprivation/Maltreatment Disorder	Deprivation/Maltreatment Disorder	Physical Abuse of Child
Physical Abuse of Child	Physical Abuse of Child	Sensory Stimulation-Seeking Disorder/Impulsive

Age Group 6-12.99

Overall	Female	Male
Attention-Deficit/Hyperactivity Disorder	Posttraumatic Stress Disorder	Attention-Deficit/Hyperactivity Disorder
Disruptive Behavior Disorder NOS	Oppositional Defiant Disorder	Disruptive Behavior Disorder NOS
Posttraumatic Stress Disorder	Disruptive Behavior Disorder NOS	Oppositional Defiant Disorder
Oppositional Defiant Disorder	Anxiety Disorder NOS	Posttraumatic Stress Disorder
Adjustment Disorder with Mixed Disturbance of Emotions and Conduct	Mood Disorder NOS	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
Mood Disorder NOS	Attention-Deficit/Hyperactivity Disorder	Mood Disorder NOS

Age Group 13-17.99

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	Depressive Disorder NOS	Major Depressive Disorder
Attention-Deficit/Hyperactivity Disorder	Oppositional Defiant Disorder	Posttraumatic Stress Disorder
Depressive Disorder NOS	Attention-Deficit/Hyperactivity Disorder	Depressive Disorder NOS

Age Group 18+

Overall	Female	Male
Major Depressive Disorder	Major Depressive Disorder	Major Depressive Disorder
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder	Posttraumatic Stress Disorder
Depressive Disorder NOS	Depressive Disorder NOS	Depressive Disorder NOS
Oppositional Defiant Disorder	Mood Disorder NOS	Oppositional Defiant Disorder
Mood Disorder NOS	Oppositional Defiant Disorder	Sexual Disorder NOS/Paraphilia NOS

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

The Child and Adolescent Functional Assessment Scale (CAFAS)[2] 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)[3] 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 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. Only FY 2011 CAFAS and PECFAS scores were used in this Descriptive Summary.

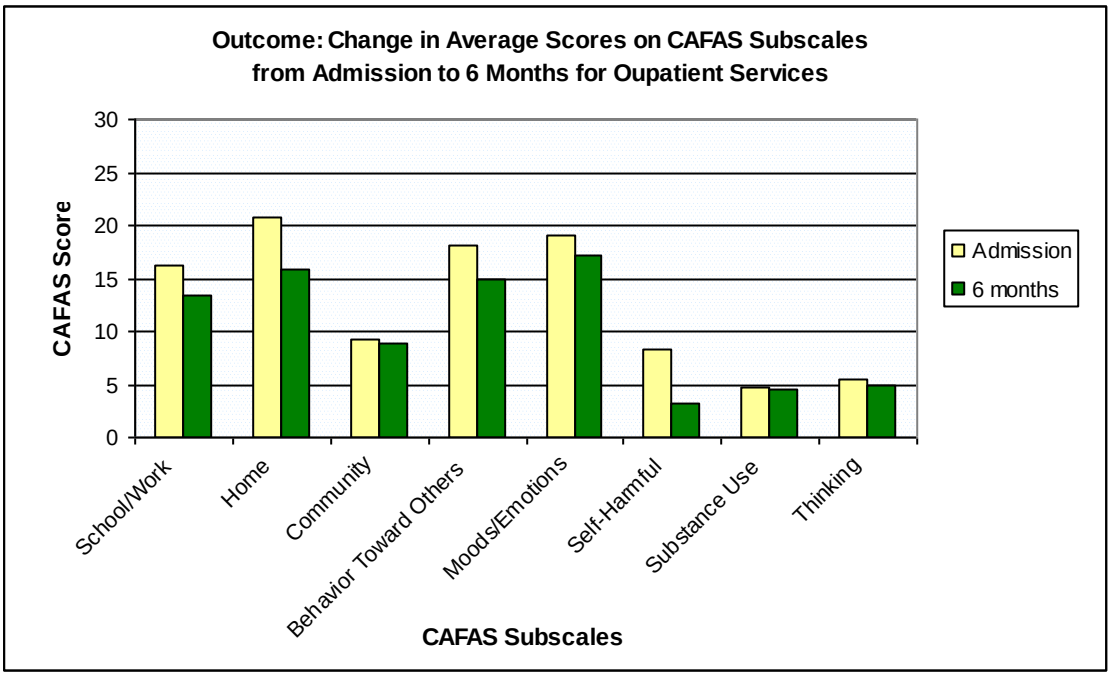
SURVEY COMMENT FROM A SATISFIED PARENT

My children have learned to use words rather than fists to express themselves.

[2] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.
[3] Hodges, K. (2005). *Manual for Training Coordinators, Clinical Administrators, and Data Managers.* Ann Arbor, MI: Author.

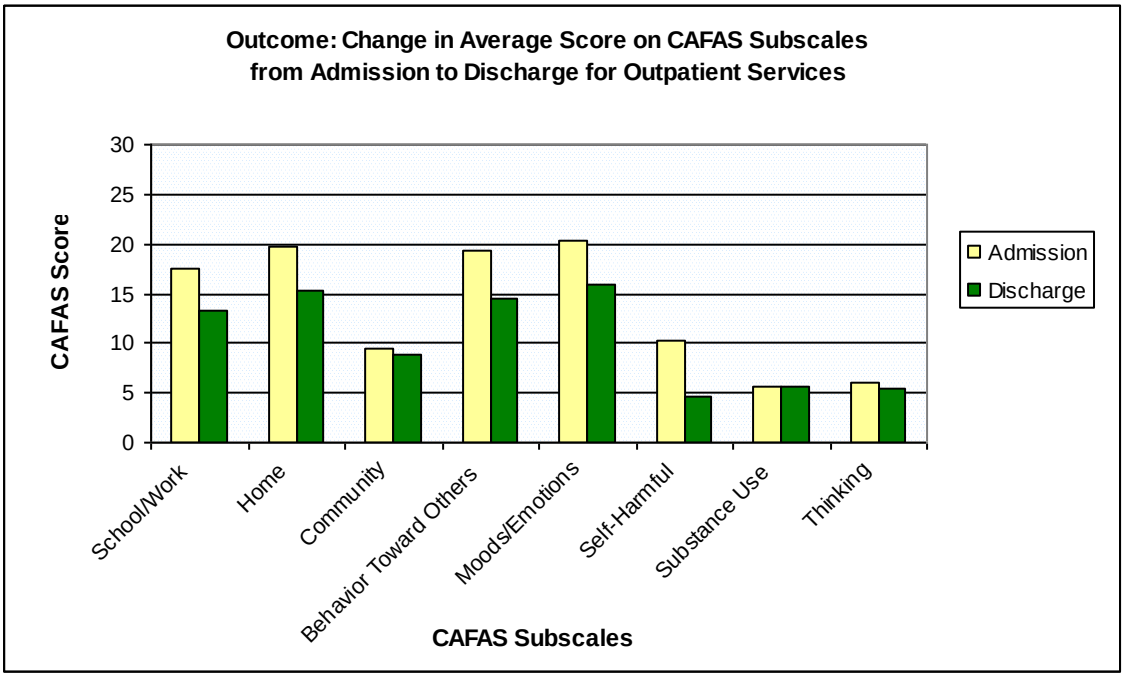
Outpatient and Children's Clinical Services

The graph below shows the admission and 6 months CAFAS subscale scores for Outpatient Services.



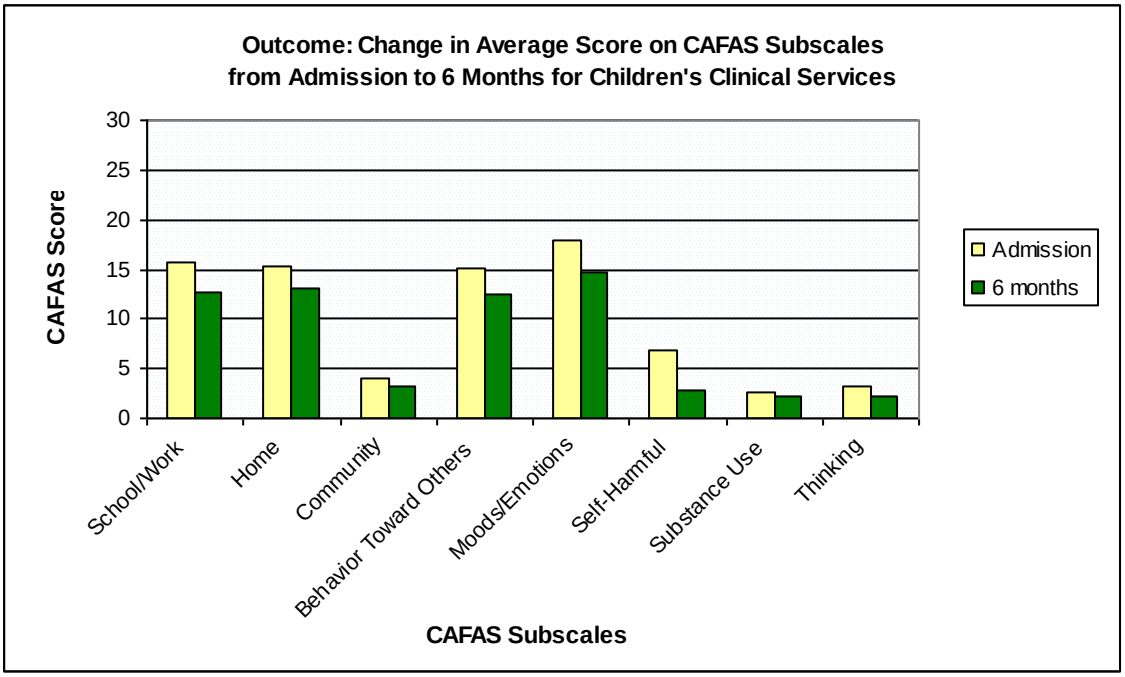
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for Outpatient Services. The mean CAFAS score was 101.98 (SD=36.80) at admission. At 6 months into services, the mean CAFAS score decreased to 82.77 (SD=36.58); t (100) = 6.33, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more. Outpatient Services nearly reaches the level for clinical significance.

The graph below shows the admission and discharge CAFAS subscale scores for Outpatient Services.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Outpatient Services. The mean CAFAS score was 108.06 (SD=41.68) at admission. At discharge, the mean CAFAS score decreased to 83.01 (SD=47.93); t (102) = 6.81, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

The graph below shows the admission and 6 months CAFAS subscale scores for Children's Clinical Services.

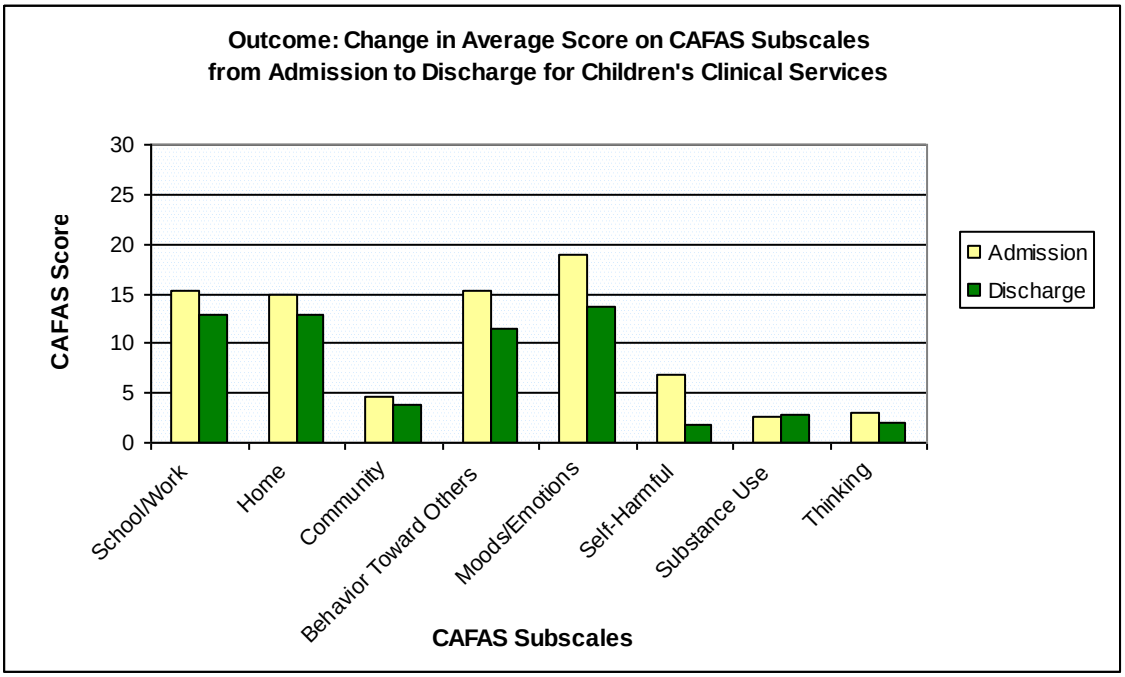


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for Children's Clinical Services. The mean CAFAS score was 80.81 (SD=34.14) at admission. At 6 months into services, the mean CAFAS score decreased to 63.55 (SD=34.35); t (196) = 7.08, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

He is getting over what happened to him.

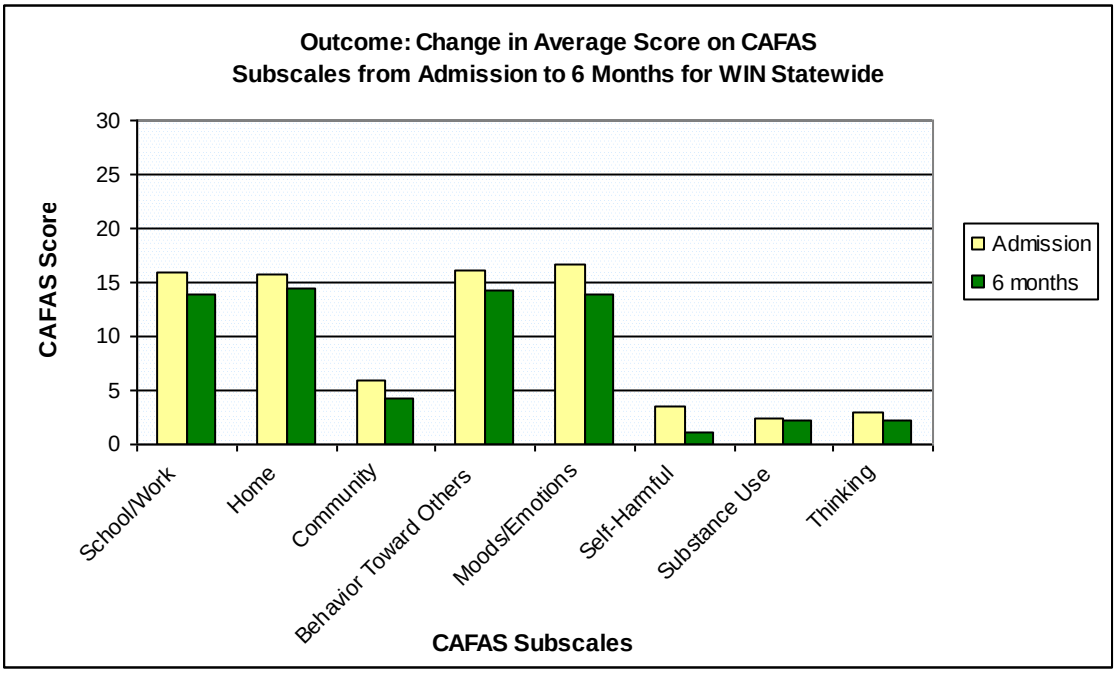
The graph below shows the admission and discharge CAFAS subscale scores for Children's Clinical Services.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Children's Clinical Services. The mean CAFAS score was 90.90 (SD=38.98) at admission. At discharge, the mean CAFAS score decreased to 68.20 (SD=43.80); t (288) = 10.69, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

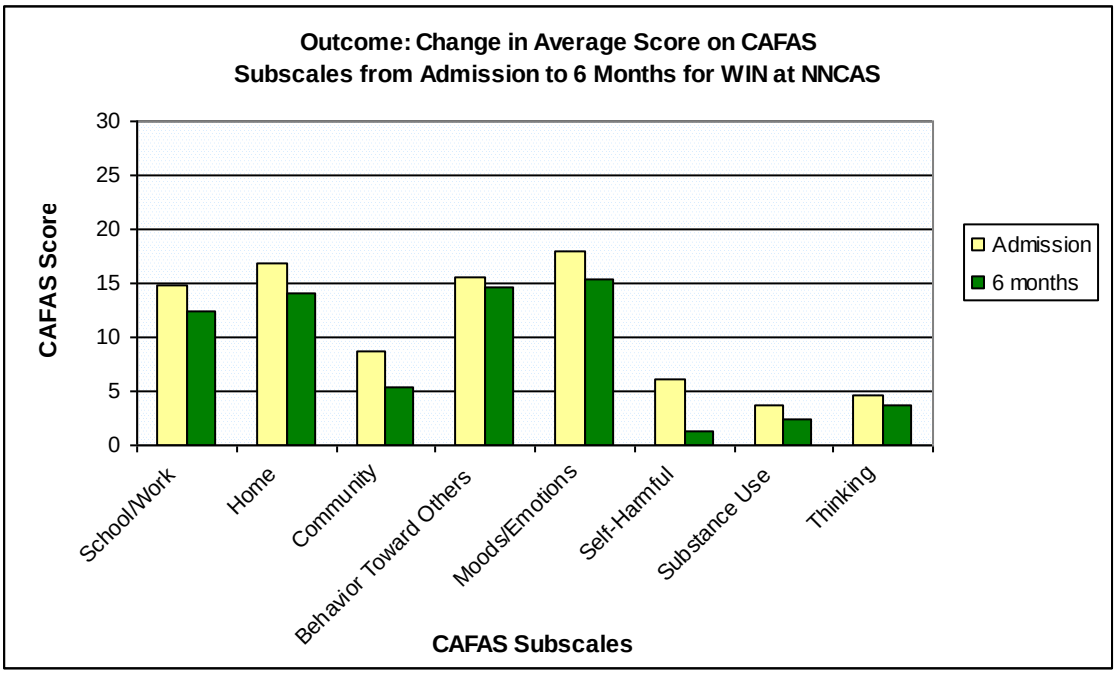
WIN

The graph below shows the admission and 6 months CAFAS subscale scores for WIN statewide.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for WIN statewide. The mean CAFAS score was 79.14 (SD=33.13) at admission. At 6 months into services, the mean CAFAS score decreased to 66.54 (SD=31.63); t (161) = 4.35, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

The graph below shows the admission and 6 months CAFAS subscale scores for WIN at NNCAS.

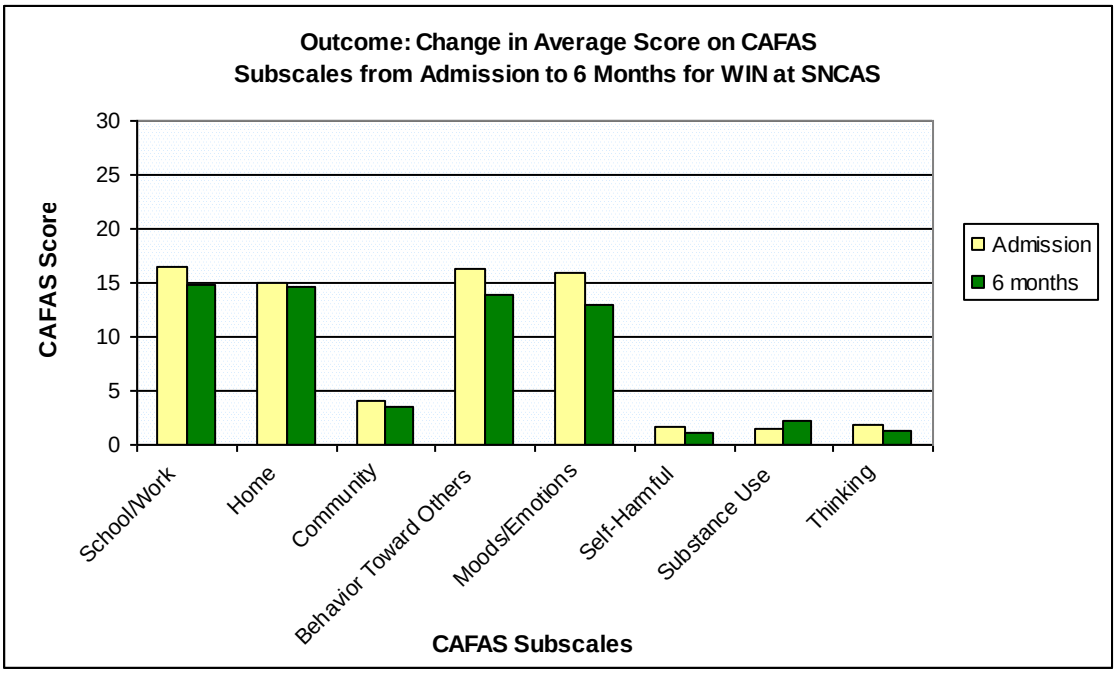


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for WIN at NNCAS. The mean CAFAS score was 88.33 (SD=38.01) at admission. At 6 months into services, the mean CAFAS score decreased to 69.39 (SD=29.24); t (65) = 3.84, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

SURVEY COMMENT FROM A SATISFIED PARENT

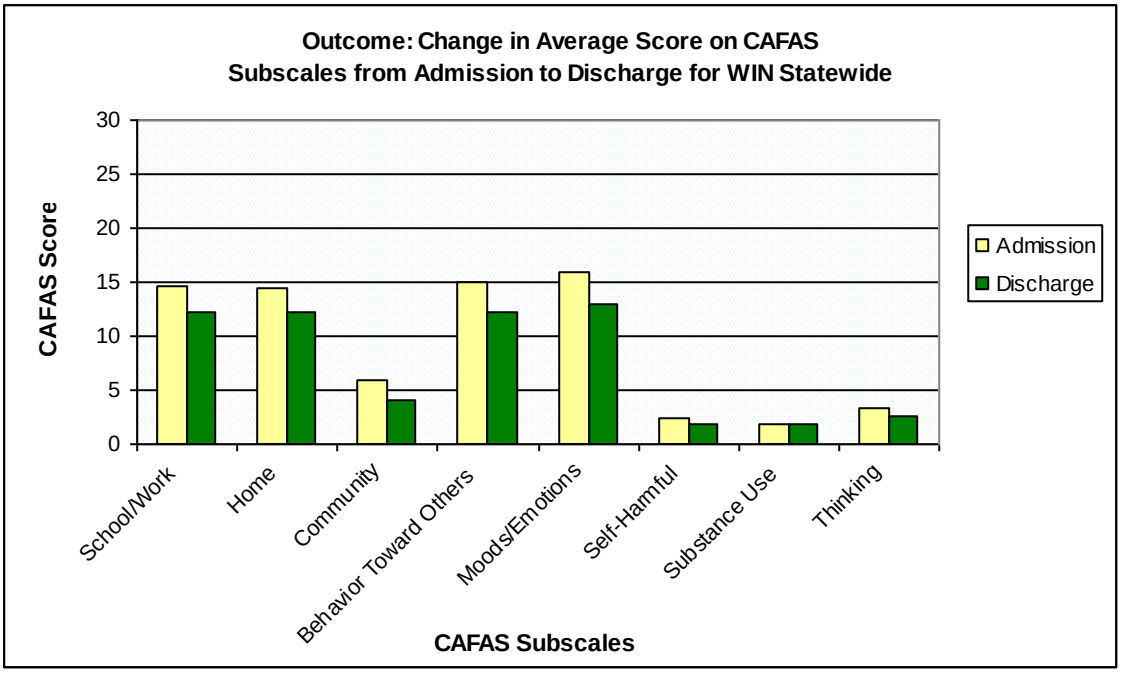
If it wasn't for our therapist, I don't know if my child would be alive today.

The graph below shows the admission and 6 months CAFAS subscale scores for WIN at SNCAS.



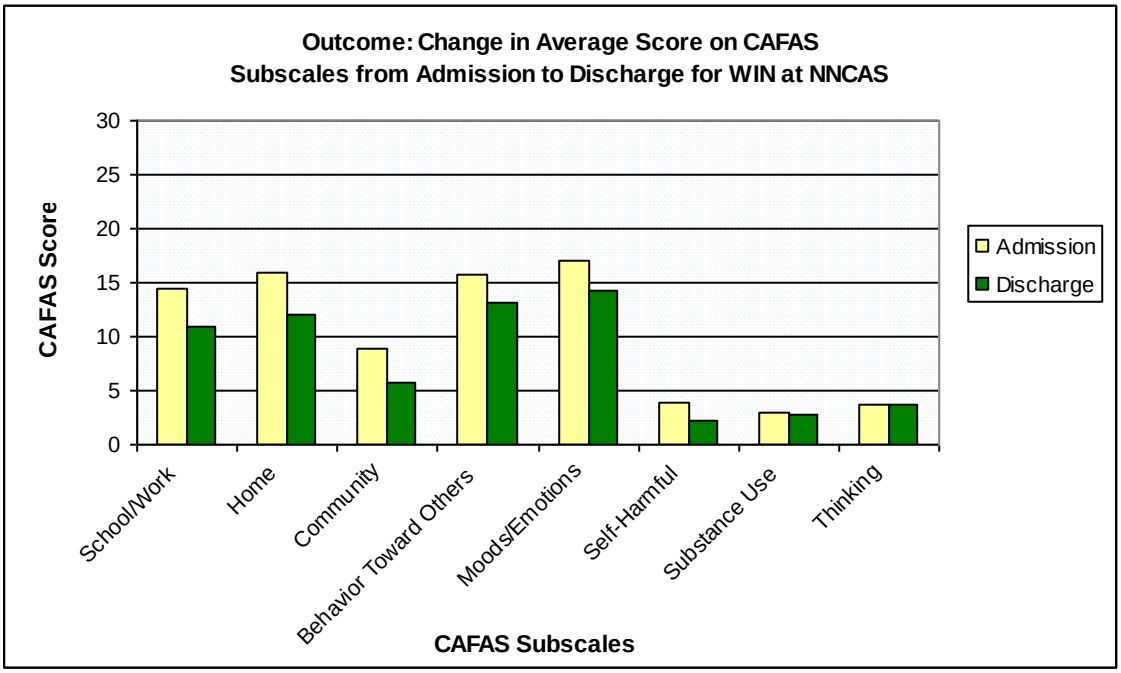
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for WIN at SNCAS. The mean CAFAS score was 72.81 (SD=27.79) at admission. At 6 months into services, the mean CAFAS score decreased to 64.58 (SD=33.18); t (95) = 2.37, p = .020. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

The graph below shows the admission and discharge CAFAS subscale scores for WIN statewide.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN statewide. The mean CAFAS score was 73.12 (SD=33.51) at admission. At discharge, the mean CAFAS score decreased to 59.90 (SD=39.63); t (201) = 5.02, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

The graph below shows the admission and discharge CAFAS subscale scores for WIN at NNCAS.

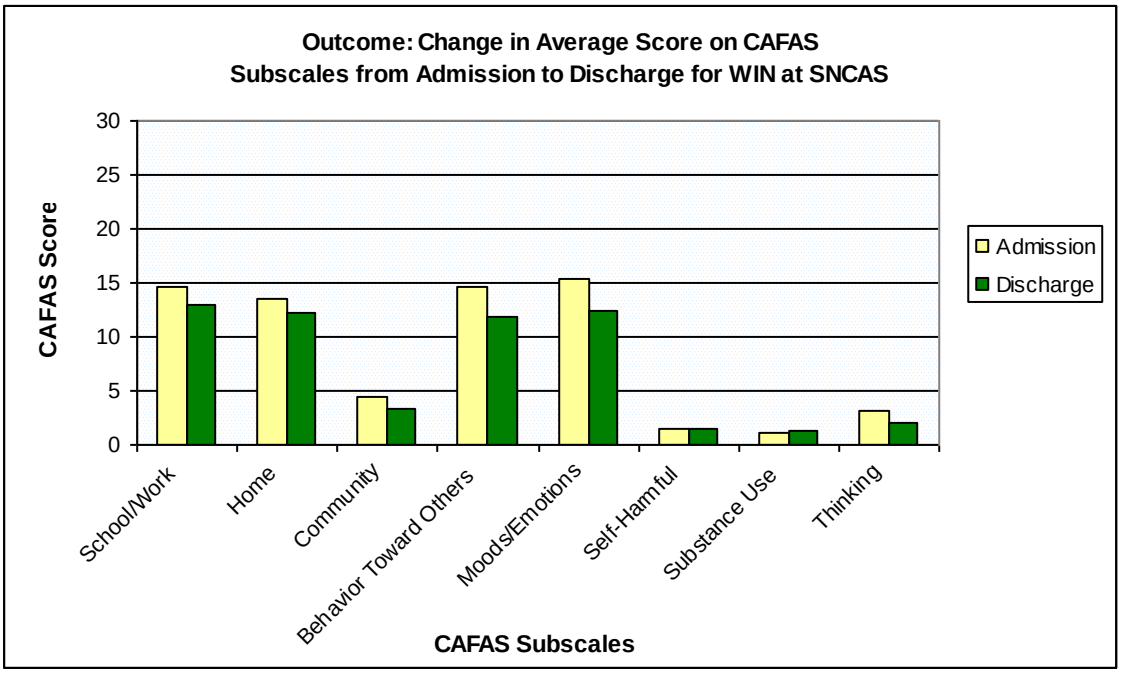


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN at NNCAS. The mean CAFAS score was 82.35 (SD=38.21) at admission. At discharge, the mean CAFAS score decreased to 64.41 (SD=43.07); t (67) = 3.77, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

It's comforting to know that he is in a safe place where he can't hurt himself or someone else.

