MEDICAID REPORT 2013
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2012 SUMMARY

DCFS 2013 ANNUAL QUALITY ASSURANCE REPORT AND PLAN

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 2012 for DCFS CMHS. It also includes the Performance and Quality Improvement Plan for 2013-14 (Attachment A). The Quality Assurance Report and the Performance and Quality Improvement Plan are to be submitted to the Division of Health Care Financing and Policy with a target date of April 1, 2013.

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 (Oasis)	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 2927 children served by the DCFS Children's Mental Health Services in Fiscal Year 2012 (July 1, 2011 through June 30, 2012). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 2927 children served by DCFS programs, 2134 (72.9%) received services in Clark County and 793 (27.1%) were served in Washoe County/Rural.

Of all children served, 60.6% were 12 years of age or younger and 55.2% were male. Caucasian children accounted for 74.5% of all those served and African-American children 20.6%. Children of Hispanic origin came to 28.8%.

In FY12, 55.9% of the children admitted to mental health services statewide were in the custody of their parent or family, 41.9% were in Child Welfare custody, 1.8% were in the custody of their parent or family and on probation, 0.2% were in Youth Parole custody, and .02% were unknown.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY12. (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 March and April (Spring) of 2012. In the survey, five Neighborhood Family Service Center sites were polled in Las Vegas and two were polled in Reno. Responding to the survey were 312 parents/caregivers and 181 youth receiving services. Spring survey results indicated a statewide average of 87% parent/caregiver positive rating and an 82% 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).

A copy of the youth version of the Youth Survey is appended. (Attachment D).

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) collect consumer service evaluations at the 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 surveys at discharge.

DCFS Residential Services Parent/Caregiver – Youth Survey Results Statewide Spring 2012 report. (Attachment E).

Quality Improvement Plans for Youth Survey Items with a 60% or Less Positive Response

DCFS Youth Survey Reports for community based services and residential services highlight survey items with a 60% or less positive response. Each program area is now responsible for developing a quality improvement plan for these items. Programs requiring a program improvement plan for one or more items were: Outpatient, CCS, WIN, Oasis, ATC, and FLH. Program Managers submitted quality improvement plans to the PEU.

SNCAS WIN, CCS and Outpatient programs had a 60% or less positive response by youth to a participation in treatment item. These programs have a quality improvement plan to increase youth involvement in the treatment planning process. The NNCAS Outpatient program developed a quality improvement plan for an item addressing positive outcomes for parents. The Outpatient program will problem-solve with families areas of their life that are unsatisfying. NNCAS WIN is addressing youth response to a general satisfaction item by following up with youth at Child and Family Team meetings to ensure they are involved in deciding services.

DCFS Treatment Home programs as previously stated collect Youth Surveys at discharge from services. The Youth Survey Reports for Residential Programs also highlight survey items with a 60% or less positive response. ATC had a parent/caregiver response item regarding awareness of services in the

community that they addressed by ensuring that families learn about resources and are linked to community services upon discharge. FLH had a parent/caregiver response item related to positive outcomes and have a plan to follow up with families during parent training sessions to address areas of their life that are unsatisfying. A life satisfaction topic will be added to the parent training component of treatment.

All Treatment Homes had a lower than expected Youth Survey return rate. All Treatment Home programs have an improvement plan to increase completion of parent/caregiver and youth surveys. Oasis had the lowest completion rate during FY 2012 and their primary improvement plan is to develop and implement a protocol to have parents/caregivers and youth complete a survey at discharge. Oasis has developed an improvement plan for items for parents/caregivers under general satisfaction, positive outcomes, functioning, and treatment explanation to youth.

DWTC and ECMHS programs had no survey items with a 60% or less positive response in the most recent Youth Survey Reports.

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. Survey results were used in a plan for improving children's mental health services and to increase staff morale. Periodically, an employee satisfaction survey will be conducted to capture feedback from staff regarding their perspective on service provision, the strengths and challenges of the agency, overall satisfaction, and recommendations for improvement.

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 F, G and H).

Supervisor Checklists

[Plan Domain(s): I, III]

Mental health supervisors 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. The Management Team agreed to integrate the supervisor checklists 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. The task of overseeing the integration of the Supervisor Checklists into Avatar was given to the Business Process Workgroup who also developed a business process for supervisor use of the checklists. After the checklists are functional in Avatar, the DCFS/PEU will collect Supervisor Checklists on a regular basis 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 2012, DWTC served 203 children in its acute care programs and 106 children in its residential programs. Under the leadership of Linda K. Santangelo, PhD, DWTC hospital Clinical Program Manager II, 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 Joint Commission's operational mandates and quality assurance proscriptions. DWTC patients and their parents/caregivers are administered consumer service evaluations upon discharge with quarterly reports being submitted to the Leadership Executive Team for continuous quality improvement. 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, nursing, and clinical peer reviews; pharmacy audits; and program utilization reviews occur quarterly. Hospital nutritional services are reviewed monthly. The entire facility undergoes an annual performance review that drives the hospital's performance improvement projects. The DWTC's last Joint Commission survey was conducted in January 2011 which recognized the accomplishments of DWTC leadership and staff by renewing their accreditation status. The next Joint Commission survey is expected on or before January 2014. DWTC is licensed by the Bureau of Health Care Quality and

Compliance (BHCQC). The hospital is likewise monitored regularly by BHCQC and the Legislative Counsel Bureau (LCB).

Medication Administration and Management

Last May, a comprehensive policy on medication administration and management for residential programs went into effect. With a focus on client safety, the policy describes the procedures for administering medications and the process for monitoring, documenting, and managing medications within residential facilities. Training and quality assurance requirements are also outlined in the policy.

As a result of the policy, quality assurance reviews were initiated at Oasis and FLH. DWTC and ATC had nursing staff who conducted medication administration and management reviews. FLH has a nurse that now reviews Medication Administration Records and the PEU conducts reviews at least annually. At Oasis the PEU conducts medication administration and management reviews monthly.

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 development, 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. There was no evaluation of the fidelity to the wraparound model this year using the Wraparound Fidelity Instrument. However, some WIN supervisors utilized the Team Observation Measure (TOM). The TOM is a fidelity tool used to observe Child and Family Teams for adherence to the principles of the Wraparound model.

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

DCFS' WIN program in partnership with Washoe County Department of Juvenile Services, Washoe County School District, Sierra Regional Center, and Nevada PEP implemented the WIN Expansion program. Each public agency contributed a staff position that would provide wraparound process to the population served by their agency. 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 a state-county interface group responsible for initiating the program. DCFS/PEU in partnership with the Washoe County WIN Expansion Committee has been charged with developing and implementing an evaluation. The first report of the WIN Expansion was completed in July 2012.

The complete report can be found in the appended Wraparound Washoe Expansion (Attachment I).

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.

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 Community Mental Health Services Block Grant (MHBG) 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.

SAMHSA redesigned the FY 2014-2015 application and plan to align with the current federal/state environments and related policy initiatives including the Patient Protection and Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Tribal Law and Order Act (TLOA). SAMHSA also set the stage for states to complete a joint application for mental health and substance abuse services to submit a bi-annual plan rather than an annual plan. Nevada will be submitting a joint Substance Abuse Prevention and Treatment Block Grant and the MHBG.

The joint Block Grant application and plan increases accountability for funds and outcomes. After full implementation of the ACA, SAMHSA recommends that Block Grant funds be directed towards: (1) funding priority treatment and support services for individuals without insurance of for whom coverage is terminated for short periods of time; (2) to fund priority treatment and support services not covered by

Medicaid, Medicare, or private insurance for low income individuals and that demonstrate success in improving outcomes; (3) to fund primary prevention; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services. Nevada's joint Block Grant includes several priority areas in which the Substance Abuse Prevention and Treatment Agency, Mental Health, and DCFS will be collecting performance indicators.

Block 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 Block Grant by capturing, collating, analyzing, and reporting children's mental health program data.

Beginning in 2011, States were 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 was 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 submits 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.

ECMHS also provides training to staff on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R).

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 plan for measuring service delivery impact upon outcomes and for improving the 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 2013 DCFS Performance and Quality Improvement 2012 Summary and are pleased to submit it on behalf of all of our dedicated DCFS Children's Mental Health Services program managers and staff.

Approved by:

_____	_____
Susan L. Mears, Ph.D. Planning and Evaluation Unit, DCFS	Date
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Kelly Wooldridge, 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
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Darryl McClintock, M.D. Medical Director, Northern Nevada Child and Adolescent Services, DCFS	Date
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Amber Howell, Administrator Division of Child and Family Services	Date

MEDICAID REPORT 2013
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2012 SUMMARY

ATTACHMENT INDEX

ATTACHMENT A

DCFS Children's Mental Health Services
Performance and Quality Improvement Plan
2013-14

MEDICAID REPORT 2013
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2012 SUMMARY

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.
>
> [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.
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.
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.
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** Checklist items will be integrated into the Avatar IMS for ease of use. Qualitative items will be reviewed by supervisors.
SC 6. Targeted case management	**SC 6.1** Evaluate wraparound	**SC 6.1.1 1.** The PEU will partner with

services will adhere to wraparound process principles	service delivery model fidelity using the Wraparound Fidelity Index (WFI) evaluation instrument **SC 6.2** Evaluate the wraparound Child and Family Team process using the Team Observation Measure	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 6.2.1** Analysis of data for feedback on adherence to Team indicators \ **SC 6.2.2** Develop a report with recommendations
SC 7. Provide DCFS CMHS staff with direct supervision at least monthly	**SC 7.1** Supervisors will meet with each staff member at least monthly for supervision	**SC 7.1.1** 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 PQI initiatives, reports, data and other requests	**SE 1.1** Provide annual descriptive summary for all children served in preceding SFY	**SE 1.1.1** Identify data elements **SE 1.1.2** Compile report elements **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 of tools 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 conduct reviews on the implementation of the Policy on Medication Administration and Management with DCFS treatment homes. **SE 3.1.6** The PEU will conduct reviews on the physical condition of the treatment homes. **SE 3.1.7** The PEU will provide training on medication administration and management at Oasis and trauma informed care for all treatment homes. **SE 3.1.8** The PEU will conduct documentation reviews on open Oasis cases. **SE 3.1.9** 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 system that accurately captures, maintains and reports client clinical, financial, demographic and other service related information	**SEF 2.1** Ensure that the Avatar database contains accurate, complete and timely information	**SEF 2.1.1** Track and report on 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
SEF 4. Monitor adequacy of major or systemic factors affecting	**SEF 4.1** Desert Willow Treatment Center (DWTC) will maintain its	**SEF 4.1.1** DWTC will abide by all Joint Commission regulations and