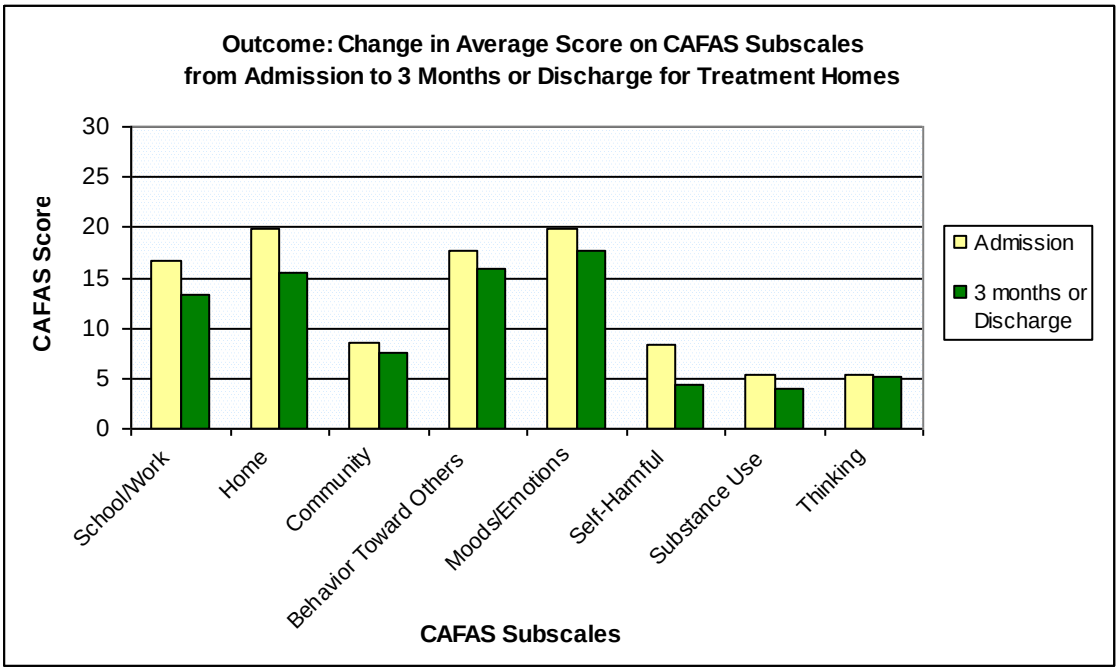
The graph below shows the admission and discharge CAFAS subscale scores for WIN at SNCAS.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN at SNCAS. The mean CAFAS score was 68.43 (SD=29.93) at admission. At discharge, the mean CAFAS score decreased to 57.61 (SD=37.72); t (133) = 3.44, p = .001. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

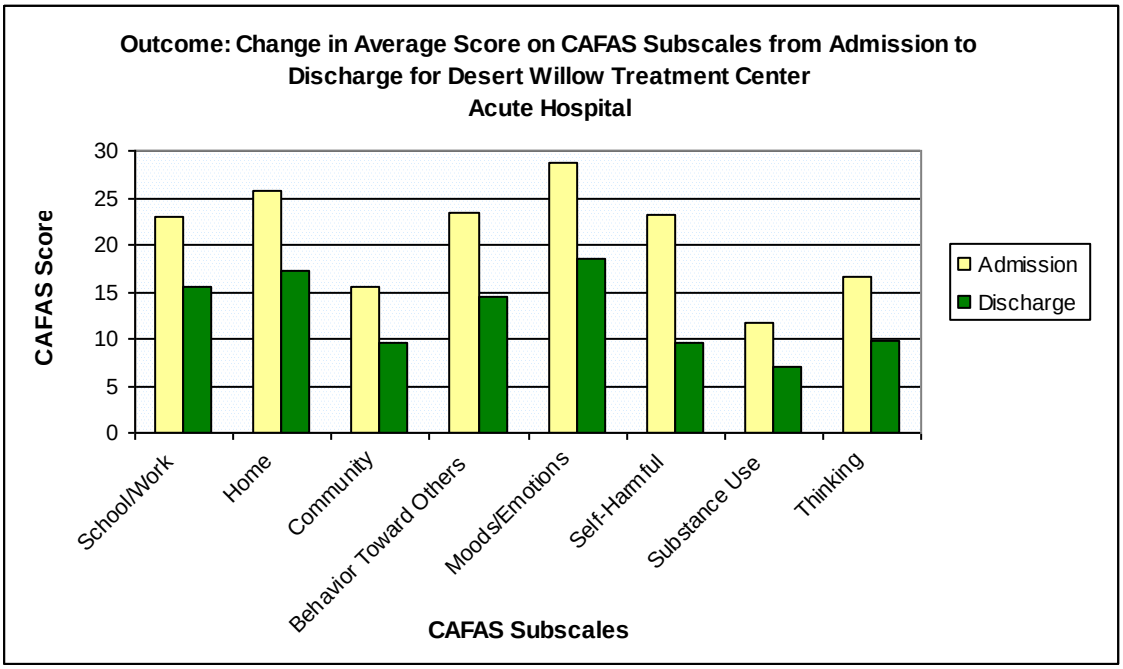
Treatment Homes

The graph below shows the admission and 3 months or discharge CAFAS subscale scores for Treatment Homes.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to 3-months or at discharge for Treatment Homes. The mean CAFAS score was 101.90 (SD=39.06) at admission. At 3 months into services or discharge, the mean CAFAS score decreased to 83.52 (SD=39.24); t (178) = 8.47, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

Desert Willow Treatment Center Acute Hospital

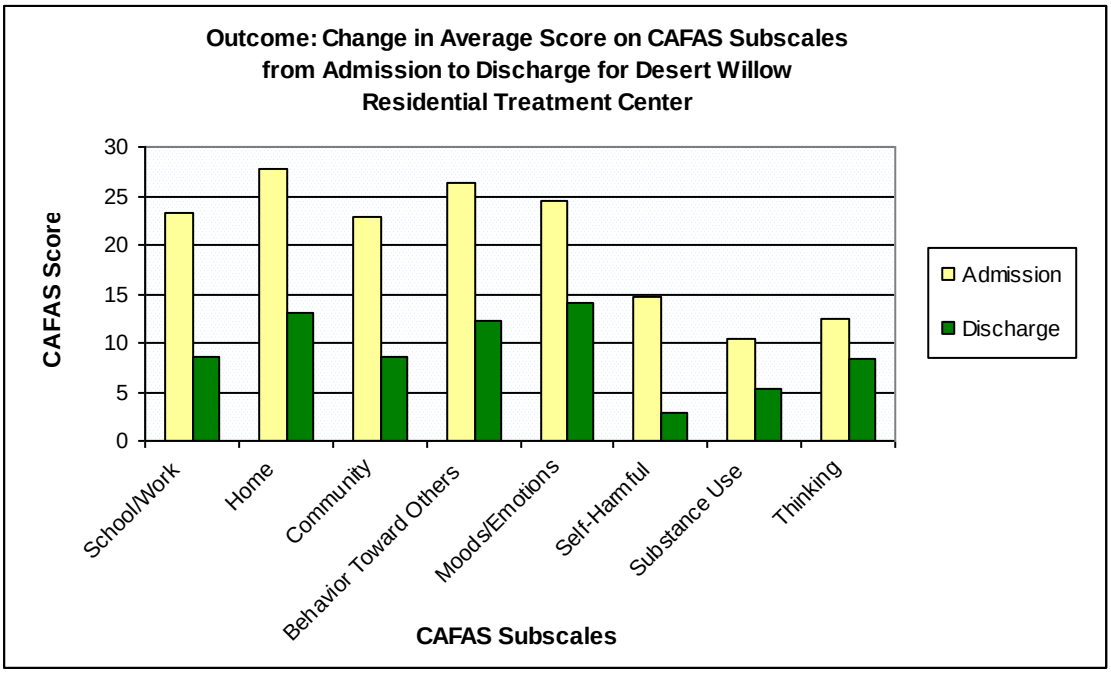


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Acute Hospital. The mean CAFAS score was 168.13 (SD=28.64) at admission. At discharge from services, the mean CAFAS score decreased to 101.50 (SD=28.29); t (159) = 25.76, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

The staff here are very polite and respectful; I really like that.

Desert Willow Treatment Center RTC



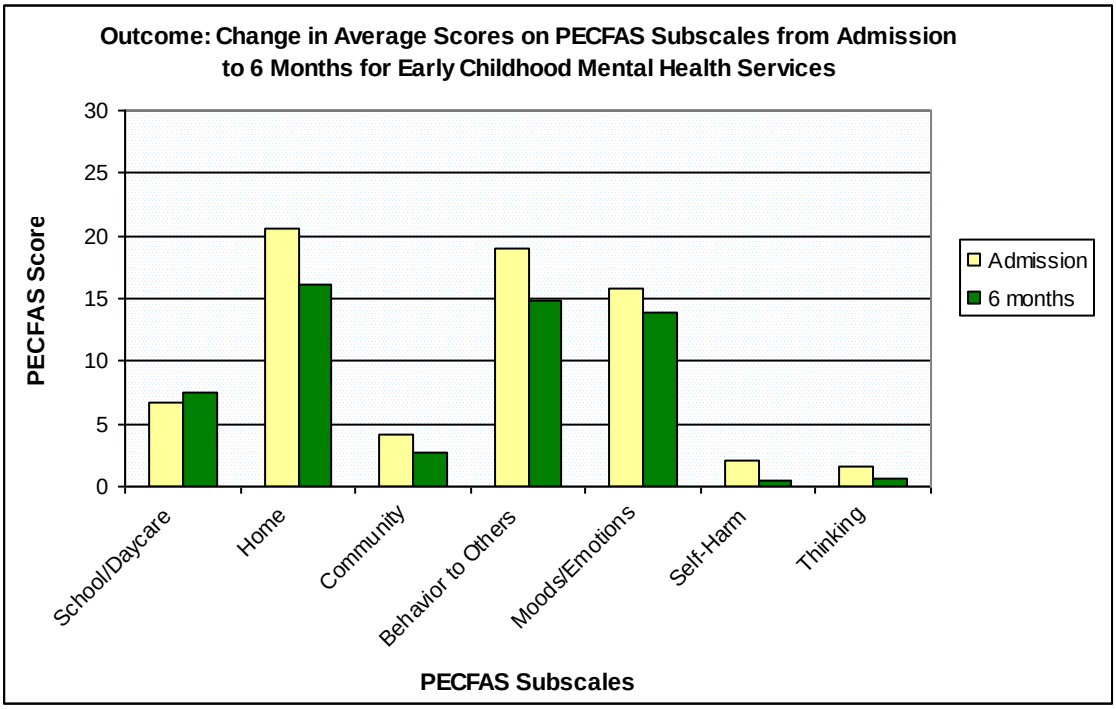
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Residential Treatment Center. The mean CAFAS score was 162.24 (SD=34.68) at admission. At discharge, the mean CAFAS score decreased to 73.28 (SD=47.17); t (66) = 18.15, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED PARENT

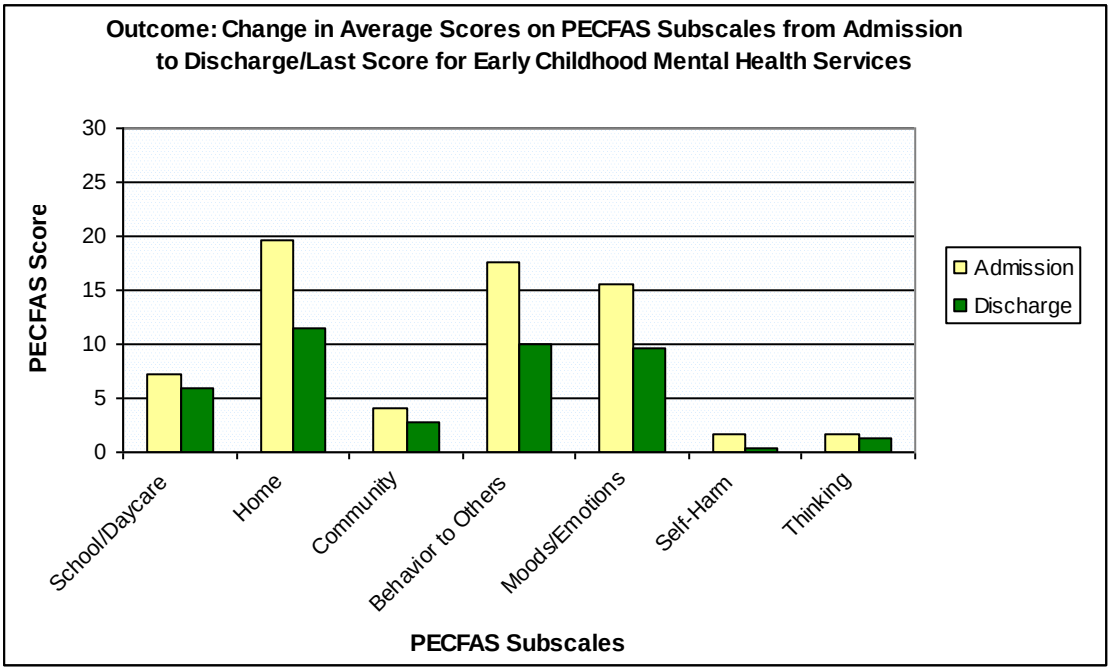
I like being able to talk about our issues and make a plan to better ourselves, our parenting skills and to understand each other better.

Early Childhood Mental Health Services NNCAS and SNCAS

The graph below shows the admission and 6 months PECFAS subscale scores for Early Childhood Mental Health Services statewide.



A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6-months for Early Childhood Mental Health Services statewide. The mean PECFAS score was 69.76 (SD=26.74) at admission. At 6 months into services, the mean PECFAS score decreased to 56.14 (SD=23.30); t (126) = 5.61, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total PECFAS score decrease of 17.5 points or more.



A paired-samples t-test was conducted to compare PECFAS total scores from admission to discharge or last PECFAS score for Early Childhood Mental Health Services statewide. The mean PECFAS score was 67.48 (SD=27.75) at admission. At discharge or last score, the mean PECFAS score decreased to 41.22 (SD=29.11); t (114) = 9.36, p = .000. These results show a clinically and statistically significant reduction in overall impairment.

Education and Juvenile Justice Outcomes

An analysis was conducted on client's absences, suspensions/expulsions, grade point average, and arrests. With respect to grade point average (GPA), each client's GPA in the most recent period was compared to his or her average for at least two grading periods to see if it improved.

The analysis of the other three measures was conducted as follows: Each client's absences, suspensions/expulsions, and arrests in the most recent period were compared to his or her average over at least two periods to see if these measures increased, decreased, or stayed the same. If a client was, despite some fluctuation from period to period, reducing or maintaining acceptable levels in these areas, then his or her most recent numbers will be less than his or her average (thereby pulling the average down toward zero) or held steady near zero.

Performance was classified into three categories:

1. A client was considered to be maintaining an excellent performance or showing improvement if he or she met any one of three criteria:

    - The client had a perfect record historically and in the most recent period;
    - The client had a history of averaging no more than two absences per grade period and had two or less in the most recent grade period (absences only); or
    - The client had a historic average of three or more per grade period and showed a reduction from the average in the most recent grade period.

2. A client was considered to have stayed the same at a level that could be improved if he or she had:

    - Three or more absences per period historically and had the same number as his or her average in the most recent period (absences only), or
    - One or more per period and the same number as his or her average in the most recent period (suspensions/expulsions and arrests only).

3. A client was considered to have decreased in performance if he or she had:

    - A historical average of three or more per period and more than his or her historical average in the most recent period, or an average from zero to two and absences in the most recent period of three or more (absences only), or
    - A historical average of one or more per period and more than his or her average in the most recent period, or a perfect record historically and one or more in the most recent period (suspensions/expulsions and arrests only).

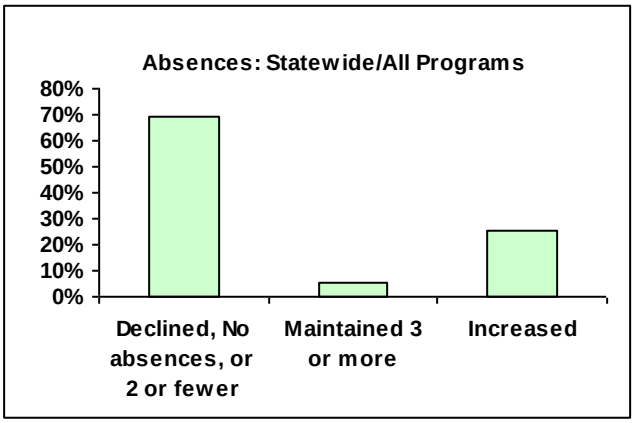
Grade Point Average (GPA): Statewide/All Programs

In FY 2011, 335 students had GPA data for at least two grading periods. Improvement in GPA compared to their own average occurred in 98 (29.3%) of the clients, and the average improvement was .3818 GPA points.

Grade Point Average (GPA): WIN

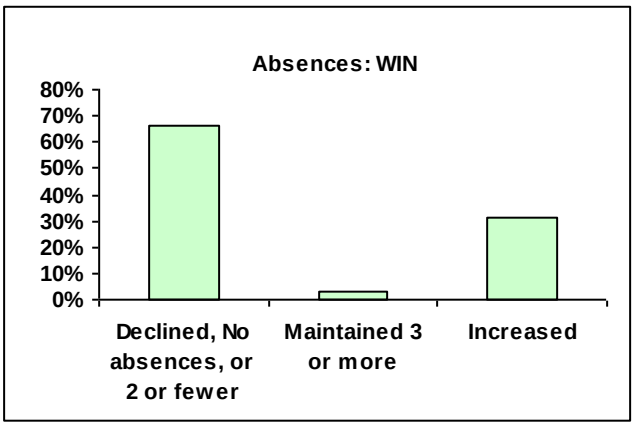
The WIN program accounted for 122 of the 335 clients with GPA data for at least two periods. In FY 2011, 43 (35.2%) WIN clients improved against their own averages, with an average improvement of .355 GPA points.

Absences: Statewide/All Programs



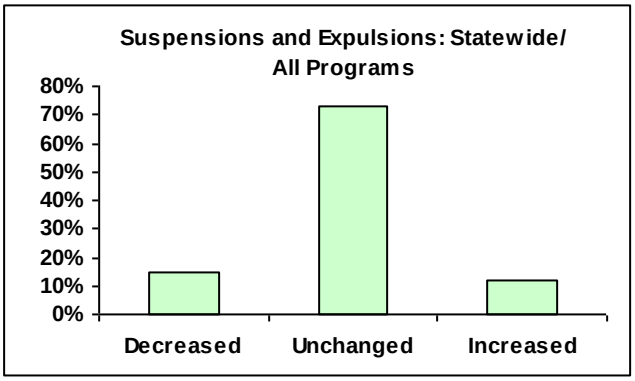
In FY2011, 692 clients had absences data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 480 (69.4%) of the clients. There were 115 (16.6%) clients who had a zero average and zero absences in the most recent period. Absences remained the same at three or more compared with a mean of three or more for 37 (5.3%) clients. Absences increased to three or more and the client average was greater than two days for 175 (25.3%) of the clients.

Absences: WIN



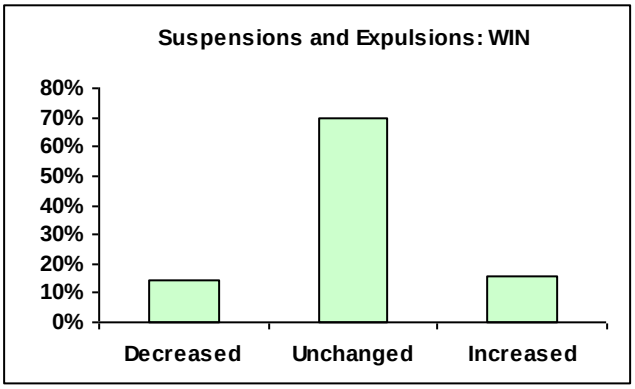
The WIN program accounted for 314 of the 692 cases with absence data over at least two grade periods. When isolated from the other programs, absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 208 (66.2%) clients. There were 39 (18.75%) clients who had a zero average and zero absences in the most recent period. Absences remained the same at three or more compared with a mean of three or more for 9 (2.9%) clients. Absences increased to three or more and the client average was greater than two days for 97 (30.9%) clients.

Suspensions and Expulsions: Statewide/All Programs



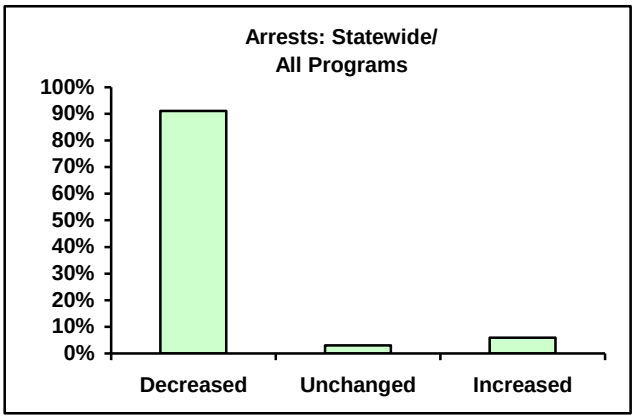
In FY2011, 668 clients had suspensions and expulsions data for at least two grade periods from which an average could be constructed. Suspensions and expulsions decreased versus the client's own average for 99 (14.8%) of the clients. For 489 (73.2%) of the clients, there was no change in suspensions and expulsions versus his or her own average, and 467 (95.5%) of them had a zero average and zero suspensions or expulsions. Suspensions and expulsions increased versus the client's own average for 80 (12.0%) of the clients.

Suspensions and Expulsions: WIN



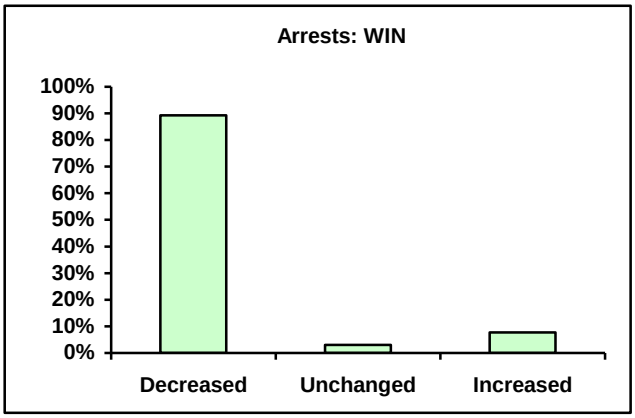
The WIN program accounted for 318 cases of the 668 cases with suspensions and expulsions data over multiple periods. Suspensions and expulsions decreased versus the client's own average for 46 (14.5%) of the clients. For 221 (69.5%) of the clients, no change occurred in suspensions and expulsions versus his or her own average, and all 221 had no suspensions or expulsions in the latest or prior periods. Suspensions and expulsions increased versus the client's own average for 51 (16.0%) of the clients.

Arrests: Statewide/All Programs



In FY2011, 729 clients had arrest data entered for at least two periods from which an average could be constructed. Of the 729 clients with arrest data, 625 (85.7%) had no arrests. Arrests decreased or remained zero versus the client's own average for 664 (91.1%) of the clients. For 22 (3.0%) of the clients there was no change in the number of arrests versus his or her own average. Arrests increased versus the client's own average for 43 (5.9%) for the clients.

Arrests: WIN



In FY2011, WIN had 299 of the 729 clients with arrest data entered for at least two periods from which an average could be constructed. Of the 299 clients with arrest data, 240 (80.3%) had no arrests. Arrests decreased or remained zero versus the client's own average for 267 (89.3%) of the clients. For 9 (3.0%) of the clients there was no change in the number of arrests versus his or her own average. Arrests increased versus the client's own average for 23 (7.7%) for the clients.

PROGRAM EVALUATION DEVELOPMENT: AGGRESSION REPLACEMENT TRAINING

Clients served in residential treatment facilities have severe and complex needs requiring care in a structured living environment to help manage their problem behaviors. Aggression Replacement Training (ART) is a cognitive behavioral intervention program that helps youths improve their social skills and moral reasoning, better manage their anger, and reduce their aggressive behavior.[4] DCFS Children's Mental Health has trained trainers to implement this program throughout its residential treatment facilities. ATC is the first program to begin collecting data on youth participating in ART. Below is demographic information on 30 youth who have participated in ART at ATC.

Gender	
Male	13 (43.3%)
Female	17 (56.7%)
Race/Ethnicity	
Caucasian	23 (76.7%)
African-American	3 (10.0%)
Hispanic	3 (10.0%)
Other	1 (3.3%)
Average Age	14.63

One of the outcome measures used for ART is the Youth Outcome Questionnaire Self-Report (YOQ-SR) which is a reliable and change sensitive measure of psychosocial distress as perceived by the adolescent.[5] The YOQ-SR has

[4] National Center for Mental Health Promotion and Youth Violence Prevention. (2007). *Aggression Replacement Training*. Retrieved on February 3, 2012 from *http://www.promoteprevent.org/publications/ebi-factsheets/aggression-replacement-training%C2%AE-art%C2%AE*

[5] Ridge, N. W., Warren, J. S., Burlingame, G. M., Wells, M. G., & Tumblin, K. M. (2009). Reliability and Validity of the Youth Outcome Questionnaire Self-Report. *Journal of Clinical Psychology.* 65 (10), 1115-1126. Retrieved on January 27, 2012 from http://www.oqmeasures.com/files/oqmeasures/Ridge-2009-YOQSR-psychometrics.pdf

64 items with six subscales which are rated on a 5-point scale with seven items reverse scored. It is designed for adolescents ages 12 to 18. The YOQ-SR total score provides an overall level of distress. A score of 46 or higher is in the clinical range; a score of 46 or less is considered to be in the non-clinical range.[6] Youth are asked to complete the YOQ-SR when they begin ART and then again when they finish the training. ATC collected the YOQ-SR on 14 youth at the beginning of their participation in ART. The average score was 63.36, which is considered well above the clinical range. ATC is encouraged to continue collecting the YOQ-SR and other outcome measures to determine if the program is achieving its goals and to provide meaningful feedback to trainers.

[6] Carepaths. Retrieved on January 27, 2012 from http://www.carepaths.com/youth-outcomes-questionnaire-yoq-2-0/

SURVEY COMMENT FROM A SATISFIED YOUTH
I'm learning things about myself and how to get along with others.

CONSUMER 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 are 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 spring of every year, DCFS conducts a statewide survey for NNCAS and SNCAS children's community-based mental health programs. 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.

This year, children's residential and psychiatric inpatient mental health service programs offered through NNCAS and SNCAS began collecting surveys at discharge from services. Like the community-based programs, parent/caregivers with children in residential and psychiatric inpatient programs and the children themselves (age 12 or older) are solicited to voluntarily participate in completing a survey. A full year of residential and psychiatric inpatient survey results will be available next year.

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 table presents 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.

Percent of Positive Response for Each Survey Domain

Community Based Services Survey – Spring 2011	Youth % positive	Parent % positive	National Benchmark for Parent Response[7]
Services are seen as accessible and convenient regarding location and scheduling	82	90	83
Services are seen as satisfactory and helpful	83	93	83
Clients get along better with family and friends and are functioning better in their daily life	79	81	62
Clients feel they have a role in directing the course of their treatment	75	91	87
Staff are respectful of client religion, culture and ethnicity	89	98	93
Clients feel supported in their program and in their community	90	95	NA
Clients are better able to cope and are doing better in work or school	82	83	NA
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff (community based domain)	83	92	NA

[7] 2009 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/dataoutcomes/urs/2010/palau.pdf

ATTACHMENT C

DCFS Community-Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2011

From mid April to the end of June, 2011, 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 and Adolescent Services (SNCAS) and Outpatient Services, Wraparound in Nevada, and Early Childhood Mental Health Services under the Northern Nevada Child and Adolescent Services (NNCAS). Parent/caregiver and youth responses are reported 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 60% or less than a 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 should be taken. Programs may also want to compare results with previous survey findings.