DCFS capacity to deliver quality CMHS services	Joint Commission certification	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 5.1.1** 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 CMHS supervisors will work with direct service staff to support and enhance service productivity	**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

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

Descriptive Summary of Children's Mental Health Services
SFY12

Division of Child and Family Services

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2012

CONTENTS

INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2012, from July 1, 2011 through June 30, 2012. The FY 2012 Descriptive Summary provides an expanded analysis of DCFS programs. This FY 2012 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 2927 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
2927	793	2134

Admissions

Statewide	NNCAS	SNCAS
1629	441	1188

Discharges

Statewide	NNCAS	SNCAS
1620	441	1179

SURVEY COMMENT FROM A SATISFIED PARENT

My child and I have learned to communicate better with each other.

CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

The average age of children served Statewide was 10.5, NNCAS was 11.5, and SNCAS was10.1.

Age Group	Statewide	NNCAS	SNCAS
0–5 years old	804 (27.5%)	126 (15.9%)	678 (31.8%)
6–12 years old	969 (33.1%)	321 (40.5%)	648 (30.4%)
13–17 years old	986 (33.7%)	296 (37.3%)	690 (32.3%)
18+ years old	168 (5.7%)	50 (6.3%)	118 (5.5%)

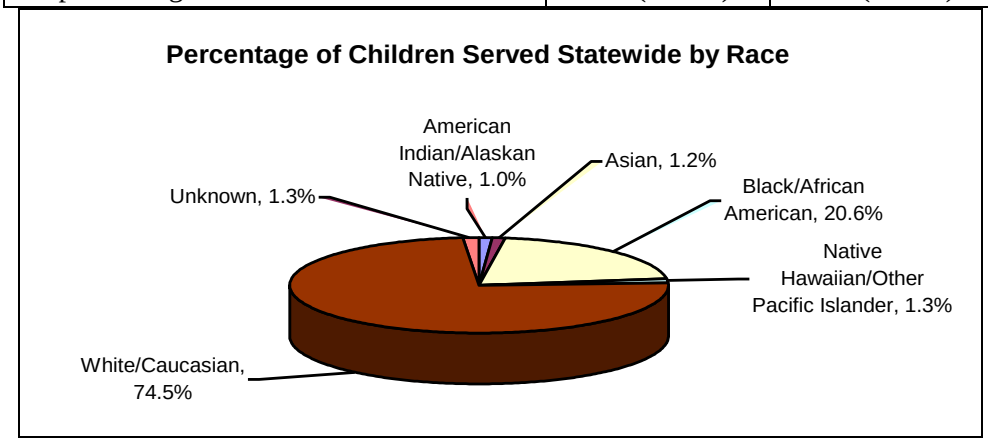
Gender

	Statewide	NNCAS	SNCAS
Male	1616 (55.2%)	354 (44.6%)	1177 (55.2%)
Female	1311 (44.8%)	439 (55.4%)	957 (44.8%)

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	30 (1.0%)	21 (2.6%)	9 (0.4%)
Asian	36 (1.2%)	1 (0.1%)	35 (1.6%)
Black/African American	603 (20.6%)	53 (6.7%)	550 (25.8%)
Native Hawaiian/Other Pacific Islander	39 (1.3%)	11 (1.4%)	28 (1.3%)
White/Caucasian	2181 (74.5%)	693 (87.4%)	1488 (69.7%)
Unknown	38 (1.3%)	14 (1.8%)	24 (1.1%)

Ethnicity	Statewide	NNCAS	SNCAS
Hispanic Origin	842 (28.8%)	182 (23.0%)	660 (30.9%)



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

Ethnicity	NNCAS	Washoe County [1]	SNCAS	Clark County [1]
Hispanic Origin	182 (23.0%)	34.8%	660 (30.9%)	39.8%

Custody Status

	Statewide	NNCAS	SNCAS
Parent/Family	1637 (55.9%)	467 (58.9%)	1170 (54.8%)
Child Welfare	1227 (41.9%)	310 (39.1%)	917 (43.0%)
DCFS Youth Parole	5 (0.2%)	1 (0.1%)	4 (0.2%)
Parental Custody on Probation	53 (1.8%)	15 (1.9%)	38 (1.8%)
Unknown	5 (0.2%)	0 (0.0%)	5 (0.2%)

Severe Emotional Disturbance Status

Statewide	NNCAS	SNCAS
2354 (80.4%)	620 (88.6%)	1643 (77.0%)

[1] Age and Racial/Ethnic Distribution of Nevada Children and Youth by County: 2010, Nevada KIDS COUNT • http://kidscount.unlv.edu, Center for Business and Economic Research, UNLV

Demographics by Program

Community-Based Services

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

Number of Children Served

Statewide	OPS	CCS
1224	362 (29.6%)	862 (70.4%)

Age

The average age of children served Statewide was 14.1, OPS was 14.0, and CCS was 14.1.