Following each service area's domain results are respondents' remarks regarding what was most helpful about the services they received, what would improve the services they received, and any additional comments they might have had.

A 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 449 parents/caregivers and 230 youth in program services. Survey participants were solicited by clerical/other office staff at the 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	79	495	16%	59
WIN	59	198	30%	50
Early Childhood Mental Health Services	99	342	29%	N/A
SNCAS Total	237	1,035	23%	109
NNCAS				
Outpatient Services	75	208	36%	66
WIN–Reno/Rural	96	133	72%	55
Early Childhood Mental Health	41	120	34%	N/A

Services				
NNCAS Total	212	461	46%	121

Statewide Total	449	1,496	30%	230

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 2011

SNCAS
Children's Clinical Services Results

Parent/Caregiver N=79; Youth N=59 **Total Served = 495 Sample = 16%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	88	75
Services were scheduled at times that were right for us.	93	81
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	94	89
The people helping my child and family stuck with us no matter what.	93	84
I felt my child and family had someone to talk to when he/she was troubled.	94	85
The services my child and family received were right for us.	89	79
I received the help I wanted for my child.	91	84
My family got as much help as we needed for my child.	89	82
POSITIVE OUTCOMES		
My child is better at handling daily life.	81	79
My child gets along better with family members.	80	77
My child gets along better with friends and other people.	79	83
My child is doing better in school and/or work.	79	79
My child is better able to cope when things go wrong	70	73
I am satisfied with our family life right now.	77	62
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	82	63
I helped to choose my child and/or family's treatment goals.	92	79
I participated in my child's and family's treatment.	96	80
CULTURAL SENSITIVITY		
Staff treated our family with respect.	95	93
Staff respected our family's religious/spiritual beliefs.	97	86
Staff spoke with me in a way that I understood.	97	89
Staff was sensitive to my family's cultural and ethnic background.	96	83
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	95	N/A

I have people that I am comfortable talking with about my child's problems.	94	N/A
In a crisis, I would have the support I need from family or friends.	93	87
I have people with whom I can do enjoyable things.	95	89
I am happy with the friendships I have.	N/A	83
I feel I belong in my community.	N/A	74
FUNCTIONING		
My child is better at handling daily life.	81	79
My child gets along better with family members.	80	77
My child gets along better with friends and other people.	79	83
My child is able to do the things he/she wants to do.	85	77
My child is doing better in school and/or work.	79	79
My child is better able to cope when things go wrong.	70	73
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	92	80
Staff explained my child and my family's rights and confidentiality issues.	97	84
I receive support and advocacy from my Nevada PEP Family Specialist.	89	77
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	91	83
Our family is aware of people and services in the community that support us.	90	75
I am better able to handle our family issues.	91	65
I am learning helpful parenting skills while in services.	92	84
I have information about my child's developmental expectations and needs.	94	70

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ▪ He has less out breaks in class and at home. He is able to do the tasks he asked to ▪ he has learned to cope with his mother's death. ▪ Counseling and WIN services and PSR worker ▪ He is better. All around he can handle life better and understand things more clearly. ▪ Support ▪ the constant helpful advice I/we would receive from therapist. ▪ my son's counseling services ▪ Having someone tell me I'm not the only parent going through this. ▪ My son feels he can talk to his therapist about anything and I feel I can always reach out ▪ He can focus on school work and have more fun at home. ▪ My children therapist has always been there for us, she has help improve our life quality by providing all kinds of referrals for programs that have benefit our children. Therapist is a good listener and relates to my children. ▪ Getting an early start on his behavior and getting on right direction with school and home. ▪ The therapist gives us solutions and tools to use when we need help. ▪ She has learned to calm herself down. Her episodes are not that bad anymore. ▪ A little bit of communication ▪ that the cost is free ▪ my work puts my child in need of care ▪ My child likes her counselor ▪ that my son has improved in his studies and his personality ▪ His behavior has changed a little because he was aggressive, he	1. What has been the most helpful thing about the services you received? ▪ My meds and being able to have people like my therapists. ▪ The talking/counseling ▪ seeing family ▪ The exercises I have to do to help me relax ▪ Meds and my therapist. ▪ My counselor ▪ That I get most of my medication for free ▪ there is someone I can talk to ▪ I am more capable of handling stress. ▪ Both of my parents do not have insurance and cannot afford my meds or doctor visits, so DCFS has been very helpful. ▪ I know my therapist better than my parents. My therapist knows me better than my parents. ▪ I get to go to sudway wen I am done ▪ the support of the staff ▪ Better able to control OCD ▪ I have someone to talk to. I have someone to talk to my parents, and help both of us out. ▪ Learn to get along and respect ▪ the most helpful thing is that when I need something for football or track or school I can always get it when I ask my caseworker. ▪ Talking to my foster Mom and the people in the service for Foster Care to help me out. ▪ When I'm in a bad mood I can talk to my therapist ▪ the most helpful thing I have received is when my therapist talks to me when I need someone to talk to everytime I come for therapy session. ▪ Truth be told everything is equally helpful. I can't choose one thing over another. ▪ well nothing big has happened in my life so not really anything. ▪ It's good to talk to somebody about my problems.

Parent/Caregiver comments	Youth comments
learned to control himself ▪ Help from a psychologist ▪ She is more content, positive. Her character has improved a lot, her grades are very good ▪ therapy and medication ▪ Provides my daughter with a safe place to get guidance and help with her troubles she may not be comfortable sharing with family. ▪ Helping my child with the therapy that she needs ▪ I have learned lots of new things and maintained my goals thanks to my therapist. ▪ that my son has focused more on school and his behavior has improved ▪ that she is getting better ▪ You have helped me a lot with my daughter's problem; she seems much better ▪ The quick reaction taken by therapist in times of emergency. And not taking anything lightly my daughter says when relating to suicidal tendencies. My therapist's reaction saved my daughter's life. ▪ everything in the therapy improves the behavior ▪ The talks with the psychologist ▪ That he knows how to manage his emotions and we aren't always upset like before. ▪ the medications and the time you give her ▪ trying to get a diagnosis (moving forwards toward a diagnosis) ▪ Support for parental decisions regarding behavioral issues. ▪ CLIENT being able to cope with his stress and anxiety. ▪ that we have a lot of communication and now we don't argue, we talk. ▪ that he has learned to control his anger ▪ Along with the help provided to my son helping us with the parenting skills to aid him has been the most help. ▪ Help my child with his emotional problem ▪ My daughter was put on the right medications for the exact problem. ▪ Being able to talk to some and get some direction with my son. ▪ I feel I have the support but we need family counseling - I feel family counseling will help us a lot ▪ our counselor ▪ Knowing that there is always someone to answer the phone to give advice on what to do when my child starts to act out and the group support from counselor, case manger, PSR worker and NV PEP ▪ They are always here to answer any of our questions ▪ they very good, help anything my child ▪ Our therapist was extremely supportive during a major crises with my daughter ▪ the knowledge that our therapist has helped our family in so many ways ▪ she has someone neutral to talk with ▪ They are here for us. Thank you. ▪ He is doing better all around ▪ he has been learning how to control himself (if he wishes to) ▪ the support I receive ▪ the kids therapy - therapist ▪ the doctor given him his meds is a psychiatrist - and the medication is so he is able to concentrate in class and be able to learn. ▪ she is happier with herself ▪ don't know, haven't been often enough ▪ Just being able to talk about our issues and make a plan to better ourselves, our parenting skills, and to understand each other better. ▪ My son has some one on his side he can trust ▪ Can rely on services to be there when needed ▪ the care and love that they show us to help my child do better	▪ Dr. has helped me with free medication. ▪ having somebody to talk to about my problems. Giving me ideas about how to handle my problems ▪ They help me and I can tell them private! ▪ The people ▪ Simply knowing that I can get the support I need. ▪ Easy to talk to ▪ can talk ▪ having a source to vent to who can support and help guide me. ▪ Most helpful thing was being able to control my temper and not scream at people constantly. ▪ I do not now ▪ me and [female name - sibling?] have been getting along more and not getting into as much fights as we use to. ▪ The most helpful thing in the services I received are helpful with my family problems and my social life. ▪ That I have learned to cope with my surroundings ▪ N/A ▪ Getting to talk to someone ▪ having someone to talk to that knows how to help ▪ The most helpful thing I received is when they try to work with [me] about my grades from school ▪ Having someone to talk to. Therapist is awesome. ▪ My behavior has gotten better ▪ I am more out more so my social abilities ▪ having someone to listen to me ▪ getting me into DWTC when I needed it

Parent/Caregiver comments	Youth comments
▪ all the support from the entire team ▪ Just having the service ▪ Just having the service there. ▪ Better behavior management ▪ One on one therapy - Day Treatment ▪ Being able to call ▪ Not in care long enough	
2. What would improve services your child and the family received? ▪ a better social worker ▪ being able to have longer session times ▪ To have the same therapist ▪ Nothing comes to mind at the moment. You all are on the right track! ▪ weekend hours. ▪ there was a very long delay in seeing the doctor. I feared my child would not last the duration to the help ▪ to have a steady therapist. ▪ Your program is been more than what we expected. ▪ With help we received we are feeling better on our son needs. This program help us a lot to understand his needs. ▪ I know my child's problems are ongoing, but I wish the weekly sessions were stretched out longer, maybe every two weeks as we progress in therapy. We have been going over a year now. ▪ if they told me my child was going in a crisis center ▪ nothing ▪ I'm new to this so I don't know what to expect ▪ if you had bilingual doctors ▪ We like the services that they have given us and they have helped us in the situation we are in. ▪ informal therapies ▪ I don't know because I am pleased with the service ▪ nothing ▪ Smaller patient / doctor ratio so the patients can get in quicker. ▪ all services are really good ▪ Everything has gone good. ▪ the wait list should be shorter ▪ that they listen to her and give advice ▪ I know because of budget cuts the office is now shared with the Social Security office with adults. I would have liked the offices kept just for the kids. At times these adults seem to be homeless and intimidating. ▪ In all, thanks for helping us ▪ For the moment, I am satisfied with the services that they have allotted me. ▪ Everything has become very good for us ▪ they depend on your health ▪ Need more time for a confirmed diagnosis which would then help with direction of treatment for child and family ▪ meeting goals ▪ nothing needs to change; it is very good ▪ For the help we have received, I feel that it is good. ▪ services received help my child and our family to face some emotional problem ▪ More money from the state to fund for medication, doctors and shrinks and counselors. To better help our kids to be a better person. ▪ Family counseling ▪ I believe my son receives the best services for his needs, I think to improve services would depend on him and how he vocalizes what he needs. ▪ help my child ▪ More in depth suicide prevention material especially for teens on anti depressants ▪ everything is fine with the services we receive ▪ Can't think of any - it's all good ▪ very much so ▪ None - I get all the help I need	2. What would improve services you received? ▪ I don't know ▪ If I could get off of my medicine ▪ more freedom, PSR services ▪ More detail in what to do for the exercises. ▪ Nothing ▪ nothing ▪ No Ideas, honestly. Sorry ▪ More or better programs (scared straight) things to show or explain the consequences of my behavior. ▪ Services are really good ▪ No! ▪ free food ▪ I honestly don't know ▪ idk sorry ▪ I think nothing would improve my service because I think it's good how it is now. ▪ Nothing, really. Everything is fine as it is now. ▪ Nothing because I have more than stable life. ▪ Nothing ▪ Nothing ▪ I would like help finding a job. A Career counselor who only works with me on finding a job. ▪ Nothing ▪ I don't know ▪ medication ▪ To focus more on what is going on around the child and first work around that then slowly dissolve into other things. ▪ I do not now ▪ everything is fine ▪ I think the services I received are fine. ▪ Nothing needs to be different ▪ nothing ▪ I am happy with services I am receiving ▪ Everything, I am fully satisfied ▪ nothing ▪ Nothing, everything is just good here • I'm satisfied with the services

Parent/Caregiver comments	**Youth comments**
▪ Nothing, really. I believe we are getting all the services we need. ▪ If you had been located closer to where we live. ▪ I would like to see more progress from my child but I do understand it takes time and patience. Sometimes it seems like the counseling service are still about the same issues, like we haven't made much progress. ▪ If the child would co-operate more and try harder ▪ Nothing ▪ Nothing at this time. I am very pleased with what assistance we are getting. ▪ None really… ▪ More clothing support seasonal - Help pay rent - bus passes, transportation	
3. Additional Comments ▪ Thank You ▪ I am very thankful for what I am receiving. Without the state's help I would be lost. ▪ we thank everyone help us success on a daily lives. Without this program we don't know what will happen or our son live. These programs is excellent sources for people with non medical insurance. I hope people will find programs like these easier. ▪ I am happy with our therapist ▪ Only to thank you for your help. The rest depends a lot on our children and our relationships. ▪ I don't want to lose my services ▪ Thanks for all the services you have given my son and family and don't stop supporting these clinics. Many thanks. ▪ We are happy with the work of our therapists ▪ The help I have received is excellent, but I often wish that I could receive them around three years; thanks for this program that has helped a lot with the development of my son. ▪ Thank you so much to my therapist for helping me be a different person. I really enjoyed my time here and felt very welcome. ▪ Only to thank you for all the support that you have given me. With all that I could help my son come out ahead and we could understand him. Thank you. ▪ thanks to the doctors and nurses ▪ the therapist was very attentive to my daughter and thanks for helping her complete her work ▪ Our therapist had done a great job at helping my daughter . If it wasn't for her and all the help she and her office has given us, I don't know if my daughter would be alive today. A big thank you to our therapist and the office at South Neighborhood. ▪ Everything is very good and thanks for all the services that have made things easier for me and this is a great help for all the people who are in my situation. ▪ I would like it if there were more service centers like this in my city and if there were more publicity so the people knew these centers for help existed. And I want to give thanks to our therapist for all her help and support that she granted us. Thanks! ▪ Nothing. Thanks for your services and God bless you. ▪ Need clearer path for Medicaid application process for guardians ▪ Thank you for the service provided for my family and my daughter. "Thanks" ▪ We give thanks to the people who were working when we came for being very kind, especially our therapist, who is very professional in what she does and a good person, kind and respectful. Thanks. ▪ thanks ▪ The Charleston facility and staff have been very helpful. ▪ we thank everyone and the staff for all the help we receive ▪ None ▪ Thanks to our therapist, she did a truly wonderful job. ▪ nr	3. Any additional comments? ▪ No ▪ Nope ▪ IDK! ▪ get free food ▪ I love our therapist! Also, (the lady at the front desk) always makes me feel welcome. ▪ I love my therapist - she's really cool, nice and she understands. ▪ Me therapists Dr. is very awesome… don't fire him you'll regret it. Thank you and have a nice day. ▪ You people rock ▪ N/A ▪ nothing ▪ I do not like to go to the PO box and grls club ▪ Our therapist is really helpful, I really like her. She is extremely nice and she is really funny and cool. ▪ I think that counselor is very good and helped us with our problems. ▪ No ▪ I love my therapist. She's awesome

Parent/Caregiver comments	Youth comments
▪ I am very thankful for all the help we have received. I do not know what we would have done if we couldn't receive these services. I absolutely appreciate the hard work and dedication from our therapist. ▪ Just want the situation to improve so we can have a life. ▪ Our therapist Rocks	

SNCAS WIN Results		
Parent/Caregiver N=59; Youth N=50 Total Served = 198 Sample = 30%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	89	72
Services were scheduled at times that were right for us.	86	72
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	84
The people helping my child and family stuck with us no matter what.	93	84
I felt my child and family had someone to talk to when he/she was troubled.	95	86
The services my child and family received were right for us.	82	74
I received the help I wanted for my child.	88	78
My family got as much help as we needed for my child.	86	76
POSITIVE OUTCOMES		
My child is better at handling daily life.	79	76
My child gets along better with family members.	73	82
My child gets along better with friends and other people.	82	86
My child is doing better in school and/or work.	74	78
My child is better able to cope when things go wrong	61	78
I am satisfied with our family life right now.	79	58
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	79	52
I helped to choose my child and/or family's treatment goals.	88	72
I participated in my child's and family's treatment.	93	71
CULTURAL SENSITIVITY		
Staff treated our family with respect.	90	90
Staff respected our family's religious/spiritual beliefs.	96	80
Staff spoke with me in a way that I understood.	95	84
Staff was sensitive to my family's cultural and ethnic background.	96	80
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	95	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.	95	94
I have people with whom I can do enjoyable things.	93	94
I am happy with the friendships I have.	N/A	90

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WIN Results

Parent/Caregiver N=59; Youth N=50 Total Served = 198 Sample = 30%	Parent/Caregiver Positive Response %	Youth Positive Response %
I feel I belong in my community.	N/A	76
FUNCTIONING		
My child is better at handling daily life.	79	76
My child gets along better with family members.	73	82
My child gets along better with friends and other people.	82	86
My child is able to do the things he/she wants to do.	93	78
My child is doing better in school and/or work.	74	78
My child is better able to cope when things go wrong.	61	78

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	76
Staff explained my child and my family's rights and confidentiality issues.	95	80
I receive support and advocacy from my Nevada PEP Family Specialist.	84	77
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	89	83
Our family is aware of people/ services in the community that support us.	91	80
I am better able to handle our family issues.	86	62
I am learning helpful parenting skills while in services.	93	84
I have information about my child's developmental expectations and needs.	93	68

Parent/Caregiver comments

1. What has been the most helpful thing about the services your child received?

- learning more about his behavior and available treatments
- They are great with everything we need
- Everything has been helpful but he doesn't want it bad enough, therefore there's no improvement
- Her change in attitude and to see her life and the things she has gotten over
- behavior in school and the community
- supports offered and respect for Foster Parents input
- all the services my child received are very helpful
- My therapist has been extremely involved in her case and is a great support for her.
- The services are consistent
- All case workers are always helping her, therapy, Dr. Appt, they have been very helpful
- just what grate staff they
- that the children have someone else they can talk with other than in home
- gained knowledge of transitional and educational programs
- ability to more better services
- Accessing all educational options
- some of the social skills they teach us in the group home
- The support that my child has
- Having a strong support team/system
- counseling
- knowing that he has someone he can talk to
- Tutor help him learn how to read
- Seeing her really open up about her anger/emotional issues - and learning to address them.
- The change in my daughter - she no longer tries to be the parent. The respect of staff - The honesty and our therapist has truly - honestly been as good as gold to me and my family.
- Quick response and everyone is on the same page.

Youth comments

1. What has been the most helpful thing about the services you received?

- I have learned new things
- Getting over what my "dad" did to me.
- regulating family visits
- I really don't know
- It helped me because I get confidence and know I can improve my behaviors
- to believe in myself and family
- They help me out when I have problems
- The most helpful thing about the services are that my team helps and cares about my behavior.
- CFT
- chails focus
- making me realize the things that I do wrong
- unknown
- Being told how to communicate better
- Child focus is helpful and I would like to keep that.
- Getting a meeting so I can talk to everyone
- med = my Lawyer, Big Red, medicaid, my therapist
- IDK
- N/A
- nothing
- having someone advocate for me
- My PSR worker and my therapist
- the time they take to check up on me
- n/a
- The workers have been there for a long time And the workers really care
- When people push me forward or constent reminders
- having people to support me through everything
- Learning things about myself; and how to get along with others
- that the medication may change my Head Ache and help me focus more
- the most thing about the services are that I have a chance to

▪ that he know that there is someone outside of the home that have his best interest at heart, that he can truly depend on, he look forward to talking with you guys. ▪ Getting support with transitions and any questions that our family has had ▪ Communication and quick response when there is a crises. ▪ The whole team ▪ Overall Daily Support ▪ Medicaid, pediatrician, siblings visits ▪ They are helping me address everything needed with him ▪ P.S.R. Worker ▪ PSR Services, Therapy, Medication/Therapist/Doctor, Great WIN Worker, The Rock, BST Service, PEP Worker, CFT Meetings. Support at school setting up IEP or SO4 Plans.. ▪ PMP Worker is very informative of services that provide the help he needs. ▪ Support to our family as well as recommendations from our WIN worker. ▪ Knowing that he has a choice in completing his treatment goals. ▪ to be honest, don't even know at the moment ▪ He is improving a great deal with his behavior and social skills. ▪ Knowing she has a team that supports and care about their need and wants ▪ being involved in her life helping her grow and being there for the family ▪ communication with the team ▪ Teaching me how to cope with their issues and to have patience ▪ support from our therapist ▪ Teamwork has been pretty good. • yes, their excellent	share how I feel about the situation • That I can talk to people about how I feel • They get things done • I like my foster parents and PSR workers • moved me from St Jude's • the respect • that when I'm going through something I know my foster mom will never give up and turn her back on me. • the most helpful thing about the services I received is that I have someone to take care of me and buy me stuff • The most helpful thing about the services I received is that I have someone to take care of me. • all of the services help me • Someone to talk to • In a good family or group home • she has been there for me when I needed it. Got things done when it needed to get done • that I can learn skills and set goals for myself before I go home • Don't know
2. What would improve services your child and the family received? ▪ Everything ▪ If there were programs for teenagers that will help them through a "Step" program on respect. ▪ satisfied with the services, don't change them ▪ Less people involved. This is a large family (6 kids in Foster home). Contacts were overwhelming in beginning. 2 CASAS, 3 therapists, 3 Olive Crest workers, PSR worker, DFS worker, WIN worker and occasional doctors, dermatologists, specialists most of these contact came 1 or more times per week. I can understand foster parent burn out not kids behaviors but demands of system. WIN worker has helped to intervene and lessen some involvement. Sometimes when trying to meet needs of children in Foster care or crisis we forget the importance of times to be a kid and miss opportunities to promote "Normal" family life. ▪ I think is nothing to change regarding to the improve services to the child and her family ▪ I'm satisfied with WIN services ▪ nothing needed ▪ My child attitude have change a lot , she's very helpful ▪ just to continue services ▪ everything seems to be adequate ▪ Realistic tools to handle behavior - different rules for toddlers and teens - less adversarial attitude toward caregivers and by DFS / licensing. ▪ nothing at this time ▪ Less paperwork / surveys etc. ▪ Nothing! Everything was helpful and clear to us. ▪ I don't know because I am pleased with the service ▪ Just continuing ongoing treatment - sticking to what works. ▪ Just consistency on ongoing treatments! ▪ Can't think of any at this time, seem as if everything is bein taken care of. ▪ I am satisfied ▪ more open communication ▪ Help with transportation ▪ All services needed for my family have been met with great satisfaction. I know each family situation is different and I	2. What would improve services you received? ▪ I don't know ▪ No ▪ Just perfect with PSR ▪ Nothing ▪ p.s.f. services ▪ N/A ▪ not so many rules ▪ Taco Bell will help my services ▪ It would make it better for me is by having allowance and getting paid $10.00 a week instead of others randomly giving it to me. ▪ no ▪ Help with transportation ▪ IDK ▪ nothing ▪ nothing ▪ Nothing ▪ going back home ▪ Nothing, I actually feel very good with the services I have received over the past years ▪ Nothing. I have an amazing team ▪ I don't know ▪ nothing! I love my team ▪ if I improve my weight a little better ▪ I like the way the services are already I feel that I have all the support I need ▪ It would help more communication with me and my foster family ▪ Nothing ▪ I need a tutor and some friends in the house ▪ freedom ▪ Nothing at all just begin [being] there for me still and supporting me ▪ Is my behavorie. My action and not beind disrepectful to people. ▪ I s my behavior. My actions and Not being disrespet ▪ easework help me moved ▪ Take some things into consideration.

know that each method has been for what is best for my family Communication is key. ▪ We are very pleased with our current services and would not change anything. ▪ nothing ▪ being able to see the therapist more ▪ Provide child care services when we have licensing class (natural kids and Foster kids) ▪ Less services with therapist more social skills out of the house ▪ Less services with Therapist more Social Skills out of the home ▪ Reinstate title 16 so my son can have his PSR worker back. He can not qualify for Medicaid. ▪ Everything was handled properly. I was very satisfied. ▪ good	▪ I would improve when I go to my dad ▪ to not give a different [?position] because people with R.A.D build a relationship with that person and then that person leaves and I have to start over ▪ if I didn't have services and I could go home ▪ Don't know
3. Additional Comments ▪ My worker has been very efficient in her work. She has helped us a lot. ▪ My child is receiving an excellent service ▪ Extremely pleased! ▪ I am glad to have her at home, she's a very special girl. ▪ keep the wood work up ▪ We should be working together - have more tolerance for opinions and experience, and be less prone to look for negativity and reasons to criticize. ▪ As said my therapist has been professional - She has been caring - showing concern - addressing problems/issues - then handling them the right way - She will be missed. ▪ It's been an absolute joy having my therapist in the team - She was the only one who actually cared - or returned my calls more than my own case worker has ever. We will miss her - And hope my new therapist is as awesome as my old therapist has been. Our therapist is the one who did something - who showed initiative when my kids needed something. Thank You. ▪ Services have helped our family adjust and tackle issues. The therapy, medication, education, WIN has been a great help. ▪ I wish that DFS would or could follow in their footsteps or take and used the methods of understanding of wanting what is best for ones family. Just listen and communicate which is and will always be key. Each family is different be mindful of this. ▪ Thank you so much for helping our family. ▪ We love our WIN worker and she has been a great member of our team.	3. Additional Comments ▪ I like my service with my PSR ▪ NOOO!!! ▪ I think why some children don't coop. with workers is because there's been so many people in and out of their life. ▪ help at home not at hospital ▪ Taco Bell is something! ▪ nr ▪ I feel like I should stay in child focus, have a PSR worker and have my therapist until I am at least 15-16. ▪ No ▪ no ▪ No Thanks ▪ My therapist is great, efficient, polite and eccentric ▪ nope ▪ Nope thanks for everything you guy's did for me I appreciate it thanks so much love ya! [signature] ▪ The workers are very verbous…

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=99; Youth = NA Total Served = 342 Sample = 29%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	86	N/A
Services were scheduled at times that were right for us.	94	N/A
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	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.	90	N/A
I received the help I wanted for my child.	90	N/A
My family got as much help as we needed for my child.	90	N/A
POSITIVE OUTCOMES		

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=99; Youth = NA Total Served = 342 Sample = 29%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is better at handling daily life.	85	N/A
My child gets along better with family members.	85	N/A
My child gets along better with friends and other people.	82	N/A
My child is doing better in school and/or work.	85	N/A
My child is better able to cope when things go wrong	76	N/A
I am satisfied with our family life right now.	77	N/A
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	79	N/A
I helped to choose my child and/or family's treatment goals.	92	N/A
I participated in my child's and family's treatment.	98	N/A
CULTURAL SENSITIVITY		
Staff treated our family with respect.	97	N/A
Staff respected our family's religious/spiritual beliefs.	97	N/A
Staff spoke with me in a way that I understood.	98	N/A
Staff was sensitive to my family's cultural and ethnic background.	96	N/A
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	95	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.	96	N/A
I have people with whom I can do enjoyable things.	96	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.	85	N/A
My child gets along better with family members.	85	N/A
My child gets along better with friends and other people.	82	N/A
My child is able to do the things he/she wants to do.	87	N/A
My child is doing better in school and/or work.	85	
My child is better able to cope when things go wrong.	76	N/A

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	91	N/A
Staff explained my child and my family's rights and confidentiality issues.	97	N/A
I receive support and advocacy from my Nevada PEP Family Specialist.	92	N/A
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	93	N/A
Our family is aware of people/ services in the community that support us.	86	N/A
I am better able to handle our family issues.	93	N/A
I am learning helpful parenting skills while in services.	90	N/A
I have information about my child's developmental expectations and needs.	96	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ▪ availability of worker - assistance	1. What has been the most helpful thing about the services you received? • NA

- Understanding what is normal and not. Getting tips on different things to try.
- My therapist has been very helpful and supportive to myself and family during the time in which we have had our nephew living with us.
- he is talking more and gaining weight and showing improvement
- understanding medical support, education
- having our questions answered
- she is learning a little impulse control and to talk about her feelings
- it is nice to have someone to talk to about our child
- My child now sees that other people than me want her to do her best
- the correct services she needs
- learning how to share and get along with siblings
- her sexual behaviors have reduced drastically
- helping him with sleep
- that they prepared us to talk and communicate easily
- He can share and play with other kids. We are still working because he is impulsive and he has trouble playing with others
- He is getting over what happened to him.
- that she's learned to share, be open minded, more social
- her time with her mom and having a person in which mom can talk too
- going to school and meeting more friends
- understanding his impulsive behavior
- she are doing much better with all the things she has going on
- the tips, the encouragement, and understanding the situation
- having the ability to do things of her own
- they are getting better with their behavior and stranger danger
- Our family looks forward to seeing our therapist, especially to come and work out our day to day issues and events
- help with his speech and attitude
- its taught the family how to understand and deal with issues
- the help to better handle my child's severe tantrums
- the extra support and help I have received. The children need to hear beneficial ways to handle their tantrums from another person other than me.
- both boys have learned how to use words rather than fists to express themselves
- learning ways to help my child and use new skills and helping the rest of the family learn new skills and apply them
- learning ways to help my child cope and use new skills and helping the rest of the family learn new skills and apply them
- diagnosis and medication
- weekly meetings with our therapist
- Weekly visits with our therapist

- she's now more confident, she learn how to play with other kids, behaves really good
- Not as many violent outbursts in the home
- It has helped him better cope with situations
- My better understanding of her behavior has made it easier to cope when she has a flare up. I know it's not all my fault.
- our therapist is willing to work with the changes in his behavior and in our family
- We just started in the program
- emotional support and guidance
- A helpful thing I've learned how to redirect and better interact with my son
- Being able to understand what's going on with my daughter and how is a positive way to handle things that are difficult for her. And to still know that it's ok
- why he does the things he does and how long it take to see results months or years
- I don't know
- learning to share
- Convenient location, work appointments to my schedule, our

therapists have been very supportive and available when needed ▪ the worker going to daycare / school instead of us going into the office ▪ They are very kind, listening, and offer good suggestions ▪ the weekly counseling paired with access to psychological evaluations has been tremendously helpful ▪ extra help with difficult issues involving our children ▪ new ideas about how to handle problems that arise ▪ really has calm down ▪ behavior modification for child and parent ▪ helping me learn ways to approach parenting and coping with long outbursts from my children ▪ coping with her anger and withdrawals and behavioral issues ▪ learning to cope with his issues on everyday basis ▪ Learning to cope with her everyday issues ▪ Learning to cope with my grandson on a daily basis ▪ the behavior have got better ▪ the most helpful thing about the services is that he's getting all the help he needs with the therapy so that's really helpful ▪ being able to reach the therapist by phone as needed and discuss issues. ▪ that she can better deal with day to day problems. Better than before ▪ correct information ▪ learning more ways to help my child ▪ being able to talk about his behaviors each week and getting suggestions on how to help him specifically ▪ her behavior. She is more happy and cheerful ▪ helping me to calm my child down and how to talk to my child ▪ The ability to talk with my child's therapist about issues and concerns. ▪ someone has been there to help my wife and I understand our child's needs ▪ emotional support provided ▪ Consistency - they believed me when I told them what was going on and helped find and secure appropriate help/services. ▪ Safety, security and learning that every time a stranger comes that she not leaving to the next strangers house. ▪ availability of provider ▪ Availability of the provider ▪ My therapist teaching me to look at things positively ▪ helping him to cope ▪ the tools given to solve and evaluate problems ▪ learning to get along with other peoples. Learning the do's and don'ts ▪ too soon to comment on this ▪ I have and am still getting ideas about his behavior especially in school ▪ My therapist helps me understand why he does/says certain things - and how to re-route his attention and how to respond to certain circumstances ▪ I have learned ways to deal with his behavior and ways to redirect him and calm him ▪ we are learning to cope and improve family life in learning also how to notice what needs my girls needs ▪ the attention she gets lets her know she's special and important to someone other than mommy ▪ ever thing is good with the work • My worker has helped my child with her self esteem	
2. What would improve services your child and the family received? ▪ Make the government more faster! ▪ I'm not sure, he's making exceptional progress ▪ more workers with a lesser load ▪ I would like to see more progress being made. My child needs a firm hand and not sure if current services are firm enough for her. ▪ I'm not sure I feel that the staff has done the best they could so	2. What would improve services you received? • NA

far.
- not sure at the moment
- for CLIENT to be in a behavior school or setting to learn how to listen and follow directions
- less hours of therapy
- knowing what was wrong with my child
- Everything is good
- I think he needs to continue his therapy
- Everything is good right now. Thank you for your support and training.
- I'm satisfied with the service they have gave me
- maybe more inter action for mom with parenting classes
- when he got services, he got much better
- no change, everything is good
- the service is alright because she has a good person working with her and someone she likes
- If there was anyway to see him when he has a temper tantrum and then for tips on how to handle it
- to keep the services going
- Nothing
- can't think of anything
- At this point all my expectations and more have [*been]* met by our therapists
- I'm happy with all services my child here. All the Therapy she have been taking is helping everyone at home, she's good girl.
- more in home or community services
- being able to have a more flexible schedule
- At this time she is moving forward very well. Everyone is doing a great job
- We're happy
- Sooner response from the case worker to get this started. She has been with me almost a year now and we just began the program.
- everyone needs to listen
- one on one with CLIENT without me or mom
- services need to be faster. My foster child went weeks without her first visit
- So far, I can't think of any but this is our second meeting
- to have the same services where we live
- I have no idea, I never even expected this much
- more time with services
- what's available? Preschool, still has abandonment issues
- none at this time
- unsure - working with new treatment program currently haven't had time to eval results yet.
- N/A
- Services are great!
- Services are great!
- Services are great!
- we have received a lot of support and improvement from your services
- Well I would like to see self-control and teaching him to call me mommy instead of *[by first name]*
- I think that the service is great. I would not improve anything
- as of now we are satisfied
- nothing
- So far, things are fine. We're still working week to week on different issues that come up
- None, the workers are wonderful
- I wouldn't change anything
- N/A
- we are good for now with current services
- My opinion personally, he was excellent.
- more workers dedicated like my therapist.
- nothing I can think of at this time
- overall a very good service provided
- nothing everything is wonderful
- too soon to comment on this
- I am very happy with my services. The one and one

experiences I have had has helped my grandson 10 fold. I want them to be with us forever. ▪ If we could hurry up and adopt him and if the system didn't move so slow, but I know this all takes time. ▪ To keep on track with learning new stuff and new ways to parent my girls and deal with their disabilities and how to grow stronger ▪ When client starts opening up more and we let her know she's here to understand any situation that bothers her. ▪ nothing	
3. Additional Comments ▪ Our therapist has done an excellent job helping me understand and give ideas to correct behavior. ▪ My therapist has been the only person during this whole process that has kept my family needs in mind and has helped support the family not just the foster child which has been very helpful to us. CLIENT has made great changes for the better while working with our therapist. It has been a pleasure to work with her. ▪ You ladies seem very caring about our situation and can tell you like to help us for the love not for the money. You deserve higher pay. ▪ I hope my son can continue the services. I want to thank our therapist for the big help with my son. Thank you, thank you. ▪ Thanks ▪ I love the service and also the communication she has with my daughter and is happy with services ▪ thank all staff for support and help in the family's situation ▪ nothing, thank you for everything ▪ our therapist was great! ▪ I felt that the workers that worked with us genuinely cared about us and wanted us to succeed ▪ My therapist has been doing a wonderful job! I would say thank you for all the support I got for her because it was not easy at all for me. ▪ Thank you! ▪ We have received services from 2 therapists. The first was GREAT. The second has been overworked and doesn't seem as interested in helping us. ▪ I am very happy with her progress. ▪ Thank You ▪ It has been a blessing to know that we had the support we needed throughout this process. Thank You! A special thanks to our therapist for all she did. ▪ working with my clinician has helped by working with me to understand how to better cope with situations ▪ all the staff has been incredibly caring and helpful and has made a huge difference in my child's behaviors and outlook on life ▪ Early childhood Services ▪ I want to thank our therapists for guidance, to help me cope with my three grandchildren ▪ I want to thank our therapists for all their guidelines which makes my life, as grandma, with three children easier to cop with them. ▪ I want to thank our therapists for outstanding guidance to help me cope with my grandchildren on a daily basis ▪ I'm so thankful that she was able to help her in everything ▪ I thank you so much my therapist for the help ▪ My therapist is very helpful and understanding. She's a great help. ▪ I have done nothing but great things with her help ▪ My therapist is a wonderful person and GREAT at what she does. She has opened my eyes to so many things that helped me understand what he is going through and how this all effects him. ▪ My therapist is GREAT!!!	3. Any additional comments? • NA

NNCAS Outpatient Services Results		
Parent/Caregiver N=75; Youth N=66 Total Served = 208 Sample = 36%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	92	91
Services were scheduled at times that were right for us.	96	92
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	98	84
The people helping my child and family stuck with us no matter what.	97	88
I felt my child and family had someone to talk to when he/she was troubled.	96	86
The services my child and family received were right for us.	96	88
I received the help I wanted for my child.	97	88
My family got as much help as we needed for my child.	100	93
POSITIVE OUTCOMES		
My child is better at handling daily life.	92	90
My child gets along better with family members.	91	89
My child gets along better with friends and other people.	88	92
My child is doing better in school and/or work.	85	93
My child is better able to cope when things go wrong	85	86
I am satisfied with our family life right now.	82	81
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	93	83
I helped to choose my child and/or family's treatment goals.	97	93
I participated in my child's and family's treatment.	98	93
CULTURAL SENSITIVITY		
Staff treated our family with respect.	99	93
Staff respected our family's religious/spiritual beliefs.	99	95
Staff spoke with me in a way that I understood.	100	93
Staff was sensitive to my family's cultural and ethnic background.	99	89
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	97	N/A
I have people that I am comfortable talking with about my child's problems.	97	N/A
In a crisis, I would have the support I need from family or friends.	96	94
I have people with whom I can do enjoyable things.	98	95
I am happy with the friendships I have.	N/A	97
I feel I belong in my community.	N/A	99
FUNCTIONING		
My child is better at handling daily life.	92	90
My child gets along better with family members.	91	89
My child gets along better with friends and other people.	88	92
My child is able to do the things he/she wants to do.	89	88
My child is doing better in school and/or work.	85	93

NNCAS

Outpatient Services Results

Parent/Caregiver N=75; Youth N=66 Total Served = 208 Sample = 36%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is better able to cope when things go wrong.	85	86

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	94	91
Staff explained my child and my family's rights and confidentiality issues.	97	93
I receive support and advocacy from my Nevada PEP Family Specialist.	93	91
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	93	92
Our family is aware of people/ services in the community that support us.	97	98
I am better able to handle our family issues.	94	87
I am learning helpful parenting skills while in services.	94	92
I have information about my child's developmental expectations and needs.	95	93

Parent/Caregiver comments

1. What has been the most helpful thing about the services your child received?

- Getting a diagnosis and getting his meds at a discounted price.
- There is an outlet for her during a crisis. [drew a happy face]
- Surviving Life Skills. Learning to deal with stress breathing exercises. Our most helpful service is our therapist. She gave my son his life back and also saved my son's life!! Without her help, understanding, patience and support I honestly do not know where my son would be in his life. She has given myself and son a bright and happy loving future. Thank you for your services and thank you so much for our positive therapist. I have no complaints, only positive. Thank you once again.
- The trust our doctor built with my child, able to have someone to talk to other than parents.
- He learned how to better release his anger.
- Meds allow him to think about his actions and have better judgment.
- The communication I receive from his therapist and how he allows me to be involved.
- that my daughter is alive
- live with me and the therapy
- My daughter is learning to respect me better
- Being able to go to West Hills.
- Seeing the terrific changes in her. She has done an awesome turn around due to the right meds, doctor and therapist.
- Dealing with social problems and how to be nice in a bad situation.
- Speaking with both my daughter and family members (myself) to help understand and improve communication.
- My therapy I think is essential to her progress in all areas
- it has helped us to recognize the kids needs and how to help them and the whole family.
- Sustainability of life and relationships.
- Consistency and repor *[rapport?]*
- Helping him cope with anger issues and strategies to calm himself when he is triggered.
- The great relationship between my son and his therapist. He can trust him and talk to him about anything.
- Getting her on the medication she needs for ADHD
- emotional support

Youth comments

1. What has been the most helpful thing about the services you received?

- I have learned how to better cope with many things in my everyday life. I have also been able to express my feelings better.
- Life skills
- to be able to control my emotions
- The most helpful thing is learning to control my emotions.
- the most helpful thing I have received from these services is the medication.
- my med appointment
- the most important thing I learned was to breathe slowly in and out when I am angered.
- The most helpful thing was getting advice that I needed to get through my issues and try a different approach.
- My therapist help me with a lot of stuff
- they have helped me find alternative but positive effectiveness in handling everyday situations, issues and such.
- they help me understand more what has been bothering me and be more open
- learned to control my anger
- for my brother and I to behave better
- n/a
- the people
- I am learning how to cope better with certain things or events. I am also more level-headed and can handle a plethora of tasks.
- Not having tantrums
- not sure
- getting on my medication
- Nothing
- My therapist help
- coping skills
- the most helpful thing about the services I've received is all the support. When I come here I am surrounded with smiles from all staff and it makes me feel good. Also my therapist has helped me so much to open up and love myself.
- it is nice to talk to someone
- meds. for anxiety
- I can have better visits and not argue all the time.

- giving CLIENT a chance to discuss her issues with someone, also help myself cope better with her issues.
- Helping my husband and I to understand our child's condition and possible limitations.
- the therapist my child sees seems to genuinely care about my child's success.
- Learning that I am not alone. Support services.
- The closeness to home and my child's school.
- good diagnosis, meds, and treatment
- We are still very early in counseling however I feel my therapist and Dr. are working on a situation to help.
- Better behavior and coping and better about defiance
- the ability to get his needed medication.
- Support for parental decisions regarding behavioral issues.
- Learning what feelings are and how to express them properly. How to talk about things before he explodes.
- has been learning more effective ways to deal with anger management other than to internalize and explode.
- The program in itself, learning coping skills, goals given. A place for child to have a voice.
- The "Wholeness" of the services. You Dr.'s Therapists work together for the child and that is the best approach.
- Meds. Family and Individual therapy.
- I feel that if we didn't have our therapist on our team my son would not be as well as he is today.
- The consistency in his treatment I feel has help a great deal.
- The most helpful thing that my boys have received is that they have someone they can talk to about what is going on in their lives.
- She is able to talk to someone.
- Reducing the emotional swings.
- Being put on medication. It has helped a lot but he can still get out of control and hard to settle down and reason with.
- This is only our 2nd visit, but very helpful on separation problems
- He now receives the medication he desperately needed.
- flexible times
- Trying to cope better without aggression. Also taking responsibility for own actions which was a big challenge. Once past that things seem to go better.
- A place for him to vent and discuss problems with his counselor.
- That we were able to function as a family, and when things are hard, I know we have support.
- too soon to tell
- Facilitating his adjustment into our family and helping him comprehend why it was necessary.
- He gets his/the meds needed and monitored by Dr. The therapy is most valuable.
- Medication and therapy.
- Being able to talk through the problems and getting solutions.
- A better understanding about behaviors - reasons - responses.
- help with disciplinary skills
- My child has someone other than a family member to share her thoughts with.
- My son has a person he trusts and can talk to without fear of being judged.
- Someone to talk to
- The counselor was receptive to our issues and goals.
- Having him somewhere to receive treatment and being in a controlled environment.
- That my therapist comes to our house which is so awesome because we only have one car and daughter needs it for work where as I can walk to work. She also helped us find outside resources for rent and utilities.
- Better able to talk to each other.
- She helps us with a lot
- Having the therapist and doctors understand my child and our family, the support I have has made my life much, much better, and as my child gets older and experiences
- everything I do in school that help me a lot
- talking about constructive way to pass time
- She listens to me, and agrees with me, and is really understanding.
- idk *[I don't know]*
- I can tell him/her what's on my mind.
- Just the time to check in
- I don't know I've only seen her about seven or eight times
- Advice
- Being able to talk to someone of intelligence
- My counselor helps me with anything that's bothering me.
- My counselor helps and talks with me about the problems and issues.
- My therapist helps me understand why my mom does the things that she does, and why I feel the way I feel.
- I have learned that when I have the strength to speak up I am heard.
- counseling
- I have learned how to control my anger.
- My Medications. I do not like my therapist.
- That I have some one I can talk to and I wont get bull answers
- I don't know.
- I can cope when things go wrong, and my family life is enjoyable and me and my dad can be friends.
- I have had someone to talk to about my problems. I am a stronger person now.
- they made me think twice about my choices
- I don't know
- N/A
- We did not have to leave our house
- undecided
- that I have learned more things I can do to up my self confidence.
- I helped my friend and family therapist.
- understanding my parents more, and knowing that there are people out there that can help me.
- Actually nothing really. She seems to take my moms side instead of seeing both sides.
- teaching me how to deal with difficult choices and dealing with my family.
- My therapists help with listening to me and how friendly she is
- Getting to know that people here care about my school achievements.
- I feel that I have someone to talk to and I enjoy to talk to, with that person.
- Talking to my therapist about my dad.
- I have a support team that makes me feel strong and confident.
- Coping skills

new challenges, they are always here for her and I. • Since my son is in a group home, it's comforting to know that he is in a safe place where he can't hurt himself or someone else.	
2. What would improve services your child and the family received? ▪ Link all calendars for easier appointment scheduling. ▪ Wouldn't change any of services I receive at this time. Just locations. ▪ that the services continue at the same level and increase the help because it helps very much to cure the patients. ▪ all of CBS ▪ therapy with the counselor ▪ Being able to have seen a doctor sooner. ▪ Nothing at the moment. ▪ My therapist is a great lady. She improves us and has a way of us looking at things differently and in a nicer way. ▪ More lengthy Dr. visits) more individual therapy(child) more individual therapy (moms) ▪ More of the same! ▪ Suggestions of options for him after he turns 18 and before his 21st B.D.. Comes around (for future planning before he hits 18 years old.) ▪ More interaction with the entire family as a whole. ▪ Nothing. Everything is great. ▪ Communication plus returning phone calls. Communication with parent regarding child's treatment. ▪ one at this time ▪ nothing at this time ▪ Well, I think I 'm very satisfied at the moment with our treatment plan. She just needs time to adjust. ▪ Actually, my child's attitude and lack of receptiveness of counseling is our biggest hurdle. ▪ More flexibility on who my child may see to prescribe his medications. ▪ Continuity of care between providers. ▪ I don't see any improvement being needed to the services. The staff are super friendly and helpful. ▪ more visits to my therapist ▪ I feel the services we receive are excellent. ▪ Having a Doctor who is more open minded and not set in his beliefs about past Dr. diagnosis. ▪ that he could have more time with his therapist. ▪ I have no suggestions. ▪ I wish there was a place where you could drop off your child for a time-out. ▪ Perhaps a bit more "group" therapy. But I believe in the Dr. and his decisions. He has instilled in me that confidence in him. ▪ Labs for med clinic. More available evening hours so kids don't miss any school. ▪ I don't think that we have to improve the treatment. I think we're good right where we are at. ▪ I know that we all need some kind of family counseling and wraparound support. ▪ no improvement needed ▪ Unable to reach the doctor she is seeing on voice mail or phone calls until Friday. The facility was closed due to snow. The meds she was on ran out. Unable to contact doctor she sees and unable to get meds needed from staff. She had to go more than a week off medication! ▪ My child seems to do well out of the home but I still have problems with him around me and close family members. He has good but mostly bad days. ▪ They are already pretty good, they probably need better funding. ▪ I'm not sure everything is what you do with information, your given so either you use the tools or don't. ▪ Can they be on call?!?! (Just kidding)	2. What would improve services you received? ▪ Nothing. I'm satisfied with the services that have been ▪ Nothing. ▪ If my family lifestyle changed. ▪ My parents coming to some sessions ▪ Undecided ▪ nothing ▪ more alone time with the NV PEP family specialist ▪ I think the services I received were a great help and don't need improving ▪ less toys ▪ Location ▪ Not a thing because I feel it's as great as can be. ▪ longer period of time ▪ I don't know ▪ I don't have any ▪ Not that I can think of., it's actually nice here ▪ having a family conference ▪ not sure ▪ nothing at this time ▪ my counselor taking my side for once ▪ I can't think of any ▪ nothing would be better than this ▪ My therapist ▪ Less always on me about every little thing ▪ nothing ▪ Nothing ▪ I don't know? ▪ idk *[I don't know]* ▪ Nothing, it's all fine ▪ If I can see her more ▪ nothing ▪ I'm not sure ▪ I don't know ▪ Nothing ▪ sometimes even though I get here on time/early my therapist will be 10-20 minutes late. Which I feel cuts off time that could be used. ▪ the ability to go home. ▪ When the patient says I want a different therapist give them a different one. That might help with anxiety. ▪ I don't like how long there ar ▪ How should I know. ▪ Not sure ▪ More family meetings ▪ I think the services I have received are good enofe. ▪ Nothing. Everything here is fine. ▪ How should I know. ▪ N/A ▪ they are fine ▪ Nothing, I like the system! ▪ Nothing that I know of right now ▪ If my therapist would be more understanding, instead of just listening to my mom's side. ▪ more family/group sessions ▪ not being afraid of getting put into inpatient. ▪ If they can try and get me in cheerleading. ▪ Everything is great. ▪ nothing ▪ doing trust exercises because it is hard for me to talk unless I can trust the person. • more food

▪ I have nothing to add. My therapist so far is doing a wonderful job with my son. It will take time to see improvements. ▪ They here at CBS is very helpful and address the needs of my son. ▪ Happy with the services received. ▪ more practice ▪ We are satisfied with the services. ▪ more hours available after school ▪ Being told what is going on - side effects, check up and so on ▪ Willingness by staff to do more in depth analysis and evaluation of possibly deep-seated psychological and behavioral problems. ▪ follow rules, laws - Make sure guardian, parent is aware of things involving child, and is able to make choices. ▪ I believe my child would benefit better at ATC ▪ None - happy with things as they are. ▪ I'm not sure, just keep up the good work - Thank You All!! ▪ I believe that it would be better for anyone in my position that they tell the family more info on your children and also have more respect for the parents.	
3. Additional Comments ▪ Thank you. ▪ None ▪ We very much enjoy coming here for therapy. Everyone was very nice to us and very helpful. ▪ ATC was a blessing for CLNT and out family, it really helped us out. CLNT was out of control before. ▪ All my heart thanks very much the health department for all the help they give others. I don't have anything bad to say. I hope this program continues. My daughter and I are very happy with our psychologist and doctor. ▪ In this place they have helped me a lot so that my daughter has learned to calm her temper ▪ I thank you! ▪ We are very pleased with the help Child Behavioral Services have been able to provide us. ▪ Keep up the great work! ▪ I believe Dr. needs to be more sensitive about family's ability to pay for services. He has mentioned that he sees people for free. We would pay for help if we could. ▪ Sometimes staff's views of him differ widely from MD, school teachers and other adults who are acquainted with him. Staff lots more hopeful - not sure if it is reality. ▪ None ▪ None ▪ nr ▪ My therapist is a great counselor, he has helped my son so much. We are truly grateful for his help. ▪ nr ▪ nr ▪ My therapist is doing a great job with my kids and I really appreciate all her help. ▪ I appreciate my therapists caring way with CLNT. ▪ I believe the treatment will be very helpful in time, as issues about her Bio-Mom and Dad continue to effect her. ▪ this evaluation is solely based on the bi/wkly appt. with the therapist and not the psychiatrist he sees once a month. ▪ I do think with the continued services we are receiving we will get ahead. ▪ My child sees a therapist on a bi-weekly basis and then a Psychiatrist once a month. This evaluation is solely based on the Psychiatrist. ▪ I am grateful for the service that are provided and the other service provide they have shown me to get and use. ▪ Children's Behavioral Services is a great facility. This facility truly saved my daughter's life. She is currently working on more effective ways of behavior management.	3. Any additional comments? ▪ thanks for your support – my therapist. I really appreciate it - It has helped me a lot. ▪ I like my therapist a lot she helps me a lot ▪ I like my therapist a lot. She helps me with my problems. ▪ *[drew a smiley face]* ▪ DCFS has really help in changing my life. ▪ no ▪ no ▪ I love my councilor. Yeah! ▪ No ▪ I need more help because I'm going mad!! ▪ Nope ▪ I like my therapist and I wouldn't like to change therapists anytime soon. ▪ the staff here are very polite and respectful. I really like that. ▪ Nope ▪ no ▪ No ▪ All the staff here are very helpful ▪ I like coming here but the servises I have received I knew will help me grajuat from my problems soon. ▪ You guys don't have to change its good just the way you are. ▪ NC ▪ N/A ▪ thanks for everything you did for me and my family. ▪ Yes. Don't ask question you already no things about. ▪ I love coming and seeing my therapist. ▪ I just got here but I am looking forward to getting to know and working with my therapist.

This program has also worked closely with my daughter's school to more effectively meet her needs. ▪ Though my answers are mostly "strongly agree" please don't mistake that for lazy survey markings. That is how I feel about your facility and I did contemplate each answer. ▪ My therapist has been a valuable addition to our lives. Thank you. ▪ I Think that my therapist and Dr.s , also have been great with my family. ▪ The staff has been wonderful to my family. I just want to say good job everybody! ▪ Thank you for all the support. We couldn't have done it without you. ▪ I am grateful for CBS. The staff is wonderful and very helpful too. ▪ I am thankful for our therapist and her staff, also for the help needed to get my daughter into the right school - A child's World'. Thanks ▪ We have been blessed by having these services available to us and know that the people here make a difference. ▪ Our therapist has been great, but I am some what in the dark on some issues. ▪ I would like my child tested for bipolar and oppositional/defiant disorder. ▪ My therapist is just awesome! CLIENT has a long history with CBS and my therapist goes above and beyond.	