Age Group	Statewide	OPS	CCS
0–5 years old	0 (0.0%)	0 (0.0%)	0 (0.0%)
6–12 years old	423 (34.6%)	130 (35.9%)	293 (34.0%)
13–17 years old	690 (56.4%)	198 (54.7%)	492 (57.1%)
18+ years old	111 (9.1%)	34 (9.4%)	77 (8.9%)

Gender

	Statewide	OPS	CCS
Male	675 (55.1%)	206 (56.9%)	469 (54.4%)
Female	549 (44.9%)	156 (43.1%)	393 (45.6%)

Race and Ethnicity

Race	Statewide	OPS	CCS
American Indian/Alaskan Native	9 (0.7%)	5 (1.4%)	4 (0.5%)
Asian	15 (1.2%)	0 (0.0%)	15 (1.7%)
Black/African American	174 (14.2%)	28 (7.7%)	146 (16.9%)
Native Hawaiian/Other Pacific Islander	24 (2.0%)	5 (1.4%)	19 (2.2%)
White/Caucasian	996 (81.4%)	323 (89.2%)	673 (78.1%)
Unknown	6 (0.5%)	1 (0.3%)	5 (0.6%)
Ethnicity	**Statewide**	**OPS**	**CCS**
Hispanic Origin	410 (33.5%)	88 (24.3%)	322 (37.4%)

Custody Status

	Statewide	OPS	CCS
Parent/Family	974 (79.6%)	299 (82.6%)	675 (78.3%)
Child Welfare	223 (18.2%)	49 (13.5%)	174 (20.2%)
DCFS Youth Parole	2 (0.2%)	1 (0.3%)	1 (0.1%)
Parental Custody on Probation	25 (2.0%)	13 (3.6%)	12 (1.4%)

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

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
1041	238 (22.9%)	803 (77.1%)

Age

The average age of children served by ECMHS Statewide was 5.2, ECMHS (NNCAS) was 6.0, and ECMHS (SNCAS) was 4.9.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	685 (65.8%)	118 (49.6%)	567 (70.6%)
6–12 years old	355 (34.1%)	119 (50.0%)	236 (29.4%)
13–17 years old	1 (0.1%)	1 (0.4%)	0 (0.0%)

Gender

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	587 (56.4%)	133 (55.9%)	454 (56.5%)
Female	454 (43.6%)	105 (44.1%)	349 (43.5%)

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	9 (0.9%)	8 (3.4%)	1 (0.1%)
Asian	8 (0.8%)	1 (0.4%)	7 (0.9%)
Black/African American	267 (25.6%)	12 (5.0%)	255 (31.8%)
Native Hawaiian/Other Pacific Islander	7 (0.7%)	4 (1.7%)	3 (0.4%)
White/Caucasian	737 (70.8%)	213 (89.5%)	524 (65.3%)
Unknown	13 (1.2%)	0 (0.0%)	13 (1.6%)
Ethnicity	**Statewide**	**ECMHS (NNCAS)**	**ECMHS (SNCAS)**
Hispanic Origin	296 (28.4%)	59 (24.8%)	237 (29.5%)

Custody Status

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	412 (39.6%)	105 (44.1%)	307 (38.2%)
Child Welfare	629 (60.4%)	133 (55.9%)	496 (61.8%)

SURVEY COMMENT FROM A SATISFIED YOUTH

My team leader or staff always listened to me and gave good advice.

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
545	182 (33.4%)	96 (17.6%)	267 (49.0%)

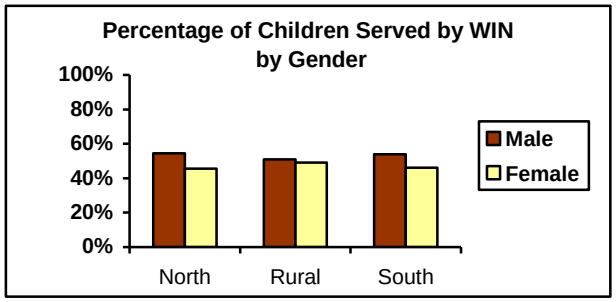
Age

The average age of children served Statewide was 13.3, North was 14.5, Rural was 11.5, and South was 13.2.

Age Group	Statewide	North	Rural	South
0–5 years old	12 (2.2%)	3 (1.6%)	9 (9.4%)	0 (0.0%)
6–12 years old	229 (42.0%)	46 (25.3%)	53 (55.2%)	130 (48.7%)
13–17 years old	261 (47.9%)	113 (62.1%)	31 (32.3%)	117 (43.8%)
18+ years old	43 (7.9%)	20 (11.0%)	3 (3.1%)	20 (7.5%)