NNCAS WIN Results		
Parent/Caregiver N=96; Youth N=55 Total Served = 133 Sample = 72%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	93	85
Services were scheduled at times that were right for us.	94	85
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	99	84
The people helping my child and family stuck with us no matter what.	95	78
I felt my child and family had someone to talk to when he/she was troubled.	94	71
The services my child and family received were right for us.	96	76
I received the help I wanted for my child.	96	76
My family got as much help as we needed for my child.	93	87
POSITIVE OUTCOMES		
My child is better at handling daily life.	85	80
My child gets along better with family members.	81	80
My child gets along better with friends and other people.	77	87
My child is doing better in school and/or work.	70	87
My child is better able to cope when things go wrong	69	73
I am satisfied with our family life right now.	67	60
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	89	65
I helped to choose my child and/or family's treatment goals.	95	69
I participated in my child's and family's treatment.	98	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	87

NNCAS

WIN Results

Parent/Caregiver N=96; Youth N=55 Total Served = 133 Sample = 72%	Parent/Caregiver Positive Response %	Youth Positive Response %
Staff respected our family's religious/spiritual beliefs.	98	93
Staff spoke with me in a way that I understood.	99	87
Staff was sensitive to my family's cultural and ethnic background.	98	78
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.	96	N/A
In a crisis, I would have the support I need from family or friends.	95	89
I have people with whom I can do enjoyable things.	95	91
I am happy with the friendships I have.	N/A	94
I feel I belong in my community.	N/A	100
FUNCTIONING		
My child is better at handling daily life.	85	80
My child gets along better with family members.	81	80
My child gets along better with friends and other people.	77	87
My child is able to do the things he/she wants to do.	79	76
My child is doing better in school and/or work.	70	87
My child is better able to cope when things go wrong.	69	73

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	82
Staff explained my child and my family's rights and confidentiality issues.	96	87
I receive support and advocacy from my Nevada PEP Family Specialist.	92	87
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	91	91
Our family is aware of people/ services in the community that support us.	96	98
I am better able to handle our family issues.	91	73
I am learning helpful parenting skills while in services.	94	83
I have information about my child's developmental expectations and needs.	93	85

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ▪ knowing my child has support on his life and to be able to be involved in his decisions. Knowing his strength and weakness ▪ getting Mojave mental Health services for me ▪ all the assistance that we are receiving to get my kids back home ▪ Support services from everyone at Social Services ▪ supporting my family when needed (anytime) ▪ support and understanding ▪ regular visits, support provided to him and setting goals for him ▪ all of it ▪ Flexibility, dedication and compassion by WIN worker ▪ Counseling ▪ everything good to improve family relationships and thanks to this program and the person who helps me ▪ school programs and other services	1. What has been the most helpful thing about the services you received? ▪ I have my friends and family, and workers to help me reach my goal. ▪ support ▪ Day treatment has helped me a lot in my daily skills. ▪ I'm not really sure ▪ Able to get the resources to get things done. ▪ the most helpful about the services I got was when I came into CBS. ▪ aggressive behavior ▪ Nothing ▪ 2 ▪ I was put on [?] concerta and now I can concentrate ▪ Getting to come home and getting to see my mom more ▪ My WIN worker has helped me by driving me to appointment, helping me with community out reach programs ▪ getting the hell out of ATC! Almost anyway

Parent/Caregiver comments	Youth comments
▪ Learning new ways to cope with behavioral issues ▪ Knowing better how to cope with his emotional ups and downs ▪ Having the team communicate about all issues ▪ Has let her be a child again. My girl is back ▪ Team support ▪ Team ▪ MY PSR worker; Therapy Child's World Treatment Team ▪ she has been supported by a team ▪ guiding us on everything. Helping her feel better about herself and her life ▪ It allows the child to know the adults work together. ▪ respect - opening up to feelings ▪ all the help we are receiving to get my children to come home ▪ she has begun to re-engage in school work at the new facility ▪ He has someone to advocate for him; to help coordinate services; he has someone he can count on to be there for him. ▪ communication ▪ Physical and emotional support ▪ That we don't feel alone with our son's problems. ▪ Piece of mind and security, I feel better in knowing I have them. ▪ Having someone to fill the blanks where services are concerned. ▪ I think the guidance she receives from her team is helpful. Being a young mother she has a lot of support so she can be successful. ▪ everything they have done for us best with phone calls home visit. ▪ consistent meetings, assignments and follow through ▪ as a team we decide what is best for her and it seems to work. - Teamwork ▪ The workers willingness to adjust goals according to my child's current needs ▪ Set in place community services that my son need. ▪ Helping us understand the support we need to help each other ▪ the organization of all the services and the support ▪ Child gets motivated to complete services that are offered. ▪ I've learned better parenting and teaching skills and my son has learned how to calm himself down when becomes upset and uses his words to explain what's wrong. ▪ the support that our therapist gives our family and linking us to services. ▪ everything they have done for us best with phone calls home visit. ▪ Our therapist has been there for us at crucial times. Protecting my child's rights. ▪ Insight from the team regarding my child - Support system for self and child ▪ their support ▪ someone to help us resolve her emotional issues ▪ the ones that come to see us are very, very open, honest, great listeners and mean a lot to us. ▪ Helping her to realize that we are on her team. ▪ Insight from the team regarding my child - support system for self and child. ▪ All of the staff were so caring and supportive of my family. ▪ ILP ▪ Maple Star ▪ Maple Star ▪ Maple Star ▪ coordinating services	▪ My behavior has been better. I've been having more friends ▪ The most helpful thing has been getting control over my emotions and using them in a positive mature way ▪ That I'm trying to get into job corps ▪ Info about benefits ▪ Summer Camps (financial camp etc…). Fashion camp Help finding a job ▪ I have had help getting what I want and need. ▪ school ▪ I learned many skills ▪ I learned a lot of stuff ▪ really none of them helped me at all ▪ being able to trust, and communicate ▪ things that I wanted to do ▪ My services helping me accomplish my goals ▪ people believing me and never giving up hope. ▪ going on outings ▪ helping me complete my goals ▪ the coping skills ▪ N/A ▪ I don't know ▪ to do my work and be prepared ▪ There's always someone there who cares about me and helps me when I need it and there's someone there to talk to me and make me feel better. ▪ getting a lot closer with friends and family ▪ My options are thoroughly explained and there is clear communication ▪ Has taught me how to care for myself and responsibility ▪ I have learned how to calm myself down when I get mad ▪ I dunno? ▪ They have pushed me to get my school grades up and to get involved with activities ▪ They helped me in the rough and good times I had. They stuck with me. ▪ I get thing I need while in care ▪ controlling my anger ▪ How everyone can relate to me. How everyone is sensitive. ▪ I know how to handle myself more ▪ seriously don't know ▪ to trust people ▪ Daily life i.e. Work, school, sports ▪ bye people givein me praise

Parent/Caregiver comments	Youth comments
▪ The ability to understand his treatment goals and planning of placements ▪ Resources, CFT meetings, support ▪ I have an excellent WIN Worker. She always shows a great interest and care with our boys. ▪ I did my own research. When I needed info about anything somebody is there to help. ▪ their support ▪ having support when needed ▪ meetings and support ▪ communication, sharing information, consistency being informed ▪ Flexibility, dedication and compassion by WIN worker ▪ That WIN makes sure everything is discussed in meetings, sibling visit and available to family. 1 to 1 time with child. ▪ Meetings at the WIN office to talk about consistency of the meetings ▪ Better understanding of needs, better communication, resources, CFT meetings helpful. ▪ Another person to take time out just for us when needed. A support team when things get tough. ▪ linking to resources ▪ Learning more about teenagers and learning to adjust to new members of our family ▪ there is someone to help brain-storm solutions for my foster child's issues. • learning parenting skills has better helped me to be a better care giver	
2. What would improve services your child and the family received? ▪ not sure at this time ▪ help at home ▪ housing assistance and other such programs ▪ None at this time. ▪ answers to how we can help him ▪ meeting other parents with similar problems ▪ The therapists helped us very much ▪ there is more communication and more understanding and more love with my children and I appreciate them more ▪ much in daily life ▪ I think the help we have been getting is great ▪ I don't think anything. Everything has been very helpful and when I had a problem and needed help, right away I got it. ▪ Nothing I can think of at this time ▪ all is well ▪ It will be nice when he has fewer needs and appointments ▪ RRS - if she could have services follow in adulthood ▪ fewer appts. ▪ any lists for housing or other such assistance ▪ If only the group therapies at the new facility could make her be more sociable; or if an individual therapist from that same facility can re-capture her motivation. ▪ I can't think of anything at this point ▪ Our worker has been of great support in helping and guidance in understanding the program ▪ Now that our case is closing with WIN, a newsletter about other family successes, or how WIN is impacted Reno's child and families would be nice. ▪ I'm not sure. I am very thankful to have them in my life. ▪ nothing ▪ I am satisfied with services received ▪ for my son to be in a facility that is closer to home but I do understand that the one he is currently in is the closest one. ▪ I am pleased with the services provided by WIN. ▪ No improvement necessary	2. What would improve services you received? ▪ If people would hear me out more often. ▪ none ▪ Being able to move with family faster! ▪ more time with family and more time on my own ▪ nothing, everything is fine the way it is. ▪ Idk (I don't know) ▪ nothing ▪ I don't know ▪ Nothing really she has been a big help ▪ letting me do my own thing ▪ nothing ▪ More fun, including learning activities ▪ If I could smoke cigarettes to relieve my stress ▪ It's good services no improvement needed ▪ More visits/communication. ▪ Nothing ▪ I would like more activities ▪ nothing ▪ Me deciding what services I get ▪ foster home staff ▪ nothing ▪ No, they're great the way they are ▪ everything a-okay ▪ see the WIN worker more often ▪ don't know ▪ my behavior like being able to calm down easier and not get so angry ▪ Let us go home with my mom ▪ I don't know ▪ Nothing really ▪ Nothing really, I have good services ▪ I would prefer not to be in foster care ▪ I dunno? ▪ None ▪ Nothing… it's awesome ▪ I don't know ▪ nothing

Parent/Caregiver comments	Youth comments
▪ If there were more services provided at Stateline NV. ▪ maybe some info how I could get help with transportation and clothes - school clothes or summer clothes - anything helps us. ▪ Nothing ▪ Help with school to stay on track (keeping him caught up) ▪ I am happy with the way they do things ▪ none at this time ▪ nothing! Everything was helpful and clear to us. ▪ That she would be back home with me! ▪ quicker response for social worker ▪ Nothing ▪ Better access to son if foster parents return calls. ▪ Some kind of group outing yearly. ▪ just got in WIN services not sure yet ▪ Just a little bit more communication other than that everything is going very well ▪ nothing • none	▪ None I believe ▪ Probably more interactions with the family ▪ to not be [?] studied ▪ More appointments • do as I told
3. Additional Comments ▪ will share with WIN worker ▪ My therapist has been awesome, helping navigate extra programs for her and providing transportation when needed. ▪ Thanks for your services. They helped me a lot with my daughter ▪ Thanks for the help you gave me because thanks to that I have my children back. Thanks for your help. ▪ Our therapist has been awesome in helping our family ▪ I have learned more coping and parenting skills in the last 9 months than I thought possible. ▪ Our therapist is absolutely wonderful. I can not say enough good about her. Thank You ▪ The improvement in transferring our daughter from a standard H.S. setting to a less distracting environment is currently helping our daughter regain her lost school work: If only 'Plato' can be installed in our home computer during summer or if 'Turning Point' can have a limited summer period. Plus the idea of getting her involved in voluntary work with the facility, i.e. as classroom aide for the preschool or nursery classes. ▪ THANK YOU!! ▪ I appreciate our therapists attention to the details - seeing that it all comes together for my child ▪ Our therapist is great and has been helpful to us. ▪ thanks for everything CPS has done for me. I'm very grateful and have learned a lot of useful tools in parenting and life. ▪ glad they are in our lives and want to help. We greatly appreciate everything. ▪ I want to thank the staff without her my family probably wouldn't be where we are today. ▪ got help with testing for school ▪ No ▪ she is my baby and I miss and love her. She is growing so fast. ▪ Appreciate WIN involvement and the ability to stay connected, communication, plans ▪ My therapist has been great to us and we would refer him to anyone. ▪ We have a great case manager on our team. She works with our schedules and treats us like real people who have lives too. Very understanding, calm, patient and we love her. ▪ He really likes his new bike and skateboard he is very grateful and so am I!	3. Any additional comments? ▪ Nope ▪ no ▪ nope ▪ no ▪ thanks ▪ My hippie friend ▪ WIN is doing a good job. Not Social Services. ▪ none ▪ NO!!! ▪ You guys do great! Keep up the good work! ▪ none at all ▪ foster care was not for me at all ▪ no ▪ nope ▪ really worth pulling me out of school? ▪ No ▪ none ▪ Thank you ▪ None ▪ no ▪ Thanks

NNCAS Early Childhood Mental Health Services Results		
Parent/Caregiver N=41; Youth N=NA Total Served = 120 Sample = 34%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	75	NA
Services were scheduled at times that were right for us.	95	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	NA
The people helping my child and family stuck with us no matter what.	95	NA
I felt my child and family had someone to talk to when he/she was troubled.	95	NA
The services my child and family received were right for us.	90	NA
I received the help I wanted for my child.	95	NA
My family got as much help as we needed for my child.	95	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	92	NA
My child gets along better with family members.	93	NA
My child gets along better with friends and other people.	90	NA
My child is doing better in school and/or work.	88	NA
My child is better able to cope when things go wrong	90	NA
I am satisfied with our family life right now.	79	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	87	NA
I helped to choose my child and/or family's treatment goals.	95	NA
I participated in my child's and family's treatment.	95	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	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.	95	NA
I have people that I am comfortable talking with about my child's problems.	95	NA
In a crisis, I would have the support I need from family or friends.	93	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.	92	NA
My child gets along better with family members.	93	NA
My child gets along better with friends and other people.	90	NA
My child is able to do the things he/she wants to do.	89	NA
My child is doing better in school and/or work.	88	NA
My child is better able to cope when things go wrong.	90	NA

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	87	NA
Staff explained my child and my family's rights and confidentiality issues.	92	NA
I receive support and advocacy from my Nevada PEP Family Specialist.	81	NA
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	82	NA
Our family is aware of people/ services in the community that support us.	93	NA
I am better able to handle our family issues.	87	NA
I am learning helpful parenting skills while in services.	84	NA
I have information about my child's developmental expectations and needs.	90	NA

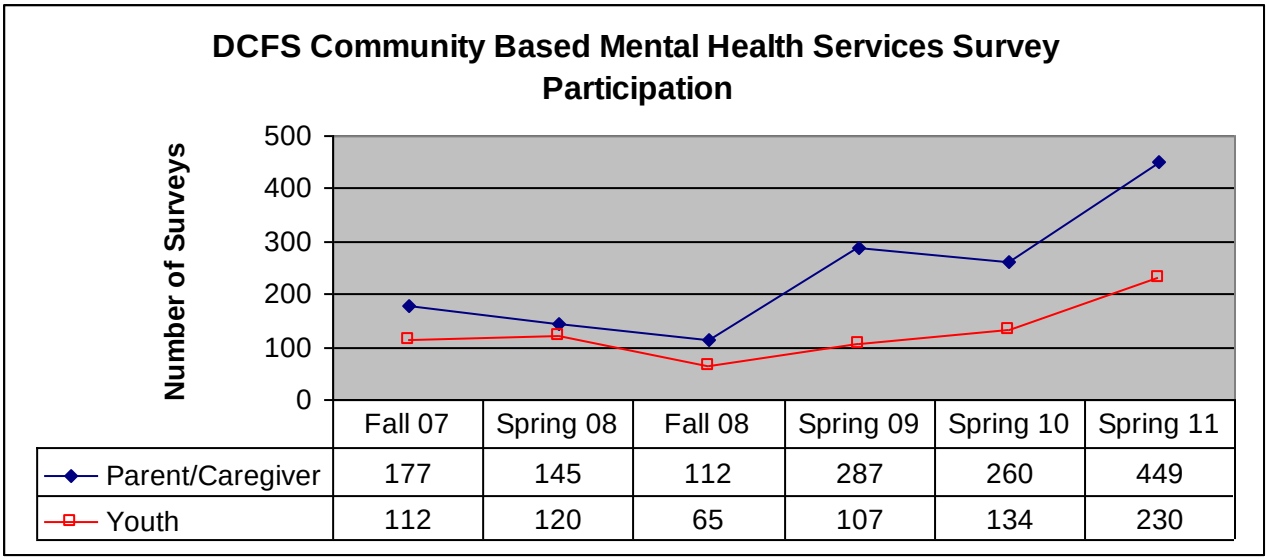
Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ▪ Our therapist is very informational and helpful. ▪ Helping our daughter with her behavior and adjust for permanency in our home and overall family expectations. ▪ that she was able to get help to cope with the issues of abuse from her father. ▪ Helping the kids open up and develop into who they are now with their troubled family, help adjust with us the (foster family) ▪ The level of care from both psychiatrist and psychologist. ▪ he is learning how to consider his options and make better choices instead of always blowing his fuse. ▪ my child has healed emotionally and gets better everyday. ▪ Better understanding himself. He now knows what is going on and the reasons why. ▪ The most helpful thing is knowing I have someone to turn to for help with my children. Knowing that they can help me or find information for me. ▪ The understanding that it gave us of the behaviors we were seeing and how to address them. ▪ It has helped with his tantrums ▪ the play therapy does help us out a lot and the Boys town helps us out a lot to were very happy to have that opportunity to have help from them. ▪ figuring out what may be wrong. ▪ Yes, he need helping, out of course, will listen and understand, comfortable talk to counselor. ▪ My child's therapist listens to me and works with me to help my child. ▪ Our therapist is always ready to listen to concerns and issues we may have with situation. ▪ the quality of care and the time spent with our family. ▪ How he is able to express himself. ▪ Developmental assistance, self management skills, parent coaching. ▪ that we have the people in place we need for help and they get us any other help we need. ▪ The wonderful way we are treated with respect and genuine care. ▪ Getting the correct diagnosis and helping us help our child/children. ▪ Giving me a better understanding of why my children behave the way they do. Still too soon to tell only been 5 weeks. Our visits have made this much better for me. I have new skills to help me deal with the behaviors ▪ They have learned to be individuals, then be a member of a group. They can play on there own. They are able to express themselves calmly. ▪ A counselor that my child can relate to, is comfortable with. Someone I can talk with as well.	1. What has been the most helpful thing about the services you received? • NA

▪ I'm fully satisfied with the services we have received. ▪ Advocate for my child that helps deal with the school district. ▪ Well at times being able to talk about issues was helpful. Getting one child on medication. ▪ He has received services since the age of 3. He copes much better. ▪ It has been a learning experience for both of us. ▪ This program helped us reunite as a family and has given all of us the tools we need to work at our program. ▪ Teaching my son how to deal with anger or frustration is a better way and coping skills. ▪ Learning boundaries and limitations. Processing information. ▪ The supportive therapist and the day treatment preschool and teachers support. ▪ the care and respect with which we are treated. Also, the ability to access help when needed. ▪ Learning how I needed to change to encourage better behavior in my child. • Communication for the deaf	
2. What would improve services your child and the family received? ▪ Everything is very new to tell. We have only had kids for couple of months. ▪ this is the first time I have met with CLIENT's therapist so anything that they can tell me to better help my daughter the better. ▪ Nothing Service was awesome, along with the awesome service Therapist was/is very courteous, respectful, the best. Thank you for all you guys do. ▪ A helicopter *[followed by a smiley face]* We just have to travel from Stagecoach/Silver Springs because there is no one closer that would even see him at 4 years old. ▪ It's just right ▪ the services we have received from the staff here at CBS have been life saving. We appreciate all the therapists and staff who have helped us with all the children we have brought here. ▪ I am happy with the services and help I'm getting at the moments. ▪ I would think that they have helped us a lot with things that I could have imagine. I really like the play therapy that we go to that helps out a lot for us. ▪ Distance from home, travel time. ▪ teach him behavior, respect, listen to counselor. Just helping him understand what he do wrong and better [im]prove. ▪ I am receiving all the help that I need at this time. ▪ Being more able to accommodate multiple children. ▪ Not to let anymore people go. ▪ I like things just like they are. ▪ I'm concerned that my child will not function well in the public school system. Knowing about alternative schools would be helpful. ▪ I feel like services are more child oriented than family - When it's the family that cares and supports the child. More for the family. ▪ I feel very privileged that our therapist is working with my daughter and myself. ▪ Can they be on call!?!? Just kidding! ▪ more visits with my son. 2) involving other family members with my son. ▪ At this time we are good. ▪ possibly having a location in sparks, closer to our home. ▪ maybe having in home training to show us how to handle real life instances.	2. What would improve services you received? • NA

3. Additional Comments	3. Any additional comments?
▪ Counseling services have been extremely helpful and greatly appreciated. Thank You! ▪ This is the first time I've seen CLIENT in four years. I'm aware that there will be some hard times but I am willing to take the time to listen and do my best to continue to help CLIENT to get through her current issues. ▪ I believe that our therapist has a great way to pick his mind and make him see things in a different perspective. He has a great relationship with her and has really responded to her. Which is very important in order to make progress. Thank You ▪ Our therapist has been so much help in so many ways. She's an amazing person. I don't know where my child's mental state would be without her. ▪ Dr. has been amazing. We love her. She is always there for us. It's been a long road, and we still do not have all the answers, but she is willing to do what ever it takes to help us. ▪ We have an excellent therapist. She is very understanding and willing to help my family any way she can. ▪ to thank our therapist for all her help and support. ▪ I would recommend them to continue this for all other people . That will be great for them. ▪ Our therapist has been helpful over the years. ▪ My grandchildren was with someone here for 2 yrs and had to switch because of forced retirement. I do not want to see that happen any more. They are good people here and we can not lose any more. ▪ the people at CBS are great! ▪ thank you for all the support and help! ▪ there used to be a social skills class here. It would be nice to have some sort of class to help with confidence issues and to see the social skills classes return. ▪ Without these services the child would lose out on education, no being able to focus. ▪ I'm learning new things that [are] great and she – Our therapist- makes a fun way of learning. ▪ This program saved our family. Thank You! ▪ I thin overall, everyone here has done as amazing job with my son and I, have been very nice, caring, and helpful.	• NA

Survey participation

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



	Fall 07	Spring 08	Fall 08	Spring 09	Spring 10	Spring 11
Parent/Caregiver	177	145	112	287	260	449
Youth	112	120	65	107	134	230

The current survey shows a statewide increase (73%) in parent/caregiver participation and a corresponding increase (72%) in youth participation when compared to the same survey conducted in the spring of last year.
Statewide there was a combined total of 679 agency parent/caregiver and youth survey participants. There was an impressive overall statewide participation increase of (72%) from the Spring 10 survey, with the majority of the increase attributed to the Northern Region.

A Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 449 parent/caregiver surveys returned statewide, 34 were in Spanish, a (209%) increase from the Spring 10 survey.

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 D

Division of Child and Family Services
OASIS ON-CAMPUS TREATMENT HOMES (OASIS)
Risk Measures and Departure Conditions Report – 2011

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 2011 report is the fourth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2011 through December 2011. OASIS submitted a timely and complete data set in 2011. OASIS is to be commended for their willingness to share this very important information.

During this reporting period a risk measure was added for "incidents" of child on child physical incidents and child on child sexual incidents. Public child welfare partners requested this data be collected and analyzed in order to further ensure child safety in out of home placement.

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 incidences goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2011 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.
- In 2011, policy implementation reviews with providers were conducted. The reviews included Structured Therapeutic Environment, Medication Management and Administration and Crisis

Triage. The reviews included face to face meetings between PEU and providers to review 2010 risk measures and departure conditions reports in order to provide technical assistance in regard to accurate reporting of data and review recommendations for quality improvement.

The focus of the policy implementation reviews was not only to determine whether providers were implementing policies as required in the State of Nevada DCFS contract, the Washoe County Department of Social Services contract, and the Clark County Department of Family Services contract but also on improving practice standards as well as quality improvement activities such as data collection, data analysis and the further development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide. In many instances, the PEU determined providers were tracking risk measure data accurately and they were reporting the data as required to the PEU. In those instances in which providers were not tracking and reporting data accurately, the policy implementation review further assisted the PEU and providers in addressing these issues in order to minimize data collection and analysis limitations.

Data analysis limitations do continue 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

Five 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 five risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance
- Physical and/or Sexual Incidents (child on child)

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 five risk areas and departure conditions.

OASIS PROGRAM INFORMATION

This report for OASIS is the analysis of risk measures and departure conditions data collected from January 2011 though December 2011.

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 three reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2011	25.75	2011	24.83
	Range: 22 to 27		Range: 21 to 28
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.

OASIS reported zero suicide attempts and suicide completions in 2011. Suicide attempts reported by OASIS for four reporting periods are noted in Table 2.

Table 2

Suicides		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2011	0	0
2010	0	0
2009	1	0
2008	4	0

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.

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.

OASIS reported 13 medication errors in 2011. Medication errors reported by OASIS for four reporting periods are noted in Table 3.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of Errors
2011	13
2010	22
2009	11
2008	7

Clinical and Medication Error Information:

- The most frequent diagnosis was Mood Disorder (4 or 31% of youth).
- Type of medication error
  - 6 (46%) omission error
  - 3 (23%) wrong time error
  - 3 (23%) other medication error:
    - 1 (8%): medication was found on the kitchen sink, could not determine when child did not receive his medications, no apparent distress with the child
    - 1 (8%): doctor did not write that he had discontinued the mediation on the medical interview form
    - 1 (8%): had to buy over the counter fish oil instead of prescribed fish oil pills
  - 1 (8%) improper dose error
- (2 or 15%) medication errors were with non-psychotropic medication. 11 or 85% medication errors were with psychotropic medication.
- Medication error outcome
  - 10 (77%) were errors that occurred that reached the patient but did not cause patient harm.
  - 3 (23%) were errors that occurred but did not reach the patient.

Highlights:

- None of the medication errors cause harm to the youth.
- The staff administering the medications received initial and refresher medication management and administration training.

Opportunities for Improvement:

- 62% (8) of the medication errors occurred in the morning, between 6:15am and 9:00am.
- 38% (5) of the medication errors occurred on Thursday.
- OASIS 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.
- 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.

AWOL

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

OASIS reported 21 AWOLs in 2011. AWOL incidents reported by OASIS in the four reporting periods are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	Number of AWOLs
2011	21
2010	7
2009	15
2008	5

The 21 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 6 (29%) were male and 15 (71%) were female.
- Average age was 15.19 with an age range of 13 to 17 years.
- 18 (86%) were child welfare custody, 1 (5%) were DCFS youth parole custody/supervision, 1 (5%) were tribal, and 1 (5%) were parental custody and no juvenile probation involvement.
- Race
  - 13 (62%) were Caucasian
  - 7 (33%) were African American
  - 1 (5%) were American Indian/Alaska Native
- None of the youth were Hispanic.

Clinical and AWOL Information:

- The most frequent diagnosis for the youth was Major Depressive Disorder (5 or 24% of youth).
- Average number of AWOL days was 9.81 days with a range of 1 to 22 days.
- 21 (100%) of youth had a history of AWOL.
- Type of supervision at AWOL
  - 7 (33%) left from specialized foster care home during the day
  - 6 (29%) left from specialized foster care home at night – staff awake

  - 5 (24%) youth left from school or work
  - 2 (10%) other:
    - 1 (5%): youth left from local pool while on an outing
    - 1 (5%): youth left from her therapist's office
  - 1 (5%) left from specialized foster care home at night – staff asleep
- Behavior during AWOL
  - 18 (86%) unknown
  - 1 (5%) sexual misconduct
  - 1 (5%) victim
  - 1 (5%) sexual activity
- Outcome
  - 9(43%) absent indefinitely
  - 3 (14%) returned through juvenile detention or law enforcement
  - 3 (14%) placed in congregate care (Child Haven)
  - 3 (14%) other: placed in psychiatric hospital
  - 2 (10%) returned involuntarily to specialized foster care home within 72 hours
  - 1 (5%) found with family and stayed with family

Opportunities for Improvement:

- OASIS experienced a significant increase in AWOLs in 2011 from 2010.
- After the AWOL incident, 76% (16) of the youth did not return to OASIS.
- All of the youth have a history of AWOL.
- 43% (9) of the AWOL incidents occurred between 7:30 am and 2:40 pm, and 33% (7) of the AWOL incidents occurred between 8:05pm and 11:10pm.
- 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.

MEDICAID REPORT 2012
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2011 SUMMARY
Restraint and Manual Guidance

Specialized foster care providers were asked to track and report on restraint and manual guidance used on children and adolescents. As it is stated in the monthly data collection report for Risk Measures and Departure Conditions, 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. Physical restraint is defined as the use of physical contact to limit a client's movement or hold a client immobile (Title 39, Nevada Revised Statutes 433 § 5476, 1999). OASIS staff used CPART for the restraint method.

In 2011, 112 restraint and manual guidance incidents were reported by OASIS. Also, the restraint and manual guidance are noted for the four reporting periods are noted in Table 5.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	Number of Restraint / Manual Guidance
2011	112
2010	207
2009	120
2008	72

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

- 78 (70%) were male and 34 (30%) were female.
- Average age was 10.10 with an age range of 7 to 17 years.
- 81 (72%) were child welfare custody, 24 (21%) were parental custody and no juvenile probation involvement, and 7 (6%) were parental custody on probation.
- Race:
    - 73 (65%) were Caucasian
    - 30 (27%) were African American
    - 8 (7%) were Unknown
    - 1 (1%) were Mixed
- 13 (12%) were Hispanic.