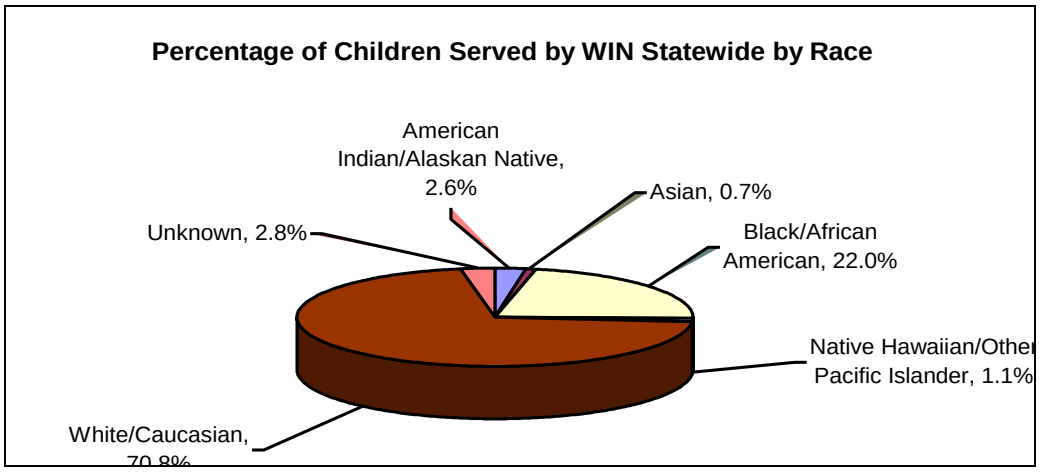
Gender

	Statewide	North	Rural	South
Male	292 (53.6%)	99 (54.4%)	49 (51.0%)	144 (53.9%)
Female	253 (46.4)	83 (45.6%)	47 (49.0%)	123 (46.1%)



Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	14 (2.6%)	5 (2.7%)	5 (5.2%)	4 (1.5%)
Asian	4 (0.7%)	0 (0.0%)	0 (0.0%)	4 (1.5%)
Black/African American	120 (22.0%)	23 (12.6%)	2 (2.1%)	95 (35.6%)
Native Hawaiian/Other Pacific Islander	6 (1.1%)	2 (1.1%)	0 (0.0%)	4 (1.5%)
White/Caucasian	386 (70.8%)	144 (79.1%)	84 (87.5%)	158 (59.2%)
Unknown	15 (2.8%)	8 (4.4%)	5 (5.2%)	2 (0.7%)
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	99 (18.2%)	38 (20.9%)	14 (14.6%)	47 (17.6%)



Custody Status

	Statewide	North	Rural	South
Parent/Family	113 (20.7%)	70 (38.5%)	32 (33.3%)	11 (4.1%)
Child Welfare	430 (78.9%)	110 (60.4%)	64 (66.7%)	256 (95.9%)
DCFS Youth Parole	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Parental Custody on Probation	2 (0.4%)	2 (1.1%)	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
158	56 (34.8%)	56 (34.8%)	49 (30.4%)

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

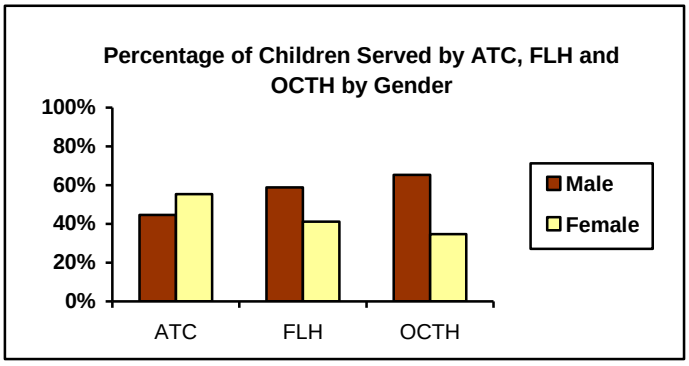
Age

The average age of children served Statewide was 14.3, ATC was 16.0, FLH was 13.2, and OCTH was 13.6.

Age Group	Statewide	ATC	FLH	OCTH
6–12 years old	44 (27.8%)	0 (0.0%)	24 (42.9%)	20 (40.8%)
13–17 years old	102 (64.6%)	53 (94.6%)	26 (46.4%)	25 (51.0%)
18+ years old	12 (7.6%)	3 (5.4%)	6 (10.7%)	4 (8.2%)

Gender

	Statewide	ATC	FLH	OCTH
Male	89 (56.3%)	25 (44.6%)	33 (58.9%)	32 (65.3%)
Female	69 (43.7%)	31 (55.4%)	23 (41.1%)	17 (34.7%)



Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	3 (1.9%)	0 (0.0%)	2 (3.6%)	1 (2.0%)
Asian	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (2.0%)
Black/African American	25 (15.8%)	5 (8.9%)	5 (8.9%)	15 (30.6%)
Native Hawaiian/Other Pacific Islander	1 (0.6%)	0 (0.0%)	1 (1.8%)	0 (0.0%)
White/Caucasian	127 (80.4%)	51 (91.1%)	48 (85.7%)	31 (63.3%)
Unknown	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (2.0%)
Ethnicity	**Statewide**	**ATC**	**FLH**	**OCTH**
Hispanic Origin	33 (20.9%)	19 (33.9%)	9 (16.1%)	5 (10.2%)

Custody Status

	Statewide	ATC	FLH	OCTH
Parent/Family	99 (61.5%)	41 (73.2%)	45 (80.4%)	13 (26.5%)
Child Welfare	50 (31.1%)	8 (14.3%)	10 (17.9%)	32 (65.3%)
DCFS Youth Parole	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Parental Custody on Probation	8 (5.0%)	7 (12.5%)	1 (1.8%)	0 (0.0%)
Unknown	4 (2.5%)	0 (0.0%)	0 (0.0%)	4 (8.2%)

SURVEY COMMENT FROM A SATISFIED PARENT

This program has made a huge improvement in my child—an improvement I did not think was going to happen.

Residential Facility and Psychiatric Hospital

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

Number of Children Served

Acute	RTC
182	102

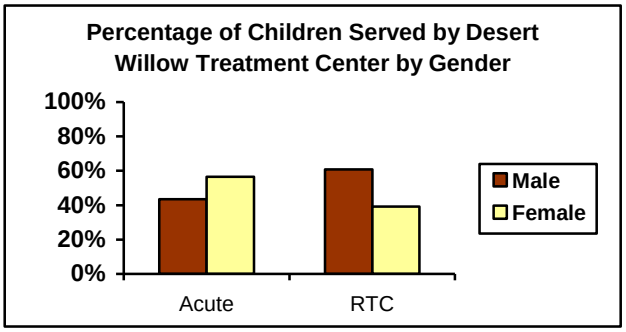
Age

The average age of children served by Desert Willow Acute was 15.5 and it was 16.0 for the Desert Willow Residential Treatment Center.

Age Group	Acute	RTC
6–12 years old	19 (10.4%)	4 (3.9%)
13–17 years old	147 (80.8%)	88 (86.3%)
18+ years old	16 (8.8%)	10 (9.8%)

Gender

	Acute	RTC
Male	79 (43.4%)	62 (60.8%)
Female	103 (56.6%)	40 (39.2%)



Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	1 (0.5%)	0 (0.0%)
Asian	4 (2.2%)	4 (3.9%)
Black/African American	25 (13.7%)	22 (21.6%)
Native Hawaiian/Other Pacific Islander	6 (3.3%)	2 (2.0%)
White/Caucasian	146 (80.2%)	72 (70.6%)
Unknown	0 (0.0%)	2 (2.0%)
Ethnicity	**Acute**	**RTC**
Hispanic Origin	64 (35.2%)	22 (21.6%)

Custody Status

	Acute	RTC
Parent/Family	172 (94.5%)	73 (71.6%)
Child Welfare	6 (3.3%)	1 (1.0%)
DCFS Youth Parole	0 (0.0%)	4 (3.9%)
Parental Custody on Probation	4 (2.2%)	24 (23.5%)

CHILDREN'S CLINICAL CHARACTERISTICS AND OUTCOMES

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their children have encountered. Of the 51 presenting problems listed, the six identified below (and listed in order of prevalence) accounted for 39.5% of all primary presenting problems reported.

- Child Neglect Victim (16.1%)
- Depression (5.7%)
- Adjustment Problems (5.7%)
- Suicide Attempt – Threat (4.6%)
- Anxiety (3.8%)
- ADHD (3.5%)

Child neglect was the most prevalent presenting problem again in FY 2012, increasing from 12.3% in FY 2011. The top four presenting problems are the same four as in FY 2011. Anxiety has replaced physical aggression in the fifth position. ADHD remains in the sixth position.

Diagnosis

In FY 2012, 39 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
Neglect of Child	Neglect of Child	Neglect of Child
Disruptive Behavior Disorder NOS	Anxiety Disorder NOS	Disruptive Behavior Disorder NOS
Adjustment Disorder	Adjustment Disorder	Adjustment Disorder
Anxiety Disorder NOS	Disruptive Behavior Disorder NOS	Anxiety Disorder n NOS
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder	Posttraumatic Stress Disorder

Age Group 6-12.99

Overall	Female	Male
Adjustment Disorder	Adjustment Disorder	Adjustment Disorder
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder	Oppositional Defiant
Mood Disorder NOS	Neglect of Child	Mood Disorder NOS
Oppositional Defiant	Anxiety Disorder NOS	Posttraumatic Stress Disorder
Disruptive Behavior Disorder NOS	Attention-Deficit /Hyperactivity Disorder	Disruptive Behavior Disorder NOS
Neglect of Child	Disruptive Behavior Disorder NOS	Neglect of Child

Age Group 13-17.99

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

Age Group 18+

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

Mood Disorder NOS	Depressive Disorder NOS	Major Depressive Disorder
Bipolar Disorder NOS	Bipolar Disorder NOS	Bipolar Disorder NOS

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

The Child and Adolescent Functional Assessment Scale (CAFAS)[1] 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.