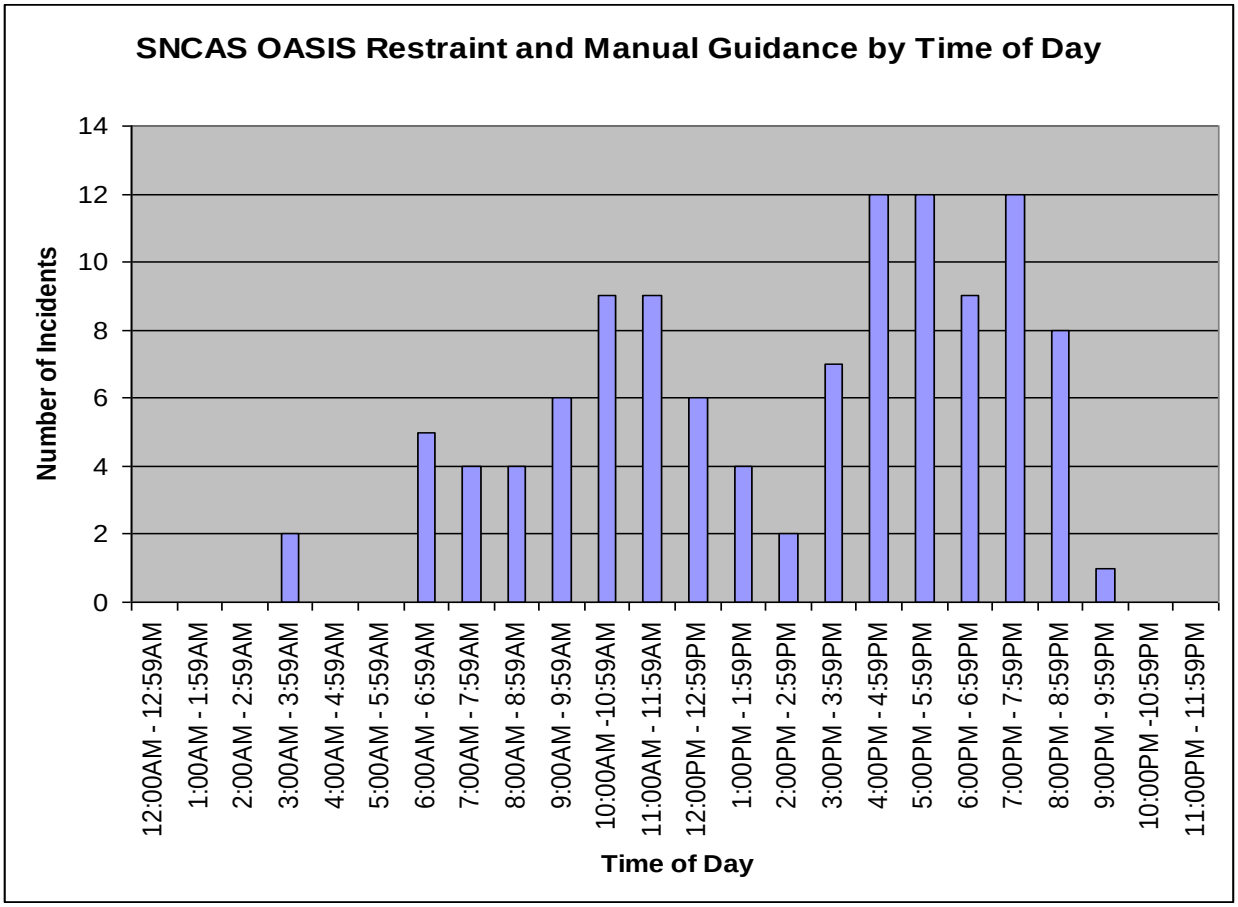
Clinical and Restraint/Manual Guidance Information:

- The most frequent diagnosis was Mood Disorder (35 or 31% of youth).
- Average length of restraint and manual guidance was 12.69 minutes, ranging from 1 to 60 minutes.
- 97 (87%) of the youth had a history of restraint and manual guidance.
- Restraint and Manual Guidance Event
    - 61 (54%) physically assaultive toward adult
    - 24 (21%) youth putting self at "risk" of harm
    - 13 (12%) youth putting others at "risk" of harm
    - 11 (10%) youth running away
    - 2 (2%) physically assaultive toward another youth
    - 1 (1%) other: staff escorted oppositional youth to the living room area
- Restraint and Manual Guidance Supervision

  - 62 (55%) group of 2 or 3
  - 32 (29%) one-on-one
  - 16 (14%) group – 4 or more
  - 2 (2%) other:
    - 1 (1%) in school setting
    - 1 (1%) youth was sent to his room to separate from another client he was arguing with
- Restraint and Manual Guidance Injury
  - 72 (64%) no one injured
  - 35 (31%) client injured
  - 5 (4%) staff injured

Highlights:

- OASIS staff received restraint and manual guidance training and refresher course.
- OASIS reported a 46% decrease in restraint and manual guidance incidents in 2011 from 2010. On average, there were 9.3 incidents of restraints and manual guidance per month in 2011 compared to 17.5 incidents of restraint and manual guidance per month in 2010.
- In 2011, OASIS reported fewer total injuries (40 total injuries) from restraints and manual guidance than in 2010 (56 total injuries) and in 2009 (45 total injuries).
- The highest percentage (35% or 39 restraints) of restraints occurred October through December. The lowest percentage (19% or 21 restraints) of restraints occurred July through September.
- The bar graph below shows the incidents of restraint and manual guidance by time of day. 46% (52) of the restraint and manual guidance incidents occurred in the hours after school and into the early evening. 16% (18) restraint and manual guidance incidents occurred between 10:00am 11:59am; 11 of the 18 incidents that occurred during this time period took place on Saturday or Sunday.



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, 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, 2007).
- 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, 1999).
- 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:
    - To learn whether restraint and seclusion are being used as emergency interventions;
    - To identify rates of restraints broken down by unit and youth characteristics;
    - To review trends in restraint use – are your program's rates increasing or decreasing?

  - To compare rates and trends between your program and similar "benchmark" programs.
  - To identify opportunities for improving the rate and safety of use; and,
  - 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.

Physical and/or Sexual Incidents (Child on Child)

Specialized foster care providers were asked to track and report occurrences of physical and/or sexual incidents.

A physical incident is defined as any intentional aggressive physical contact occurring between 2 youth (e.g., biting, choking, jumping on, kicking, punching, scratching, pushing, spitting, etc.) regardless of injury. Such an incident would have resulted in an incident report or other required documentation to licensing entities, legal guardian, etc.

A sexual incident is defined as a program participant sexually touches or assaults another individual without consent. Some type of physical touching behavior characterizes this behavior.

SNCAS OASIS reported 2 child on child physical and sexual incidents. Child on child physical and sexual incidents reported by OASIS is noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2011	2

Physical and/or sexual incidents (child on child) reflect the following descriptive information:

- Victim
  - 2 (100%) were male.
  - Average age was 7.5 with an age range of 7 to 8 years
  - 2 (100%) were child welfare custody.
- Initiator
  - 2 (100%) were male.
  - Average age was 11
  - 2 (100%) were child welfare custody.

Clinical and Physical and/or Sexual (child on child) Information:

- The most frequent diagnosis was
  - Attention Deficit Hyperactivity Disorder (1 or 50% of youth) and Mood Disorder (1 or 50% of youth) for the victim
  - Conduct Disorder (2 or 100% of youth) for the initiator
- Physical and/or sexual incidents
  - 2 (100%) of sexual incident
- History of physical or sexual incidents
  - 1 (50%) of the victims
  - None for the initiators
- None of the initiator youth had a history of initiating against other children.
- Type of supervision for the incident
  - 2 (100%) occurred in the home during the day, staff awake
- 2 (100%) provider reported the incident to the legal guardian
- 2 (100%) provider reported the incident to child protective services

Highlights:

- Both incidents were reported to the legal guardian and child protective services.

Opportunities for Improvement:

- At the time of pre-placement planning and admission, an assessment of relevant risk factors and the youth's history of being the victim or being the initiator of physical or sexual incidents should be explored as this will inform the treatment planning and services provided in order to better ensure child safety and placement stability.
- Focus on developing protocols regarding supervision in the home; 2 (100%) of the incidents reported by SNCAS OASIS occurred when staff was awake and presumably available for supervision. Both of the incidents occurred at home, during the day.
- Teach staff and supervisors how to identify behavioral symptoms of possible physical and sexual incident including but not limited to:
  - Nightmares, sleep problems, and/or extreme fears without explanation
  - An older child regressing to a younger child's typical behavior (finger-sucking, bedwetting, etc.)
  - Using different or adult words for body parts
  - Begins to show fear of going to certain places and/or spending time with another youth
  - Resists routine bathing
  - Observation of unexplained marks or injuries
  - Changes in interactions with another youth

  (Stop It Now, 2010; World Health Organization, 2006)
- Teach staff and supervisors how to provide support to youth concerning the disclosure of the physical and/or sexual incident (World Health Organization, 2006).

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 52 discharges in the 2011 reporting period.

The 52 departures reflect the following descriptive information.

- 25 (48%) were male and 27 (52%) were female.
- Average age was 13.29 with an age range of 7 to 17 years.
- Race
    - 23 (44%) were Caucasian
    - 21 (40%) were African American
    - 4 (8%) were Unknown
    - 2 (4%) were Native Hawaiian/Other Pacific Islander
    - 1 (2%) were American Indian/Alaska Native
    - 1 (2%) were Asian
- 6 (12%) of youth were of Hispanic origin.
- Custody Status
    - 37 (71%) were in child welfare custody
    - 10 (19%) were in parental custody and no juvenile probation involvement
    - 4 (8%) were in parental custody and on probation
    - 1 (2%) were in DCFS youth parole custody/supervision
- 51 (98%) were Medicaid or SCHIP recipients
- The average length of stay at OASIS in 2011 was 168.44 days, ranging from 0 days to 969 days (2.7 years).

Clinical and Departure Information:

- The most frequent diagnosis at admission was Mood Disorder (12 or 23% of youth) followed by Major Depressive Disorder (6 or 12% of youth).
- The most frequent diagnosis at discharge was Mood Disorder (12 or 23% of youth) followed by Major Depressive Disorder (6 or 12% of youth).
- The average CASII composite score at admission was 24.56.
- The average CASII composite score at discharge was 22.98.
- Reason for departure
    - 18 (35%) placed in less restrictive setting
    - 11 (21%) youth ran away from placement (AWOL)
    - 9 (17%) placed in more restrictive setting
    - 6 (12%) reunified with biological family
    - 6 (12%) adopted/adoptive placement
    - 1 (2%) independent living program
    - 1 (2%) other: discharged to go to Hawaii to see her brother
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 11, which equals the restrictiveness score of between regular foster care and individual home – emergency shelter.
    - 6 (12%) unknown: youth went AWOL
    - 12 (24%) home of parents, child
    - 1 (2%) adoptive home
    - 1 (2%) supervised independent living
    - 2 (4%) regular foster care
    - 7 (14%) family-based treatment home
    - 8 (16%) group treatment home
    - 3 (6%) group emergency shelter
    - 7 (14%) residential treatment center

- 1 (2%) youth correction center
- 4 (8%) state and private mental hospital

- 27 (52%) youth completed treatment goals prior to discharge.
- Transition plan appropriate
  - 44 (85%) yes
  - 8 (16%) no
  - Explanations:
  1. 2 (4%) youth went AWOL
  2. 1 (2%) child involved in sexually inappropriate behavior
  3. 1 (2%) child was too violent
  4. 1 (2%) child did not finish treatment
  5. 1 (2%) natural mother could not find an appropriate placement
  6. 1 (2%) provider was not notified of pending charge
  7. 1 (2%) youth did not have a chance to earn reward
- Discharge plan appropriate
  - 47 (90%) yes
  - 5 (10%) no
  - Explanations:
  1. 2 (4%) youth went AWOL
  2. 1 (2%) child was not ready for discharge
  3. 1 (2%) child did not complete treatment goals
  4. 1 (2%) child did not have transition period with foster family
- Who recommended departure
  - 37 (71%) child and family team
  - 8 (15%) provider agency
  - 5 (10%) N/A; youth went AWOL
  - 1 (2%) judge/hearing master
  - 1 (2%) other: police legal 2000
- 4 (50%) of the departures recommended by the provider agency gave 14 calendar days notice

Youth in Child Welfare Custody

Of the 52 discharges reported by OASIS in the 2011 reporting period, 37 (71%) were in the custody of a public child welfare agency.

The 37 departures reflect the following descriptive information.

- 18 (49%) were male and 19 (51%) were female.
- Average age was 12.78 with an age range of 7 to 17 years.
- Race
  - 16 (43%) were African American
  - 14 (38%) were Caucasian
  - 4 (11%) were Unknown
  - 1 (3%) were Native Hawaiian/Other Pacific Islander
  - 1 (3%) were American Indian/Alaska Native
  - 1 (3%) were Asian
- 5 (14%) of youth were of Hispanic origin.
- 37 (100%) were Medicaid or SCHIP recipients
- The average length of stay at OASIS in 2011 was 187.43 days, ranging from 0 days to 969 days (2.7 years).

Clinical and Departure Information:

- The most frequent diagnosis at admission was Mood Disorder (10 or 27% of youth) followed by Major Depressive Disorder (5 or 14% of youth).
- The most frequent diagnosis at discharge was Mood Disorder (10 or 27% of youth) followed by Major Depressive Disorder (5 or 14% of youth).
- The average CASII composite score at admission was 24.73.
- The average CASII composite score at discharge was 23.49.
- Reason for departure
    - 14 (38%) placed in less restrictive setting
    - 8 (22%) youth ran away from placement (AWOL)
    - 7 (19%) placed in more restrictive setting
    - 4 (11%) reunified with biological family
    - 2 (5%) adopted/adoptive placement
    - 1 (3%) independent living program
    - 1 (3%) other: discharged to go to Hawaii to see her brother
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 12, which equals the restrictiveness score of individual home – emergency shelter.
    - 5 (14%) unknown: youth went AWOL
    - 4 (11%) home of parents, child
    - 1 (3%) adoptive home
    - 1 (3%) supervised independent living
    - 2 (6%) regular foster care
    - 6 (17%) family-based treatment home
    - 6 (17%) group treatment home
    - 3 (8%) group emergency shelter
    - 5 (14%) residential treatment center
    - 4 (11%) state and private mental hospital
- 17 (46%) youth completed treatment goals prior to discharge.
- Transition plan appropriate
    - 31 (84%) yes
    - 6 (17%) no
    - Explanations:

    1. 1 (3%) youth went AWOL
    2. 1 (3%) child involved in sexually inappropriate behavior
    3. 1 (3%) child was too violent
    4. 1 (3%) child did not finish treatment
    5. 1 (3%) provider was not notified of pending charge
    6. 1 (3%) youth did not have a chance to earn reward
- Discharge plan appropriate
    - 33 (89%) yes
    - 4 (11%) no
    - Explanations:

    1. 1 (3%) youth went AWOL
    2. 1 (3%) child was not ready for discharge
    3. 1 (3%) child did not complete treatment goals
    4. 1 (3%) child did not have transition period with foster family

- Who recommended departure
  - 25 (68%) child and family team
  - 6 (16%) provider agency
  - 4 (11%) N/A; youth went AWOL
  - 1 (3%) judge/hearing master
  - 1 (3%) other: police legal 2000
- 2 (33%) of the departures recommended by the provider agency gave 14 calendar days notice

Overall Highlights:

- The average length of stay is approximately 5 months. In 2010, the average length of stay was also 5 months.
- There was no change in the ROLES score in 2011 from 2010. For both years, the ROLES score was between regular foster care and individual home – emergency shelter.
- Upon discharge, 31% (16) of the youth were placed in a less restrictive setting.
- 71% (31) of the departures were recommended by the child and family team.

Children in Child Welfare Custody Highlights:

- The average length of stay is approximately 5 months. In 2010, the average length of stay was approximately 6 months.
- The ROLES score decreased in 2011 from 2010. In 2011, the ROLES score was individual home – emergency shelter. In 2010, the ROLES score was group treatment home.
- Upon discharge, 22% (8) of the youth were placed in a less restrictive setting.
- 68% (25) of the departures were recommended by the child and family team.

Opportunities for Improvement:

- Compared to 2010, OASIS reported fewer youth departures having Child and Family Teams (CFTs) recommend the departures. In 2010, 79% of the departures were recommended by the CFT, and in 2011 71% of the departures were recommended by the CFT.
- CFTs 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. 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

OASIS submitted all of its 2011 risk measures and departure conditions. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2011 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of medication errors, AWOLs, supervision and child safety, placement stability, and CFTs. While OASIS did report fewer restraint and manual guidance incidents in 2011 than in 2009 and 2010; it is recommended that the provider agency continue to work with staff in practicing de-escalation techniques as well as to continue to reduce injuries to both staff and youth.

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 is also developing and will distribute to provider policy implementation and review tools for discipline, restraint and use of force, privacy and confidentiality and dispute resolution. The PEU would encourage the provider's use of these tools to assist in developing their own program improvement planning to address some of the areas identified in their 2011 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

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ATTACHMENT E

Division of Child and Family Services
DCFS ADOLESCENT TREATMENT CENTER (ATC)
Risk Measures and Departure Conditions Report - 2011

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 2011 report is the fourth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2011 through December 2011. ATC submitted a timely and complete data set in 2011 and is to be commended for their willingness to share this very important information.

During this reporting period a risk measure was added for "incidents" of child-on-child physical incidents and child-on-child sexual incidents. Public child welfare partners requested this data be collected and analyzed in order to further ensure child safety in out of home placement.

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 incidences goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2011 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.

- In 2011, policy implementation reviews with providers were conducted. The reviews included Structured Therapeutic Environment, Medication Management and Administration and Crisis Triage. The reviews included face to face meetings between PEU and providers to review 2010 risk measures and departure conditions reports in order to provide technical assistance in regard to accurate reporting of data and review recommendations for quality improvement.

The focus of the policy implementation reviews was not only to determine whether providers were implementing policies as required in the State of Nevada DCFS contract, the Washoe County Department of Social Services contract, and the Clark County Department of Family Services contract but also on improving practice standards as well as quality improvement activities such as data collection, data analysis and the further development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide. In many instances, the PEU determined providers were tracking risk measure data accurately and they were reporting the data as required to the PEU. In those instances in which providers were not tracking and reporting data accurately, the policy implementation review further assisted the PEU and providers in addressing these issues in order to minimize data collection and analysis limitations.

Data analysis limitations do continue 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

Five 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 five risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance
- Physical and/or Sexual Incidents (child on child)

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 five risk areas and departure conditions.

ATC PROGRAM INFORMATION

MEDICAID REPORT 2012
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2011 SUMMARY

This report for ATC is the analysis or risk measures and departure conditions data collected from January 2011 though December 2011.

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**	
2011	15.6	2011	19.2
	Range: 14 to 18		Range: 17 to 23
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
2008	18		
	Range: 15 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.

Attempted and completed suicide incidents reported by ATC are reflected in Table 2. ATC reported zero incidents of attempted or completed suicide in the 2011 reporting period.

Table 2

SUICIDE INCIDENTS		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2011	0	0
2010	1	0
2009	0	0
June 2008 – Dec 2008	0	0

Practice Guidelines and Opportunities for Improvement

- Ensure that all provider agencies have a suicide protocol, and specialized foster parents and staff are trained to use 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 3

Table 3

MEDICATION ERRORS	
Reporting Period	**Number of Errors**
2011	2
2010	0
2009	1
June 2008 – Dec 2008	0

Clinical and Medication Error Information

- One youth had a diagnosis of Mood D/O NOS and one youth had a diagnosis of Bipolar D/O
- Both medication errors were omission errors and both of the medication errors involved psychotropic medication

- Medication error outcome was that both errors did not cause the patient harm
- One error occurred on Tuesday and the other occurred on Wednesday
- Both errors occurred in the evening, between 5:00 PM and 8:00 PM
- ATC reported all agency staff received initial and refresher training in medication administration.

Practice Guidelines and Opportunities for Improvement

- Workplace distraction is a leading factor contributing to omission medication errors. The majority of medication errors reported by ATC were omission errors. 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). 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.
- 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, 1993).

The PEU is available to provide technical assistance on any of these issues and opportunities for improvement. 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 in the four reporting periods are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	**Number of AWOLs**
2011	8
2010	4
2009	8
June 2008 – Dec 2008	0

Descriptive Information

- 4 (50%) female, 4 (50%) male
- Average age was 15.8 with an age range of 14 to 17 years
- 8 (100%) Caucasian
- 1 (12.5%) Hispanic origin
- Custody

- 4 (50%) parental custody with probation involvement
- 3 (37.5%) child welfare custody
- 1 (12.5%) parental custody with no probation involvement

Clinical and AWOL Information

- The most frequent diagnosis was Bipolar D/O (2 or 25% of youth)
- Average length of absence was 5.5 days with a range of 1 to 12 days.
- 8 (100%) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
  - 5 (62.5%) left from specialized foster home during the day, staff awake
  - 3 (37.5%) left the specialized foster home during the night, staff awake
- Behavior during AWOL
  - 3 (37.5%) substance abuse
  - 3 (37.5%) unknown
  - 1 (12.5%) sexual activity
  - 1 (12.5%) Other: youth went directly to West Hills
- AWOL Day
  - 3 (37.5%) Tuesday
  - 2 (25%) Sunday
  - 2 (25%) Saturday
  - 1 (12.5%) Thursday
- AWOL Time
  - 7 (87.5%) went AWOL at between 7:00 PM and 8:45 PM
  - 1 (12.5%) went AWOL at 12 noon
- Outcome
  - 2 (25%) returned through juvenile detention
  - 6 (75%) Other:
    - Explanation:
      1. Arrested and detained at Jan Evans
      2. Found by agency staff, picked up by DCFS guardian, placed with relatives
      3. In detention one week, committed to China Springs
      4. In detention, being referred to a more secure treatment center
      5. Turned in by mother to Jan Evans Detention, remains in detention
      6. Youth went directly to West Hills.

Practice Guidelines and Opportunities for Improvement

- Focus on developing protocols regarding supervision in the home and AWOL prevention when staff is awake. In this reporting period and in the 2010 reporting period, 100% of the AWOLs occurred when staff was awake and presumably available for supervision.
- 100% of youths who went AWOL from ATC in this reporting period had a history of AWOL. Develop a protocol for children and adolescents who threaten to run away and for youth who have a history of AWOL. 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. ATC should address the issue of family connections, normalcy and personal safety by:
  - scheduling regular visitation with family members
  - promoting family ties such as placement with siblings
  - nurturing other positive relationships in the youth's life, such as a mentor
  - offering activities and recreational opportunities that will interest youth
  - providing personal safety training
  - informing 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. Restraint and manual guidance are both methods 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 staff present during the restraint/manual guidance incidents received both initial and refresher training.

The number of restraint incidents reported by ATC in the four reporting periods is noted in Table 5.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	**Number of Restraints/Manual Guidance**
2011	4
2010	6
2009	3
June 2008 – Dec 2008	4

Descriptive Information

- 3 (75%) were male and 1 (25%) were female
- Average age was 13.5 with an age range of 13 to 14 years.
- 4 (100%) were Caucasian.
- 2 (50%) were of Hispanic origin
- 4 (100%) were in child welfare custody

Clinical and Restraint/Manual Guidance Information

- The most frequent diagnosis was Reactive Attachment D/O (2 or 50% of youth)
- 2 (50%) youth had a restraint used on them previously.
- Average length of restraints was 4.5 minutes, ranging from 3 to 5 minutes.
- Restraint and Manual Guidance Event
  - 3 (75%) physically assaultive toward an adult
  - 1 (25%) physically assaultive toward another youth
- Restraint Month
  - 2 (50%) June
  - 1 (25%) December
  - 1 (25%) August
- Restraint Time
  - 3 (75%) occurred between the hours of 6:35 PM and 8:35 PM
  - 1 (25%) occurred at 3:30 PM
- 4 (100%) type of supervision was group – 2 or 3
- Injury report
  - 4 (100%) No one injured

Highlights:

- No youth or staff was injured as a result of restraints used during the current reporting period.

Practice Guidelines and 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, 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, 2007).
- 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, 1999).
- 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 staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Physical and/or Sexual Incidents (child on child)

Specialized foster care providers were asked to track and report the number of child-on-child physical and sexual incidents.

A physical incident is defined as any intentional aggressive physical contact occurring between 2 youth (e.g., biting, choking, jumping on, kicking, punching, scratching, pushing, spitting, etc.) regardless of injury. Such an incident would have resulted in an incident report or other required documentation to licensing entities, legal guardian, etc.

A sexual incident is defined as a program participant (i.e., child or youth in placement with the provider) sexually touches or assaults another individual without consent. Some type of physical touching behavior characterizes this behavior.

Child-on-child physical and sexual incidents reported by ATC are noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2011	2

Descriptive Information

- Victim
  - 2 (100%) of the victims were male
  - Average age of victims was 15 with an age range of 15 to 16 years
  - 1 (50%) of victims were in parental custody with probation involvement; 1 (50%) of victims were in child welfare custody
- Initiator
  - 2 (100%) of the initiators were male
  - Average age of initiators was 14.5 with an age range of 14 to 15
  - 2 (100%) of initiators were in child welfare custody

Clinical and Physical and/or Sexual (child on child) Information

- The most frequent diagnosis was
  - 1 (50%) PTSD, 1 (50%) Bipolar D/O for the victim
  - 1 (50%) PTSD, 1 (50%) Mood D/O for the initiator
- History of physical or sexual abuse
  - 1 (50%) of the victims had a history of physical or sexual abuse

  - 2 (100%) of the initiators had a history of physical or sexual abuse
  - 2 (100%) of initiators had a history of initiating physical or sexual incidents.
- Physical and/or sexual incidents
  - 2 (100%) physical incidents
- Type of supervision
  - 2 (100%) of the incidents occurred in the home during the day, staff awake
- Incident reporting
  - 2 (100%) of the incidents were reported to the guardian
  - Neither (0%) of the incidents were reported to Child Protective Services

Practice Guidelines and Opportunities for Improvement

- At the time of pre-placement planning and admission, an assessment of relevant risk factors and the youth's history of being the victim or being the initiator of physical or sexual incidents should be explored as this will inform the treatment planning and services provided in order to better ensure child safety and placement stability. This is an important opportunity for improvement at ATC since all of incidents involved youth who had a history being initiators of such incidents.
- Focus on developing protocols regarding supervision in the home; both of the incidents reported by ATC occurred when staff was awake and presumably available for supervision.
- Teach staff and supervisors how to identify behavioral symptoms of possible physical and sexual incident including but not limited to:
  - Nightmares, sleep problems, and/or extreme fears without explanation
  - An older child regressing to a younger child's typical behavior (finger-sucking, bedwetting, etc.)
  - Using different or adult words for body parts
  - Begins to show fear of going to certain places and/or spending time with another youth
  - Resists routine bathing
  - Observation of unexplained marks or injuries
  - Changes in interactions with another youth (Stop It Now, 2010; World Health Organization, 2006)
- Teach staff and supervisors how to provide support to youth concerning the disclosure of the physical and/or sexual incident (World Health Organization, 2006).

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-three (43) discharges in the 2010 reporting period.

Descriptive Information

- 26 (60.5%) were male and 17 (39.5%) were female
- Average age was 14.9 with an age range of 12 to 17 years
- Race
  - 34 (79.1%) Caucasian
  - 6 (14%) Black/African-American
  - 2 (4.7%) mixed race.

  - 1 (2.3%) American Indian
- 11 (25.6%) were of Hispanic origin.
- Custody Status
  - 18 (41.9%) parental custody and on probation
  - 15 (34.9%) parental custody with no juvenile probation involvement
  - 10 (23.3%) child welfare custody
- 41 (95.4%) of the discharged youth were Medicaid or SCHIP recipients
- The average length of stay for youth discharged from ATC in 2011 was 130.5 days, ranging from 1 day to 268 days. 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 most frequent diagnoses at admission
  - 10 (23.3%) Mood D/O NOS
  - 6 (14%) Bipolar D/O
  - 5 (11.6%) Posttraumatic Stress Disorder
  - 4 (8.7%) Major Depressive Disorder, Recurrent, Unspecified
- The 3 most frequent diagnoses at discharge
  - 8 (18.6%) Mood D/O, NOS
  - 7 (16.3%) Bipolar D/O
  - 5 (11.6%) Posttraumatic Stress D/O
- The average CASII composite score at admission was 24.1.
- The average CASII composite score at discharge was 21.5.
- Reason for departure
  - 18 (41.9%) reunified with biological family
  - 9 (20.9%) placed in a less restrictive environment
  - 5 (11.6%) placed in a more restrictive environment
  - 4 (9.3%) relative placement
  - 3 (7%) AWOL
  - 2 (4.7%) removed by placing agency
  - 2 (4.7%) Other:
    - Explanation: both youth were discharged against medical advice by parent
- The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) is used to calculate the restrictiveness of living score for youth at discharge from the specialized foster care program.

  The restrictiveness of living scores reported by ATC as well as the setting for each score is noted in Table 7.

Table 7

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	**Restrictiveness Score**	**Setting**
2011	10.4	Regular foster care
2010	11.3	Specialized foster care
2009	11.2	Specialized foster care
2008	6.2	Home of a relative

Setting in which child/adolescent will live
- 19 (44.2%) home of birth/adoptive parents, for a child
- 4 (9.3%) home of a relative
- 2 (4.7%) regular foster care
- 1 (2.3%) family based treatment home
- 7 (16.3%) group treatment home
- 2 (4.7%) residential treatment center
- 1 (2.3%) youth correction center
- 7 (16.3%) county detention center

- 28 (65.1%) youth had completed treatment at discharge
- Who recommended discharge
  - 37 (86.1%) child and family teams.
  - 1 (2.3%) judge/hearing master
  - 1 (2.3%) N/A; youth went AWOL
  - 2 (4.7%) Other: parent discharged youth against medical advice
  - 1 (2.3%) probation/parole officer
  - 1 (2.3%) provider agency with required notice given
- Treatment Completed
  - 28 (65.1%) Yes
  - 15 (34.9%) No
- Transition plan appropriate
  - 40 (93%) Yes
  - 3 (7%) No
    - Explanation:
      1. (2) youth were discharge by parent against medical advice
      2. family was not prepared
- Discharge plan appropriate
  - 40 (93%) Yes
  - 3 (7%) No.
    - Explanation:
      - (2) youth were discharge by parent against medical advice
      - family was not prepared

Highlights
- 86.1% of the discharges were recommended by CFTs.
- 65.1% of the youths completed treatment at discharge.

- Upon discharge, 72.1% of youth were going to a less restrictive environment. In the 2010 reporting period, 60% of youth were going to a less restrictive environment.

Youth in Child Welfare Custody

Of the 43 discharges reported by ATC in the 2011 reporting period, 10 (23.3%) were in the custody of a public child welfare agency.

Descriptive Information

7 (70%) female, 3 (30%) male

- Average age was 15 with an age range of 13 to 17 years.
- Race
  - 5 (50%) were Caucasian
  - 5 (50%) were Black/African American
- 3 (30%) were of Hispanic origin
- 10 (100%) were Medicaid recipients.
- The average length of stay at ATC in 2011 for youth in the custody of a public child welfare agency was 156.4 days, ranging from 48 to 262 days. In the 2010 reporting period, the average length of stay was 109.6 days, ranging from 11 days to 205 days.