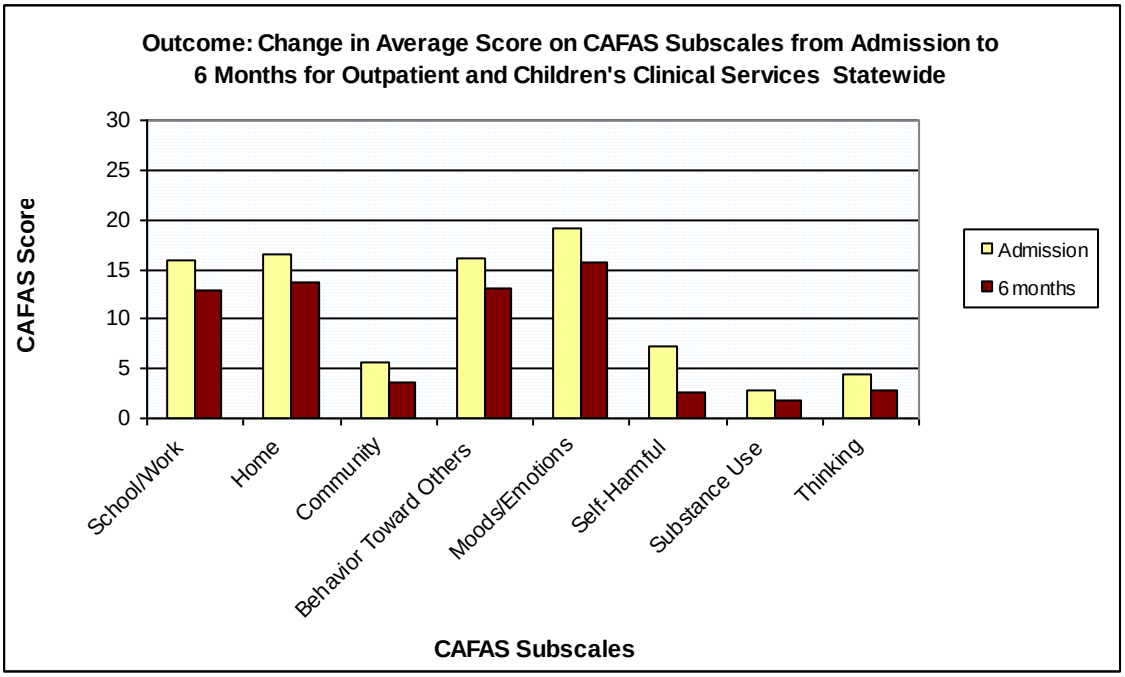
The Preschool and Early Childhood Functional Assessment Scale (PECFAS)[2] was also designed to assess degree of impairment in functioning of children ages 3 to 7 years with behavioral, emotional, psychological or psychiatric problems. PECFAS scores range from 0 to 210, with a higher score indicating 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 2012 CAFAS and PECFAS scores were used in this Descriptive Summary.

Outpatient and Children's Clinical Services

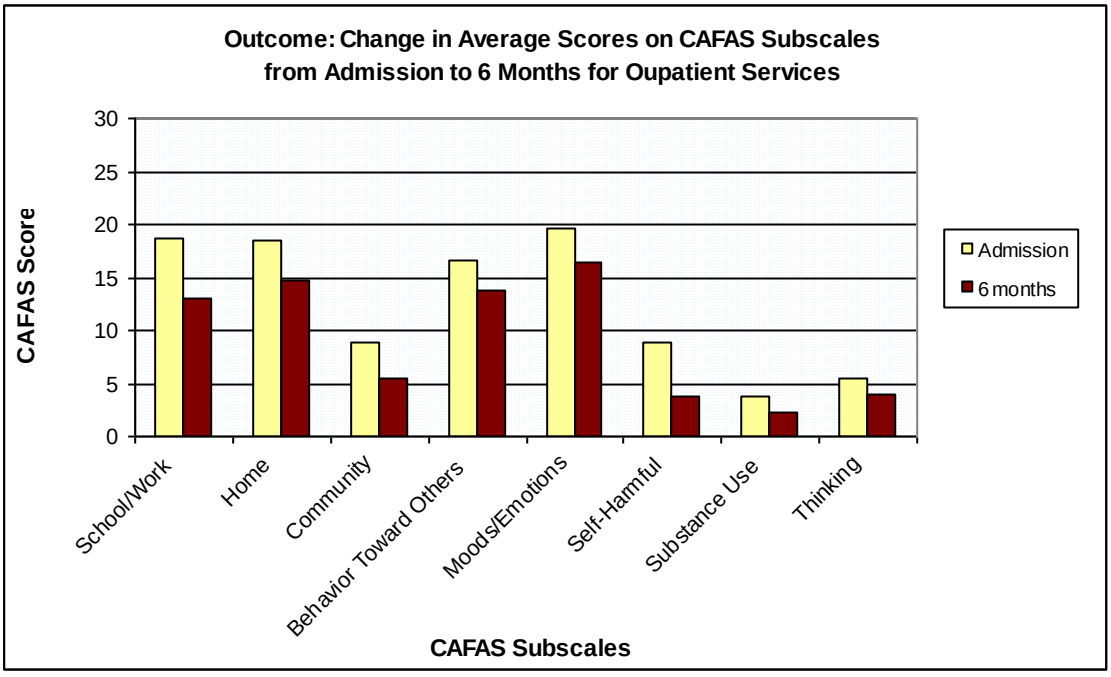
The graph below shows the admission and 6 months CAFAS subscale scores for Outpatient and Children's Clinical Services statewide.

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



A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Outpatient and Children's Clinical Services statewide. The mean CAFAS score was 87.95 (SD= 37.44) at admission. At 6 months into services, the mean CAFAS score decreased to 66.19 (SD= 33.57); t (301) = 10.37, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 6 months.