Clinical and Departure Information

The most frequent diagnosis at admission was Bipolar D/O NOS (2 or 20% of youth). This was also the most frequent diagnosis at discharge as well (3 or 30%).

- The average CASII composite score at admission was 24.6.
- The average CASII composite score at discharge was 21.2.
- Reason for departure
  - 6 (60%) placed in a less restrictive setting
  - 2 (20%) reunified with biological family
  - 1 (10%) relative placement
  - 1 (10%) removed by placing agency
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 11.6, which equals the restrictiveness of living in specialized foster care. In the 2010 reporting period the average score was 12.9, which equals the restrictiveness of living in a family based treatment home.
  - 2 (20%)) home of birth/adoptive parents, for a child
  - 1 (10%) home of a relative
  - 1 (10%) regular foster care
  - 1 (10%) family based treatment home
  - 4 (40%) group treatment home
  - 1 (10%) county detention center
- 7 (70%) completed treatment
- Who recommended departure
  - 10 (100%) child and family team
- Transition plan appropriate
  - 10 (100%) Yes
- Discharge plan appropriate
  - 10 (100%) Yes

Children in Child Welfare Custody Highlights:

Upon discharge, 90% of youth returned to a less restrictive environment. In the 2010 reporting period, 72.3% of youth returned to a less restrictive environment.

Upon discharge, 30% of the youth reached permanency. In the 2010 reporting period, 22.3% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives)

70% of youth completed treatment.

100% of the discharges were recommended by Child and Family Teams.

Practice Guidelines and Opportunities for Improvement

- During the pre-placement process, a placement preparation plan should be developed by the Child and Family Team (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.
- 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. 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 2011 risk measures and departure conditions. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2011 Risk Measures and Departure Conditions report reflects multiple of practice guidelines and opportunities for improvement in the areas of medication errors, AWOL, restraint and manual guidance, physical and sexual incidents, and CFTs in treatment planning to ensure child safety, permanency and well-being.

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 and will shortly be distributing similar tools for the provider's discipline policy, client confidentiality and privacy policy, disputes and grievances policy, and restraint and use of force policy. The PEU would encourage the provider's use of these tools to develop and enhance their own program improvement planning to address some of the areas identified in their 2011 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

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ATTACHMENT F

Division of Child and Family Services
DCFS FAMILY LEARNING HOMES (FLH)
Risk Measures and Departure Conditions Report - 2011

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 2011 report is the fourth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2011 through December 2011. FLH submitted a timely and complete data set in 2011 and is to be commended for their willingness to share this very important information.

During this reporting period a risk measure was added for "incidents" of child-on-child physical incidents and child-on-child sexual incidents. Public child welfare partners requested this data be collected and analyzed in order to further ensure child safety in out of home placement.

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 incidences goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2011 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.

- In 2011, policy implementation reviews with providers were conducted. The reviews included Structured Therapeutic Environment, Medication Management and Administration and Crisis Triage. The reviews included face to face meetings between PEU and providers to review 2010 risk measures and departure conditions reports in order to provide technical assistance in regard to accurate reporting of data and review recommendations for quality improvement.

The focus of the policy implementation reviews was not only to determine whether providers were implementing policies as required in the State of Nevada DCFS contract, the Washoe County Department of Social Services contract, and the Clark County Department of Family Services contract but also on improving practice standards as well as quality improvement activities such as data collection, data analysis and the further development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide. In many instances, the PEU determined providers were tracking risk measure data accurately and they were reporting the data as required to the PEU. In those instances in which providers were not tracking and reporting data accurately, the policy implementation review further assisted the PEU and providers in addressing these issues in order to minimize data collection and analysis limitations.

Data analysis limitations do continue 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

Five 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 five risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance
- Physical and/or Sexual Incidents (child on child)

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 five risk areas and departure conditions.

FLH PROGRAM INFORMATION

This analysis is based on data collected from January 2011 though December 2011.

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**	
2011	18.9	2011	20.8
	Range: 16 to 20		Range: 19 to 24
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.

Attempted or completed suicides reported by FLH are reflected in Table 2.

Table 2

SUICIDE INCIDENTS		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2011	3	0
2010	0	0
2009	0	0
June 2008 – Dec 2008	1	0

Based on the descriptive and clinical data reported, it appears the 3 suicide attempts were for the same youth. The youth was a 17 year old female of the Caucasian race and non-Hispanic origin. She was in parental custody with probation involvement.

The youth had a diagnosis of Bipolar D/O and on 2 occasions attempted suicide by cutting; the third suicide attempt was by wrapping a belt around her neck and squeezing the belt tightly. The youth had a history of suicide attempts.

In 2 instances following the suicide attempts, the youth was taken for a psychiatric evaluation however, she was not hospitalized either time. In the last instance, the youth was taken by law enforcement to Jan Evans and was later admitted to ATC.

In all 3 incidents, FLH reported it implemented the agency's suicide protocol. In all 3 incidents, the agency reported staff was trained in the agency's suicide protocol.

Highlights:

- FLH has a suicide protocol in place and staff involved in these 3 suicide attempts was trained in the protocol.

Practice Guidelines and Opportunities for Improvement

- Ensure that all provider agencies have a suicide protocol, and specialized foster parents and staff are trained to use 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 FLH are noted in Table 3.

Table 3

MEDICATION ERRORS	
Reporting Period	**Number of Errors**
2011	9
2010	3
2009	3
June 2008 – Dec 2008	0

Clinical and Medication Error Information

- The 3 most frequent diagnoses
  - 3 (33.3%) Posttraumatic Stress D/O
  - 2 (22.2%) ADHD
  - 2 (22.2%) Bipolar D/O
- Type of medication error
  - 3 (33.3%) Omission error
  - 2 (22.2%) Improper Dose
  - 1 (11.1%) Wrong drug preparation
  - 3 (22.2%) Other:
    - Explanation: (3 incidents) Client dropped medication during administration and could not find it. Client given another pill from bottle.
- 9 (100%) of the medication errors involved psychotropic medications
- Medication error outcome
  - 6 (66.7%) an error occurred but did not reach the patient
  - 3 (33.3%) an error occurred but the error did not cause the patient harm
- Medication error day
  - 6 (66.7%) Tuesday
  - 2 (22.2%) Wednesday
  - 1 (11.1%) Sunday
- Medication error time
  - 6 (66.7%) occurred at 8:00 PM
  - 2 (22.2%) occurred at 8:00 AM
  - 1 (11.1%) occurred at 2:00 PM
- Custody Status
  - 5 (55.6%) parental custody with probation involvement
  - 3 (33.3%) child welfare custody
  - 1 (11.1%) parental custody with no probation involvement
- FLH reported all agency staff received initial and refresher training in medication administration and management.

Opportunities for improvement:

- Three of the medication errors reported by FLH were omission errors. 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).

- 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.
- More than half of the medication errors occurred in the evening at or close to bedtime. FLH may want to review practice, staffing and program routines from during the evening (after dinner time but before bedtime) since these times represent the preponderance of medication error incidents reported by the program.
- 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, 1993).

The PEU is available to provide technical assistance on any of these issues and opportunities for improvement. 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 are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	**Number of AWOLs**
2011	6
2010	7
2009	8
June 2008 – Dec 2008	3

Descriptive Information

- 5 (83.3%) female, 1 (16.7%) male
- Average age was 16.5 with an age range of 14 to 17 years

- Race
  - 3 (50%) Caucasian
  - 2 (33.3%) Black/African American
  - 1 (16.7%) was Native Hawaiian
- 6 (100%) non-Hispanic origin
- Custody Status
  - 3 (50%) were in child welfare custody
  - 2 (33.3%) were in parental custody with not probation involvement
  - 1 (16.7%) was in parental custody and had probation involvement

Clinical and AWOL Information

- The most frequent diagnosis was Bipolar D/O (2 or 33.3%)
- Average length of absence was 5 days with a range of 3 to 7 days.
- 6 (100%) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL
  - 3 (50%) left from specialized foster home during the day, staff awake
  - 2 (33.3%) left the specialized foster home during the night, staff awake
  - 1 (16.7%) left from school or work
- Behavior during AWOL
  - 5 (83.3%) unknown
  - 1 (16.7%) substance abuse
- AWOL Day
  - 3 (50%) Tuesday
  - 1 (16.7%) Wednesday
  - 1 (16.7%) Saturday
  - 1 (16.7%) Friday
- AWOL Time
  - 3 (50%) occurred between 8:00 PM and 11:00 PM
  - 2 (33.3%) occurred at 10:40 AM
  - 1 (16.7%) occurred at 4:00 PM

- Outcome
  - 2 (33.3%) absent indefinitely
  - 2 (33.3%) found with family and returned to the specialized foster home
  - 1 (16.7%) found with family and stayed with family
  - 1 (16.7%) returned through juvenile detention

Practice Guidelines and Opportunities for Improvement

- Focus on developing protocols regarding supervision in the home and AWOL prevention when staff is awake. In this reporting period, 83.3% of the AWOLs occurred when staff was awake and presumably available for supervision. In the 2010 reporting period, 100% of the AWOLs occurred when staff was awake and presumably available for supervision.
- 100% of youths who went AWOL from FLH in this reporting period as well as in the 2010 reporting period had a history of AWOL. Research tells us that children with a history of AWOL are at greater risk of going AWOL again. Having this historical AWOL information for children provides FLH staff with the opportunity to minimize this risk by developing a protocol for those

children and adolescents who threaten to run away and for youth who have a history of running away or going AWOL. 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. This is a focus FLH should attend to since 50% of youth who went AWOL in this reporting period were found with their family. FLH should address the issue of family connections, normalcy and personal safety by:
  - scheduling regular visitation with family members
  - promoting family ties such as placement with siblings
  - nurturing other positive relationships in the youth's life, such as a mentor
  - offering activities and recreational opportunities that will interest youth
  - providing personal safety training
  - informing 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 staff present during the restraint/manual guidance received both initial and refresher restraint training; one staff did not receive the annual training.

The number of restraint incidents reported by FLH is noted in Table 5.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	**Number of Restraints/Manual Guidance**
2011	21
2010	6
2009	7
June 2008 – Dec 2008	2

Descriptive Information

- 20 (95.2%) male, 1 (4.8%) female
- Average age was 7.6 with an age range of 5 to 12 years.
- Race
  - 18 (85.7%) Caucasian
  - 3 (14.3%) were American Indian
- 2 (9.5%) were of Hispanic origin
- Custody Status
  - 18 (85.7%) child welfare
  - 3 (14.3%) parental custody with no probation involvement

Clinical and Restraint/Manual Guidance Information

- The 3 most frequent diagnoses
  - 15 (71.4%) Posttraumatic Stress D/O
  - 3 (14.3%) Intermittent Explosive D/O
  - 2 (9.5%) Bipolar D/O
- 17 (81%) of youth had a restraint used on them previously.
- Average length of restraints was 15.2 minutes, ranging from 1 to 50 minutes. In the 2010 reporting period, the average length of restraints was 19 minutes, ranging from 3 minutes to 75 minutes.
- Restraint Event
  - 8 (38.1%) physically assaultive toward another youth
  - 6 (28.6%) putting self at risk of harm
  - 5 (23.8%) physically assaultive toward an adult
  - 2 (9.5%) youth running away
- Restraint Time
  - 3 (14.4%) occurred between the hours of 8:00 AM and 10:30 AM
  - 4 (19.2%) occurred between the hours of 12:30 PM and 5:00 PM
  - 14 (67.2%) occurred between the hours of 5:00 PM and 9:00 PM
- Restraint Month
  - 7 (33.3%) May
  - 6 (28.6%) April
  - 3 (14.3%) September
  - 2 (9.5%) March
  - 1 (4.8%) June
  - 1 (4.8%) July
  - 1 (4.8%) December

- Type of supervision
  - 14 (66.6%) group 4 or more
  - 4 (19.1%) group 2 or more
  - 3 (14.3%) one-on-one
- Injury report
  - 16 (76.2%) no one was injured
  - 2 (9.6%) client injured
    - Explanation:
      1. youth received rug rash on the right and left check
      2. youth received rug burn on his elbow
  - 5 (24%) staff injured
    - Explanation:
      1. client bit staff and scratched staff's hand
      2. staff bruised on neck from client grabbing her in a strangle hold
      3. staff was kicked in the jaw and client spit in staff face/eye.
      4. (2 incidents) staff hurt their backs and had bruises from client hitting them. Client also spit at them.
- All staff involved in restraint incidents received the initial restraint training. All staff, with the exception of one, received the refresher restraint training.

Practice Guidelines and Opportunities for Improvement

- FLH's use of restraint increased by almost 30% over the 2010 reporting period.
  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 staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Physical and/or Sexual Incidents (child on child)

Specialized foster care providers were asked to track and report the number of child-on-child physical and sexual incidents.

A physical incident is defined as any intentional aggressive physical contact occurring between 2 youth (e.g., biting, choking, jumping on, kicking, punching, scratching, pushing, spitting, etc.) regardless of injury. Such an incident would have resulted in an incident report or other required documentation to licensing entities, legal guardian, etc.

A sexual incident is defined as a program participant (i.e., child or youth in placement with the provider) sexually touches or assaults another individual without consent. Some type of physical touching behavior characterizes this behavior.

Child-on-child physical and sexual incidents reported by FLH are noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2011	4

Descriptive Information

- Victim
  - 4 (100%) of the victims were male
  - Average age of victims was 12.3 with an age range of 11 to 14 years
  - 1 (50%) of victims were in parental custody with probation involvement; 1 (50%) of victims was in parental custody with no probation involvement
- Initiator
  - 4 (100%) of the initiators were male
  - Average age of initiators was 10.5 with an age range of 9 to 12
  - 2 (100%) of initiators were in child welfare custody; 2 (50%) were in parental custody with no probation involvement

Clinical and Physical and/or Sexual (child on child) Information

- The most frequent diagnoses
  - 2 (50%) Psychotic D/O NOS for the victim
  - 2 (50%) Mood D/O; 2 (50%) Bipolar D/O for the initiator
- History of physical or sexual abuse
  - 2 (50%) of the victims had a history of physical or sexual abuse

- 3 (75%) of the initiators had a history of physical or sexual abuse
- 2 (50%) of initiators had a history of initiating physical or sexual incidents.

- Physical and/or sexual incidents
  - 3 (75%) sexual incidents
  - 1 (25%) physical incidents
- Type of supervision
  - 3 (75%) of the incidents occurred in the home during the day, staff awake
  - 1 (25%) of the incidents occurred in the home at night, staff awake
- Incident reporting
  - 4 (100%) of the incidents were reported to the guardian
  - 4 (100%) of the incidents were reported to Child Protective Services

Practice Guidelines and Opportunities for Improvement

- Focus on developing protocols regarding supervision in the home; all of the incidents reported by FLH occurred when staff was awake and presumably available for supervision.
- At the time of pre-placement planning and admission, an assessment of relevant risk factors and the youth's history of being the victim or being the initiator of physical or sexual incidents should be explored as this will inform the treatment planning and services provided in order to better ensure child safety and placement stability. This is an important opportunity for improvement at FLH since 2 of the 4 incidents involved youth who had a history for being initiators of such incidents.
- Teach staff and supervisors how to identify behavioral symptoms of possible physical and sexual incident including but not limited to:
  - Nightmares, sleep problems, and/or extreme fears without explanation
  - An older child regressing to a younger child's typical behavior (finger-sucking, bedwetting, etc.)
  - Using different or adult words for body parts
  - Begins to show fear of going to certain places and/or spending time with another youth
  - Resists routine bathing
  - Observation of unexplained marks or injuries
  - Changes in interactions with another youth

  (Stop It Now, 2010; World Health Organization, 2006)
- Teach staff and supervisors how to provide support to youth concerning the disclosure of the physical and/or sexual incident. (World Health Organization, 2006)

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 27 discharges in the 2011 reporting period.

Descriptive Information

- 18 (66.8%) male, 9 (33.3%) female.
- Average age was 12.4 with an age range of 6 to 17 years.
- Race
  - 21 (77.8%) Caucasian

  - 3 (11.1%) Black/African-American
  - 2 (7.4%) Native Hawaiian
  - 1 (3.7%) American Indian
- 1 (3.7%) youth was of Hispanic origin.
- Custody Status
  - 13 (48.2%) parental custody with no juvenile probation involvement
  - 8 (29.6%) child welfare custody
  - 6 (22.2%) parental custody and probation involvement
- 23 (85.2%) of the discharged youth were Medicaid or SCHIP recipients
- The average length of stay for youth discharged from FLH in 2011 was 162.5 days, ranging from 9 to 233 days. In the 2010 reporting period, the average length of staff 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 3 most frequent diagnoses at discharge
  - 6 (22.2%) Mood Disorder, NOS
  - 5 (18.5%) Posttraumatic Stress Disorder
  - 4 (14.8%) Bipolar D/O, NOS
- The average CASII composite score at admission was 24.2.
- The average ECSSI composite score at admission was 22.
- The average CASII composite score at discharge was 22.2.
- Reason for departure
  - 16 (59.3%) reunified with family
  - 3 (11.1%) placed in a less restrictive environment
  - 2 (7.4%) new specialized foster home, different agency
  - 2 (7.4%) adopted/adoptive placement
  - 2 (7.4%) placed in a more restrictive environment
  - 1 (3.7%) new specialized foster home, same agency
  - 1 (3.7%) relative placement
- The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) is used to calculate the restrictiveness of living score for youth at discharge from the specialized foster care program.

  The restrictiveness of living scores reported by FLH as well as the setting for each score is noted in Table 7.

Table 7

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	**Restrictiveness Score**	**Setting**
2011	6.6	Adoptive Home
2010	11.3	Specialized foster care
2009	10.8	Specialized foster care
2008	7.5	Adoptive Home

Setting in which child/adolescent will live
- 17 (63%) home of parents, for a child
- 1 (3.7%) home of a relative
- 2 (7.4%) adoptive home
- 2 (7.4%) regular foster care
- 2 (7.4%) family based treatment home
- 2 (7.4%) group treatment home
- 1 (3.7%) residential treatment center

- 21 (77.8%) youth had completed treatment at discharge.
- Who recommended discharge
  - 23 (85.2%) child and family team
  - 3 (11.1%) parent
  - 1 (3.7%) provider agency
- Transition plan appropriate
  - 25 (92.6%) Yes
  - 2 (7.4%) No
    - Explanation:
      1. Client continued to need treatment level placement. Parents did not want to commute to participate in therapy and parent training.
      2. Father lived in Las Vegas and did not want to wait until client graduated from FLH to go to live with him after mother signed legal custody over to father. CFT did not have time to put services in place before he left however, father arranged outpatient.
- Discharge plan appropriate
  - 25 (92.6%) Yes
  - 2 (7.4%) No
    - Explanation:
      1. Parents did not support Boys Town model. Wanted to use corporal punishment and FLH did not support this.
      2. Same reason.

Highlights:
- Upon discharge, 77.8 % of the youth were going to a less restrictive environment.
- Upon discharge, 74.1% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- 77.8% of youth completed treatment at the time of discharge.
- 85.2% of the discharges were recommended by Child and Family Teams.

Youth in Child Welfare Custody

Of the 27 discharges reported by FLH in the 2011 reporting period, 8 (29.6%) were for youth in the custody of a public child welfare agency.

Descriptive Information

7 (87.5%) male, 1 (12.5%) female

- Average age was 11.3 with an age range of 7 to 17 years.
- Race
  - 5 (62.5%) Caucasian
  - 1 (12.5%) Native Hawaiian
  - 1 (12.5%) American Indian
  - 1 (12.5%) Black/African American
- 100% (8) were Medicaid recipients.
- The average length of stay at FLH in 2011 was 173.8 days, ranging from 9 days to 296 days. In the 2010 reporting period, the average length of stay was 109.6 days, ranging from 11 days to 205 days.

Clinical and Departure information

The most frequent diagnosis at admission was Posttraumatic Stress D/O (3 or 37.5% of youth).

- The most frequent diagnoses at discharge were Posttraumatic Stress D/O (2 or 25% of youth) and ADHD (2 or 25% of youth)
- The average CASII composite score at admission was 25.6.
- The average CASII composite score at discharge was 23.
- Reason for departure
  - 2 (25%) new specialized foster home, different agency
  - 2 (25%) placed in a less restrictive setting
  - 1 (12.5%) new specialized foster home, same agency
  - 1 (12.5%) adopted/adoptive placement
  - 1 (12.5%) placed in a more restrictive setting
  - 1 (12.5%) relative placement
- Setting 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 living in a specialized foster home. In the 2010 reporting period, the average score was 12.9, which equals the restrictiveness score of living in a family based treatment home.
  - 1 (12.5%) home of a relative
  - 1 (12.5%) adoptive home
  - 2 (25%) regular foster care
  - 2 (25%) family based treatment home
  - 1 (12.5%) group treatment home
  - 1 (12.5%) residential treatment center
- 6 (75%) completed treatment at discharge.
- Who recommended departure
  - 7 (87.5%) child and family team
  - 1 (12.5%) provider agency
- Transition plan appropriate
  - 100% (8) yes

- Discharge plan appropriate
- 100% (8) yes

Children in Child Welfare Custody Highlights:

Upon discharge, 50% of youth returned to a less restrictive environment.
Upon discharge, 25% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives)
75% of youth completed treatment at the time of discharge.
87.5% of the discharges were recommended by child and family teams.

Practice Guidelines and Opportunities for Improvement

- During the pre-placement process, a placement preparation plan should be developed by the Child and Family Team (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 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

FLH submitted all of its 2011 risk measures and departure conditions. This provider has consistently demonstrated its commitment to program improvement by its willing collaboration with the DCFS Planning and Evaluation Unit.

This 2011 Risk Measures and Departure Conditions report reflects multiple of practice guidelines and opportunities for improvement in the areas of medication errors, AWOL, restraint and manual guidance, physical and sexual incidents, and CFTs in treatment planning to ensure child safety, permanency and well-being.

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 and will shortly be distributing similar tools for the provider's discipline policy, client confidentiality and privacy policy, disputes and grievances policy, and restraint and use of force policy. The PEU would encourage the provider's use of these tools to develop and enhance their own program improvement planning to address some of the areas identified in their 2011 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

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ATTACHMENT G

WRAPAROUND FIDELITY INDEX (WFI-2) SUMMARY REPORT

SEPTEMBER, 2011

WIN SOUTH PROGRAM

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 Southern 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

- 142 youth were randomly selected 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 300 WFI interviews for 142 youth.**
  - The number of facilitator interviews was 142.
  - The number of parent/caregiver interviews was 103.
  - The number of youth interviews was 55.

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 phase and respondent
- 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.

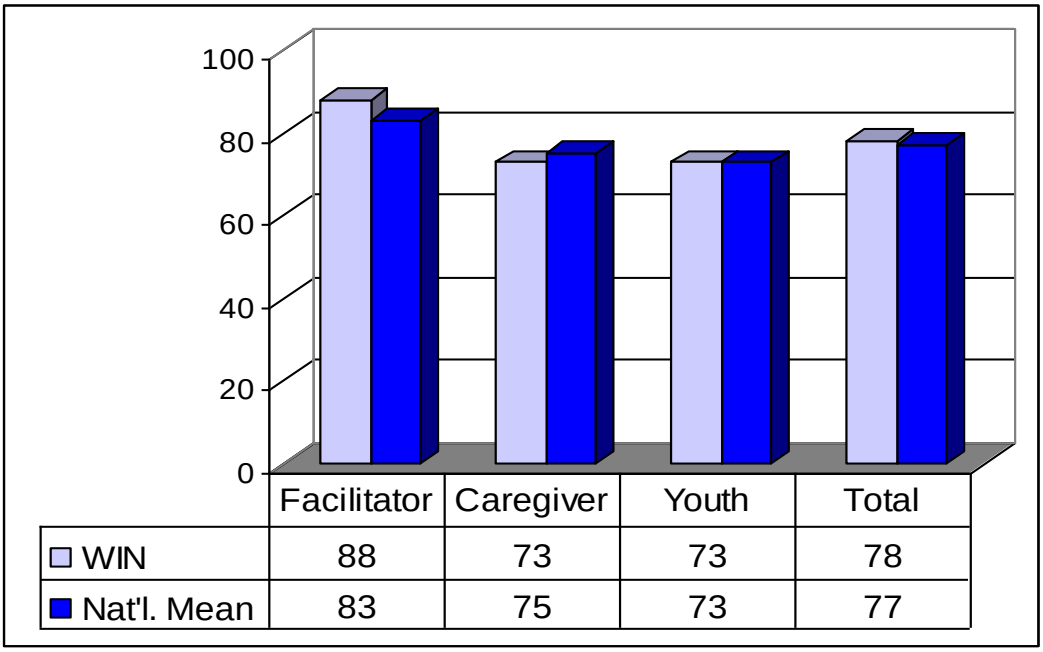
Results – Youth Information and Demographics

GENDER	Male	78 (54.9%)
	Female	64 (45.1%)
RACE	White/Caucasian	70 (49.3%)
	Black/African-American	52 (36.6%)
	American Indian/Alaskan Native	1 (.7%)
	Mixed Race	14 (9.9%)
ETHNICITY	Hispanic origin	31 (21.8%)
AGE	Mean	13.04
ENROLLED IN SCHOOL (LAST 30 DAYS)		135 (95.1%)
CAREGIVER RELATIONSHIP TO YOUTH		
	Parent	37 (26.1%)
	Adoptive parent	9 (6.3%)
	Foster parent	74 (52.1%)
	Aunt or uncle	8 (5.6%)
	Grandparent	7 (4.9%)
	Other Family Member	2 (1.4%)
	Friend (adult friend)	1 (.7%)
	Other	3 (2.1%)
LEGAL CUSTODY		
	Ward of the state or county	116 (81.7%)
	Two parents	9 (6.3%)
	Birth mother only	10 (7.0%)
	Adoptive parent(s)	4 (2.8%)
	Grandparent(s)	1 (.7%)
	Birth father only	1 (.7%)
	Siblings	1 (.7%)
PLAN TO REUNITE WITH BIRTH PARENTS		34 (23.9%)
MONTHS IN WRAPAROUND		Mean: 14.47

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

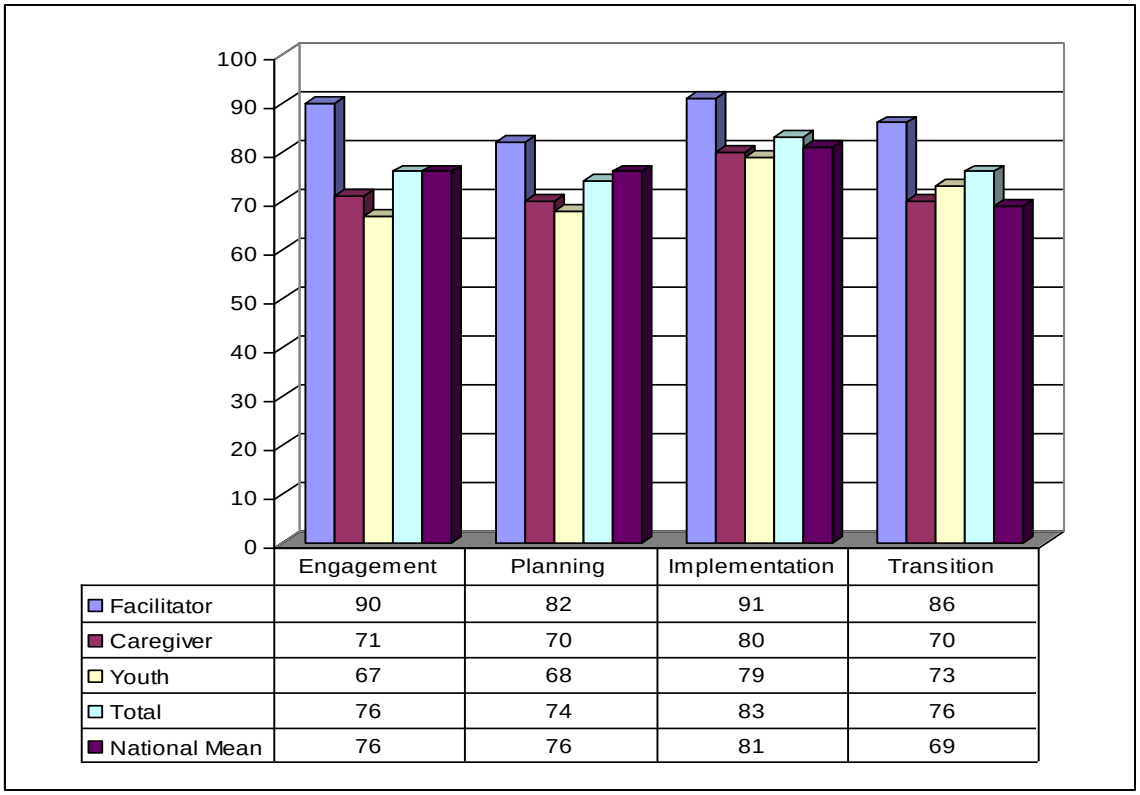
Youth	116 (81.7%)
Birth mother	55 (38.7%)
Birth father	14 (9.9%)
Adoptive parent	7 (4.9%)
Sibling	59 (41.5%)
Friend of parent/caregiver	9 (6.3%)
Friend of youth	2 (1.4%)
Grandparent	20 (14.1%)
Other family member	24 (16.9%)
Family support partner or advocate	7 (4.9%)

Results – Overall Fidelity WIN Southern Region



	Facilitator	Caregiver	Youth	Total
WIN	88	73	73	78
Nat'l. Mean	83	75	73	77

Results – Fidelity Scores by Phase and Group



	Engagement	Planning	Implementation	Transition
Facilitator	90	82	91	86
Caregiver	71	70	80	70
Youth	67	68	79	73
Total	76	74	83	76
National Mean	76	76	81	69

WFI Items: Engagement Phase

Item	Facilitator N=142	Nat'l. Mean	Caregiver N=103	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?	1.94	1.88	1.58	1.65
1.2 Before the first team meeting, did you fully explain the wraparound (WA) process and the choices the family could make?	1.90	1.83	1.50	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?	1.90	1.86	1.59	1.75
1.4 Did the family members select the people who would be on their WA team?	1.41	1.49	0.64	0.86
1.5 Is it difficult to get team members to attend team meetings when they are needed?	**1.73** *Strength*	1.37	1.60	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?	1.93	1.77	1.45	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?	1.92	1.81	1.46	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?	1.83	1.61	1.43	1.56
2.3 Can you summarize the services, supports, and strategies that are in the family's WA plan?	**0.17** *Improve-ment*	0.69	0.46	0.61
2.4 Are the supports and services in the WA plan connected to the strengths and abilities of the child and family?	1.89	1.89	1.82	1.74
2.5 Does the WA plan include strategies for helping the child get involved in her or his community?	1.41	1.53	1.13	1.24
2.6 Are there members of the WA team who do not have a role in implementing the plan?	1.96	1.71	1.63	1.67
2.7 Does the team brainstorm many strategies to address the family's needs before selecting one?	1.94	1.90	1.85	1.73
2.8 Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?	1.83	1.82	1.27	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?	1.79	1.62	1.49	1.50
2.10 Would you say that people other than the family have higher priority than the family in designing their WA plan?	1.58	1.58	1.38	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?	1.82	1.88	1.69	1.73

WFI Items: Implementation Phase

ITEM	FACILITATOR N=142	NAT'L. MEAN	CAREGIVER N=103	NAT'L. MEAN
3.1 Are important decisions ever made about the child or family when they are not there?	1.73	1.73	1.67	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?	1.91	1.81	1.83	1.70
3.3 Does the WA team get the child involved with activities she or he likes and does well?	1.41	1.50	.90	1.20
3.4 Does the team find ways to increase the support the family gets from its friends and family members?	1.63	1.50	1.42	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	1.71	1.70
3.6 Is there a friend or advocate of the child or family who actively participates on the WA team?	1.32	0.97	0.99	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?	1.99	1.95	1.76	1.74
3.8 Are the services and supports in the WA plan difficult for the family to access?	1.86	1.63	1.51	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?	**1.99** *Strength*	1.80	1.72	1.59
3.10 Do members of the team always use language the family can understand?	1.91	1.93	1.92	1.93
3.11 Does the team create a positive atmosphere around successes and accomplishments at each team meeting?	1.96	1.93	1.88	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?	1.96	1.84	1.72	1.67
3.13 Do you think the WA process could be discontinued before the family is ready for it to end?	**1.87** *Strength*	1.50	1.43	1.35

3.14 Do all the members of the team demonstrate respect for the family?	1.94	1.90	1.82	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?	1.93	1.86	1.77	1.71

WFI Items: Transition Phase

Item	Facilitator N=142	Nat'l. Mean	Caregiver N=103	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?	1.21	1.11	0.77	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?	**1.71** *Strength*	1.34	1.29	1.20
4.3 Has the WA process helped the child solve her or his own problems?	1.68	1.52	1.32	1.30
4.4 Has the team helped the child or youth prepare for major transitions by making plans to deal with these changes?	1.86	1.74	1.37	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?	1.89	1.75	1.65	1.61
4.6 Has the WA process helped the family develop or strengthen relationships that will support them when WA is finished?	1.75	1.65	1.52	1.49
4.7 Do you feel like the child and family will be able to succeed without the formal WA process?	**1.74** *Strength*	1.31	1.42	1.22
4.8 Will some members of the team be there to support the family when formal WA is finished?	**1.97** *Strength*	1.68	1.60	1.65

WFI Items: Engagement Phase

Item	Youth N=55	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?	1.72	1.84
1.2 Before your first team meeting, did your WA facilitator fully explain how the WA process would work?	1.69	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?	1.49	1.52
1.4 Did you help pick the people who would be on your WA team?	.60	0.66
1.5 Do you have a friend or advocate who participates actively on your WA team?	1.04	0.99
1.6 Would you have different people on your team if you could?	1.39	1.20

WFI Items: Planning Phase

Item	Youth N=55	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?	1.26	1.22
2.2 During meetings, does your team brainstorm many ideas to meet your needs before picking one?	1.65	1.74
2.3 Does the team know what you like and the things that you do well?	1.77	1.80
2.4 Does your WA plan include things that get you involved with activities in your community?	1.16	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?	1.60	1.59
2.6 Does your WA plan include mostly professional services?	**0.35** *Improve-ment*	0.74
2.7 If things go wrong or there is a crisis, is there a plan that says what everyone must do?	1.42	1.37
2.8 Do you and your family get the help that you need?	1.69	1.75

WFI Items: Implementation Phase

Item	Youth N=55	Nat'l. Mean
3.1 Are important decisions made about you or your family when you are not there?	1.32	1.19
3.2 When your WA team has a good idea, can it figure out some way to make it happen?	1.79	1.73
3.3 Does your WA team get you involved with activities you like and do well?	.90	1.20
3.4 Do people on the team help you do things with your friends and family?	1.47	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?	1.54	1.49
3.6 Does your team come up with new ideas for your WA plan whenever something is not working?	1.71	1.77
3.7 Are the places you go to for services hard to reach because they are far away?	1.32	1.55
3.8 Do members of your team always use language you can understand?	1.93	1.77
3.9 Do your WA team meetings make you feel good about your successes and accomplishments?	1.76	1.70
3.10 Does everyone on your team talk and give their ideas during your WA team meeting?	1.80	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?	1.43	1.49
3.12 Do all the members of your team show respect for you and your family?	**1.69** *Improve-ment*	1.87
3.13 Do you have a chance to give your ideas during the WA team meetings?	1.79	1.77

WFI Items: Transition Phase

Item	Youth N=55	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?	0.97	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?	1.61	1.46
4.3 Has the WA process helped you become friends with other youth in the community?	1.29	1.25
4.4 Has your team helped you prepare for major changes?	1.69	1.53
4.5 Will people on your team be there to help you when WA is finished?	1.70	1.72

ATTACHMENT H

Seclusion and Restraint Emergency Procedures for Children and Youth
Denial of Rights
Report to the Commission on Mental Health and Developmental Services
September 15, 2011

This report summarizes seclusion and restraint emergency procedures information for DCFS residential programs and private facilities from **516** Denial of Rights forms. Data are taken from forms that had seclusion or restraint episodes occur in fiscal year 2011. The high risk criteria proposed by the Commission on Mental Health and Developmental Services is applied to the 516 forms and the results are included in this report. Also, census information and number of restraints are presented for DCFS treatment home programs.

Results

The following table shows the number of denial of rights reports based on forms received by facilities for fiscal year 2011. These counts do not necessarily represent the total number of seclusions and restraints for each facility.

Public Facilities	Number of Reports	Private Facilities	Number of Reports
Adolescent Treatment Center	7 (1.4%)	Monte Vista Hospital	22 (4.3%)
DWTC Adolescent Acute	0 (%)	Spring Mountain Treatment Center	220 (42.6%)
DWTC RTC 1	4 (.2%)	West Hills Hospital	5 (1%)
DWTC RTC 2	0 (%)	Willow Springs Treatment Center	194 (37.6%)
DWTC SATP	0 (%)		
Family Learning Homes	1 (.2%)		
Oasis West 11	7 (1.4%)		
Oasis East 12	6 (1.2%)		
Oasis West 12	18 (3.5%)		
Oasis 13	8 (1.6%)		
Oasis 14	27 (5.2%)		
Total	**75 (14.5%)**		**441 (85.5%)**

Public Facility Results

Demographic Information
Average age: 10.13 ranging from age 7 to 17
Average height: 58.76 inches ranging from 48 to 68
Average weight: 97.86 pounds ranging from 65 to 191

Gender	
Male	51 (68%)
Female	24 (32%)

Race	
American Indian/Alaskan Native	1 (1.3%)

Black/African American	35 (46.7%)
Asian	1 (1.3%)
Native Hawaiian/Other Pacific Islander	1 (1.3%)
White/Caucasian	20 (26.7%)
Other	7 (9.3)
Mixed Race	9 (12%)
Missing	1 (1.3%)
Ethnicity	
Hispanic Origin	8 (10.7%)

Custody Status	
Parent/Family	15 (20%)
Child Welfare	60 (80%)

Children and Adolescents ages 9-17	**Number Reported**	**Children under age 9**	**Number Reported**
Restrained for up to 2 hours	46 (61.3%)	Restrained for up to 1 hour	28 (37.3%)
Secluded for up to 2 hours	-	Secluded for up to 1 hour	-
Secluded and Restrained for up to 2 hours	1 (1.3%)	Secluded and Restrained for up to 1 hour	-
Total	47 (62.7%)	**Total**	28 (37.3%)

Seclusions and Restraints

Was the seclusion or restraint discussed with the physician? Yes = 38 (50.7%)

Was the seclusion: Locked = 1 (1.3%)
Unlocked = 0
Not Applicable = 71 (96%)
Missing = 3 (4%)

Average total time in seclusion: 90 minutes

There were no reports of mechanical restraint. There were 74 reports of physical restraints. There were 25 restraints where more than one type of physical restraint method was used. There were only two reports of medication administration.

What types of physical restraints were used?

Type of Physical Restraint	**Number of Reports**
Escort	31
Standing	18
Seated	4
Supine	5
Prone	43
Other Hold Implemented	0
Total	101

Respondents described using Conflict Prevention and Response Training (CPART or CPAR) with 2 or 3 person holds.

Average total time in a physical restraint: 13.82 minutes ranging from 1 to 100 minutes.

What are the behavioral descriptors of events?

Behaviors	Number of Events
Bites	16
Cuts	5
Hits	39
Imminent harm to others	35
Imminent harm to self	40
Kicks	35
Physical fighting	27
Punches	34
Pushes	28
Scratches	22
Spits	9
Threatening gestures	33
Throwing objects at another	10

Was the patient medically compromised? Yes = 10 (13.3%)

What type of medical problem does the patient have?

Medical Problems	Number of Problems
Known History of Cardiac or Respiratory Disease	0
Morbid Obesity	0
Seizure Precautions	0
Pregnancy	0
Recent Vomiting	0
Spinal Injury	0
Other*	9

*Other included: borderline diabetic, hemophilia, and legally blind

Was there injury to the patient during the procedure? Yes = 19 (25.3%)

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

Type of Intervention	Number of Interventions
Ventilation of feelings	39
Verbal reassurance	35
Verbal redirection	65
Timeout	45
Environmental change	35
Praise/empathy statement	37
1:1 Interaction with staff	61
Coupling statements	28
Limit setting	53
Rationale/reality statements	40
Reduction in stimuli	38

Did the patient have a Personal Safety Plan? Yes = 71 (94.7%)
Was the plan followed? Yes = 67 (88.3%)

Was there a debriefing? Yes = 71 (94.7%)

Was the parent/guardian/custodian notified? Yes = 74 (98.7%)

Behavior Management Team Review:

Was the seclusion and restraint intervention necessary? Yes = 74 (98.7%)

Did the intervention have the appropriate documentation? Yes = 46 (61.3%)

Was the seclusion and restraint intervention justified? Yes = 45 (60%)

Criteria for High Risk Seclusion and Restraint Violations of Client Rights

a. Multiple events

DCFS facilities had eight children that received more than four incidents of seclusion and restraint. The maximum number of incidents of seclusion and restraint was 11.

b. No prior intervention efforts:

DCFS facilities had one incident where there was no prior intervention.

c. No existence of personal safety plan:

DCFS facilities had four incidents where there was no safety plan in place.

d. No existence of follow up plan:

DCFS facilities had eight incidents where the safety plan was not followed.

e. Were hours extended:

DCFS had no requests to extend hours but five forms did not have this information completed.

f. Excessive duration(s) as defined by more than 2 hours for children ages 9 to 17 and more than 1 hour for children under age 9.

DCFS had no reported incidents of children ages 9 to 17 spending more than two hours in seclusion and/or restraint. DCFS had no reported incidents of children under age 9 spending more than one hour in seclusion and/or restraint.

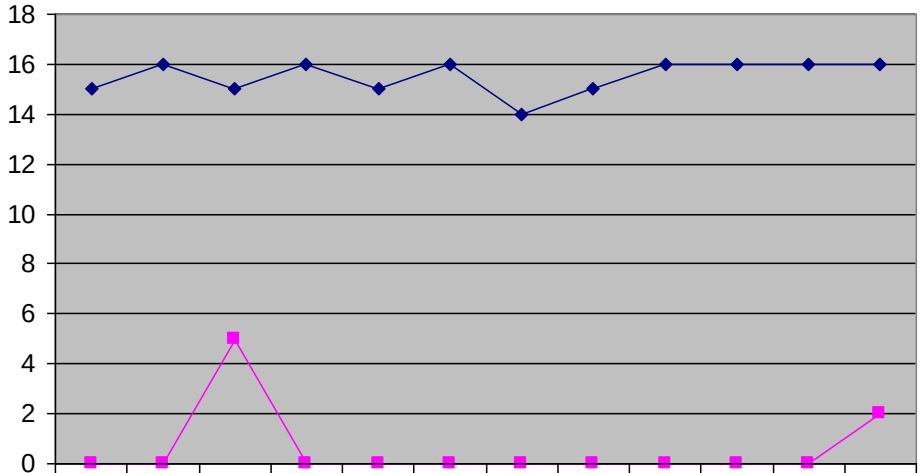
g. No signatures:

Nurses, physicians, and program managers have a signature line on the form. DCFS facilities had physician signatures for all but one incident. The one incident that had no physician signature was signed by a manager. Not all DCFS facilities are staffed with nurses and therefore will not have a nurse's signature.

Monthly Census and Number of Restraints

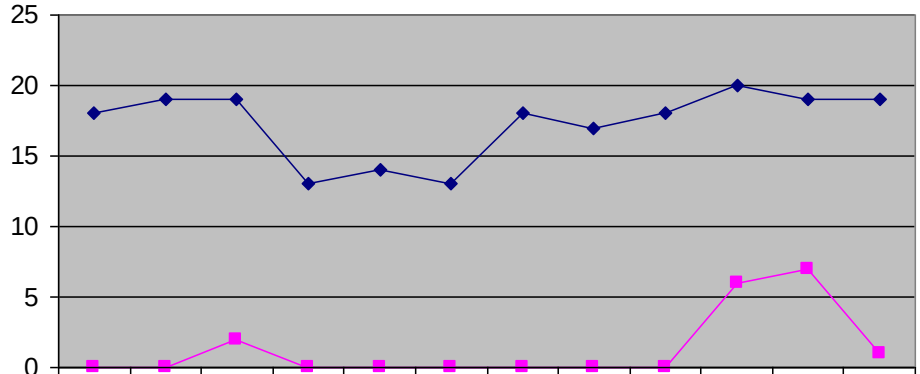
The graphs below show the monthly census and number of restraints for FY 2011 for the three DCFS treatment home programs: Adolescent Treatment Center, Family Learning Homes, and Oasis. The monthly census is obtained from the Avatar database and the monthly count of restraints is obtained from the Risk Measures and Departure Conditions report sent from treatment homes to the Planning and Evaluation Unit.

Adolescent Treatment Center: Census and Restraints for FY2011

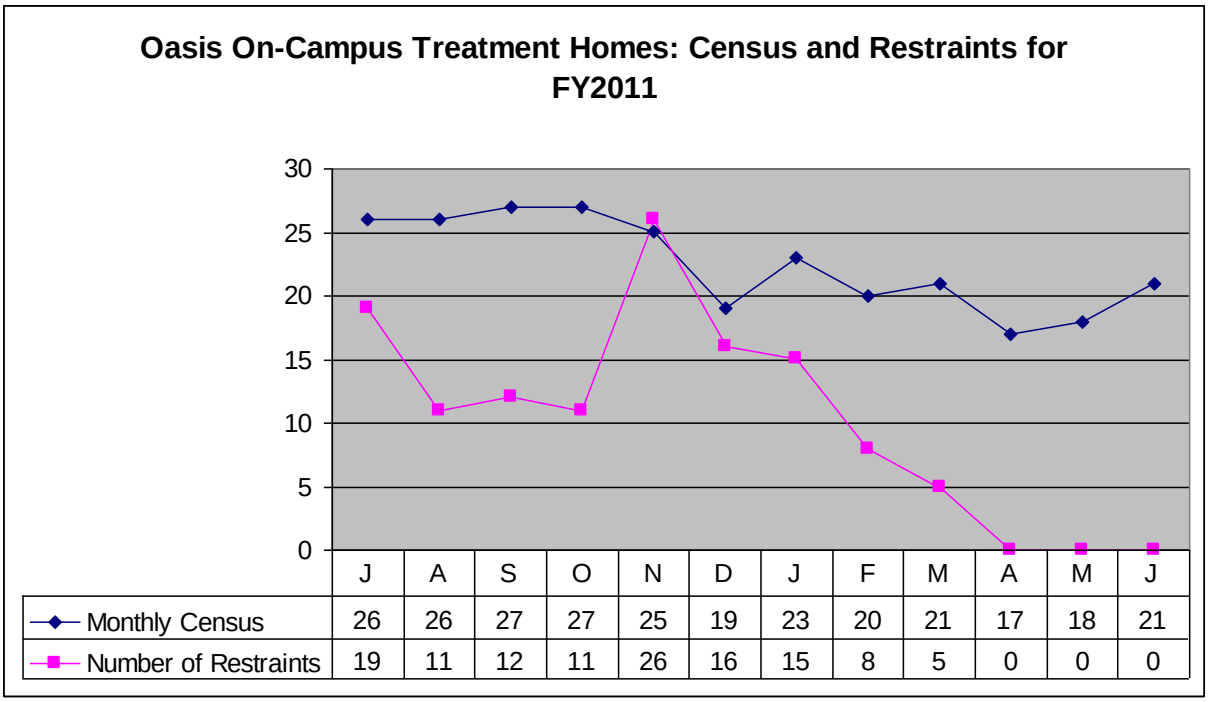


	J	A	S	O	N	D	J	F	M	A	M	J
Monthly Census	15	16	15	16	15	16	14	15	16	16	16	16
Number of Restraints	0	0	5	0	0	0	0	0	0	0	0	2

Family Learning Homes: Census and Restraints for FY2011



	J	A	S	O	N	D	J	F	M	A	M	J
Monthly Census	18	19	19	13	14	13	18	17	18	20	19	19
Number of Restraints	0	0	2	0	0	0	0	0	0	6	7	1



Both the Adolescent Treatment Center and the Family Learning Homes show a consistently low rate of restraints while their census remains relatively stable. Oasis begins with a high rate of restraints that taper off in the last three months of FY 2011. Oasis's census shows some fluctuation. These graphs provide a comparison of the census with number of restraints.

Private Facility Results

Demographic Information
Average age: 11.44 ranging from age 6 to 17
Average height: 57.80 inches ranging from 41 to 82
Average weight: 105.60 pounds ranging from 45 to 268

Gender	
Male	296 (67.1%)
Female	123 (27.9%)
Missing	22 (5%)

Race	
American Indian/Alaskan Native	13 (2.9%)
Black/African American	87 (19.7%)
Asian	2 (.5%)
White/Caucasian	269 (61%)
Other	36 (8.2%)
Mixed Race	7 (1.6%)
Missing	27 (6.1%)
Ethnicity	

Hispanic Origin	46 (10.4%)
Custody Status	
Parent/Family	313 (71%)
Child Welfare	97 (22%)
DCFS Youth Parole	3 (.7%)
Missing	28 (6.3%)

Children and Adolescents ages 9-17	**Number Reported**	**Children under age 9**	**Number Reported**
Restrained for up to 2 hours	145 (32.9%)	Restrained for up to 1 hour	39 (8.8%)
Secluded for up to 2 hours	40 (9.1%)	Secluded for up to 1 hour	20 (4.5%)
Secluded and Restrained for up to 2 hours	124 (28.1%)	Secluded and Restrained for up to 1 hour	37 (8.4%)
Total	309 (70.1%)	**Total**	96 (21.8%)

Seclusions and Restraints

Was the seclusion or restraint discussed with the physician? Yes = 377 (85.2%)

Was the seclusion: Locked = 223 (50.6%)
Unlocked = 19 (4.3%)
Not Applicable = 162 (36.7%)
Missing = 37 (8.4%)

Average total time in seclusion: 49 minutes ranging from 1 to 170.

The total number of mechanical or physical restraints cannot be determined due to missing and conflicting data.

What type of mechanical restraint was used?

Type of Restraint	**Number of Reports**
Cuff/Belt	0
Legs	1
Wrists	1
4-Point	7
5-Point	2
Mitts	1
Geri Chair	0
Mechanical Other	1
Total	13

Average total time in mechanical restraint: 36.29 minutes ranging from 1 to 115.

What type of physical restraint was used?

Type of Physical Restraint	**Number of Reports**
Escort	137
Standing	67

Seated	11
Supine	7
Prone	26
Other Hold Implemented	164
Total	412

Respondents described several restraint models such as Conflict Prevention and Response Training (CPART or CPAR), Crisis Prevention Institute (CPI), and David Mandt System (Mandt). The position of the hold was also frequently described (e.g., patient control position, team control position, protective position, etc).

Average total time in a physical restraint: 4.29 minutes ranging from 1 to 115.

What are the behavioral descriptors of events?

Behaviors	**Number of Events**
Bites	54
Cuts	6
Hits	200
Imminent harm to others	311
Imminent harm to self	173
Kicks	199
Physical fighting	116
Punches	128
Pushes	113
Scratches	58
Spits	62
Threatening gestures	189
Throwing objects at another	122

Was the patient medically compromised? Yes = 17 (3.9%)

What type of medical problem does the patient have?

Medical Problems	**Number of Problems**
Known History of Cardiac or Respiratory Disease	11
Morbid Obesity	4
Seizure Precautions	1
Pregnancy	0
Recent Vomiting	0
Spinal Injury	0
Other*	5

*Other included: asthma, chest pain with abnormal EKG, leucopenia, lymphocytosis, microcephaly, and possible sleep apnea.

Was there injury to the patient during the procedure? Yes = 40 (9.1%)
What was the staff intervention prior to the restraint or seclusion of the patient?

Type of Intervention	**Number of Interventions**
Ventilation of feelings	229
Verbal reassurance	185
Verbal redirection	386
Timeout	229

Environmental change	198
Praise/empathy statement	83
1:1 Interaction with staff	287
Coupling statements	34
Limit setting	301
Rationale/reality statements	113
Reduction in stimuli	145

Did the patient have a Personal Safety Plan? Yes = 373 (84.6%)

Was the plan followed? Yes = 315 (71.4%)

Was there a debriefing? Yes = 427 (96.8%)

Was the parent/guardian/custodian notified? Yes = 419 (95%)

Behavior Management Team Review:

Was the seclusion and restraint intervention necessary? Yes = 237 (53.7%)

Did the intervention have the appropriate documentation? Yes = 189 (42.9%)

Was the seclusion and restraint intervention justified? Yes = 22 (5%)

Criteria for High Risk Seclusion and Restraint Violations of Client Rights

a. Multiple events

Private facilities do not consistently provide a unique identifier for each child. Therefore, multiple events per child can not be determined.

b. No prior intervention efforts:

Private facilities had 17 incidents where there was no prior intervention.

c. No existence of personal safety plan:

Private facilities had 62 incidents where there was no safety plan in place and six forms were missing this information.

d. No existence of follow up plan:

Private facilities had 47 incidents where the safety plan was not followed. In addition, 79 forms were missing this information.

e. Were hours extended:

Private facilities had 21 incidents where the RN extended the hours and 128 forms did not have this information completed.

f. Excessive duration(s) as defined by more than 2 hours for children ages 9 to 17 and more than 1 hour for children under age 9:

Private facilities reported three children ages 9 to 17 that spent more than 2 hours in seclusion and/or restraint. Private facilities reported four children under age 9 that spent more than 1 hour in seclusion and/or restraint.

g. No signatures:

Nurses, physicians, and program managers have a place on the form for signature. All but four incident forms had the signature of the physician. All four that were missing physician signatures had a nurse's signature. There were 37 forms that were missing the nurse's signature and 29 were missing the manager's signature.

Discussion

Research has shown that there are identifiable characteristics of children who are more frequently placed in restraint or seclusion. Common demographic characteristics include being younger in age, a member of a minority, male, and being in the custody of child welfare services. [8] Public facilities mirror these findings closely. Seclusion and restraint results show that children tend to be young with an average age of 10.13 and mostly male (68%). As identified in previous seclusion and restraint reports, minority children have a consistently higher rate of restraints; nearly half of the children in public facilities (46.7%) were African American. Also, following the trend noted in previous reports, 80% of children who experienced a restraint incident were in child welfare custody.

Private facilities do not reflect the research findings possibly due to serving a different population. Children who experience seclusion and restraints in private facilities do tend to be young (average age is 11.44) and mostly males (67.1%). The majority of children are white (61%) and in the custody of their parents or family (71%).

High risk criteria identified by the Commission on Mental Health and Developmental Services (Commission) for possible selection of denial of rights for children's mental health facilities was applied to the incidents of seclusions and restraints for FY 2011. The goal is to provide Commissioners with information to assist them in deciding if these criteria will be helpful in the selection of high risk denial of rights incidents. However, to analyze data for multiple events for one child a unique identifier must be included on each Denial of Rights form.

DCFS treatment homes' monthly census data and monthly count of restraints are presented in graphs. The Adolescent Treatment Center and the Family Learning Homes have consistently low use of restraints. Both programs use Aggression Replacement Training, a psycho-education intervention that teaches youth to improve their anger control and to increase pro-social behavior. The Oasis On-Campus treatment homes had a high rate of restraint use until the last quarter of FY 2011. Apparently, staff have become aware of their overuse of restraints and are using de-escalation techniques and identifying agitation in children earlier on. One of the homes that serve young boys was closed which also contributed to the decline in the use of restraints.

Limitations

The following are limitations to the data.

- Missing and incomplete information on forms prevent a more accurate and complete analysis of the data.

[8] De Masi, M & Boyd, D. (2007, September). *Behavior support & management: Coordinated standards for children's system of care.* New York: Council on Children and Families

- To determine whether a child receives more than 4 episodes of seclusion or restraint, each child needs a unique identifier that is consistently recorded on the form.

- An independent count of seclusions and restraints are not available for most facilities making it difficult to ascertain whether all Denial of Rights forms are received.

Recommendations

Research on the use of seclusion and restraint recommends monitoring and data reporting to provide facilities with ongoing information on seclusion and restraint use. [9] Methods to evaluate the use of seclusion and restraint are available. Measures developed by the National Association of State Mental Health Program Directors Research Institute Inc.[10] utilize restraint hours per 1000 inpatient hours and the percentage of clients restrained which uses a measure of restraints with census data. Both measures can provide trend data and a measure of performance. Trend data and performance measures may be a useful way for the Commission to track and monitor seclusion and restraint use for standards of care.

[9] Huckshorn, K. (2005, May). *Six core strategies to reduce the use of seclusion and restraint planning tool.* Alexandria, VA: National Technical Assistance Center.
De Masi, M & Boyd, D. (2007, September). *Behavior support & management: Coordinated standards for children's system of care.* New York: Council on Children and Families.
[10] NRI Performance Measurement System. (2009, August). *National public dates, age stratification report: Restraint hours.* Alexandria, VA: National Association of State Mental Health Program Directors Research Institute, Inc.