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

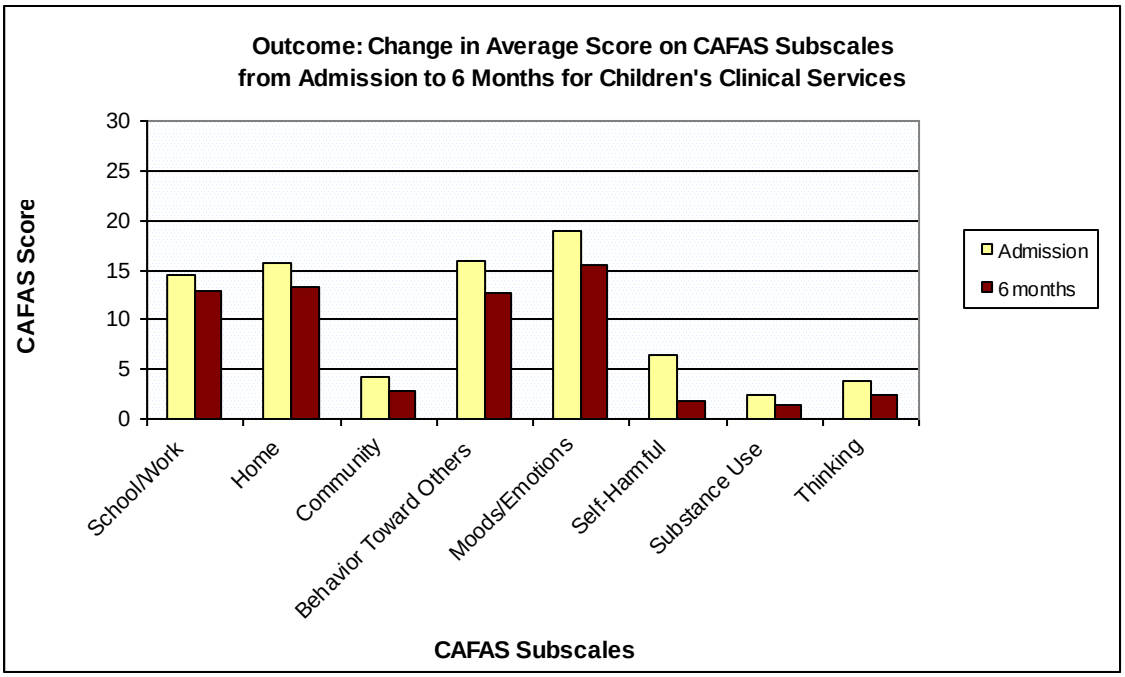


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Outpatient Services. The mean CAFAS score was 100.63 (SD= 34.39) at admission. At 6 months into services, the mean CAFAS score decreased to 73.44 (SD= 34.36); t (95) = 8.01, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 6 months.

SURVEY COMMENT FROM A SATISFIED YOUTH

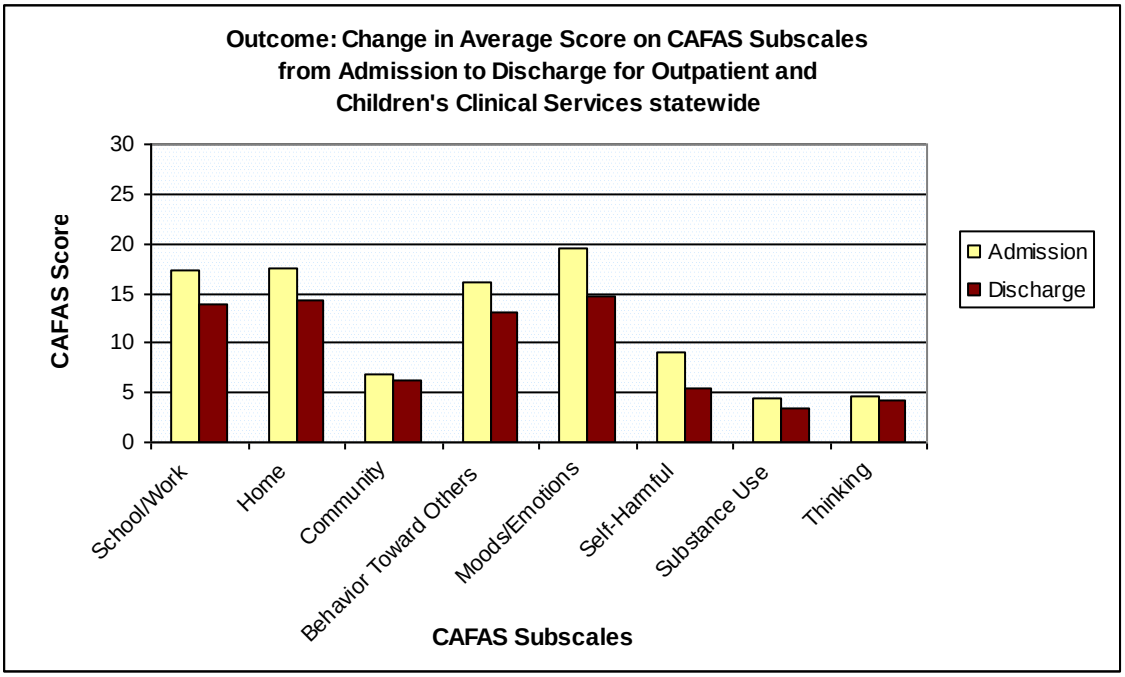
They have taught me how to cooperate with my family and others my age and showed me how to properly act like a teenager who respects herself and others, and can do anything.

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



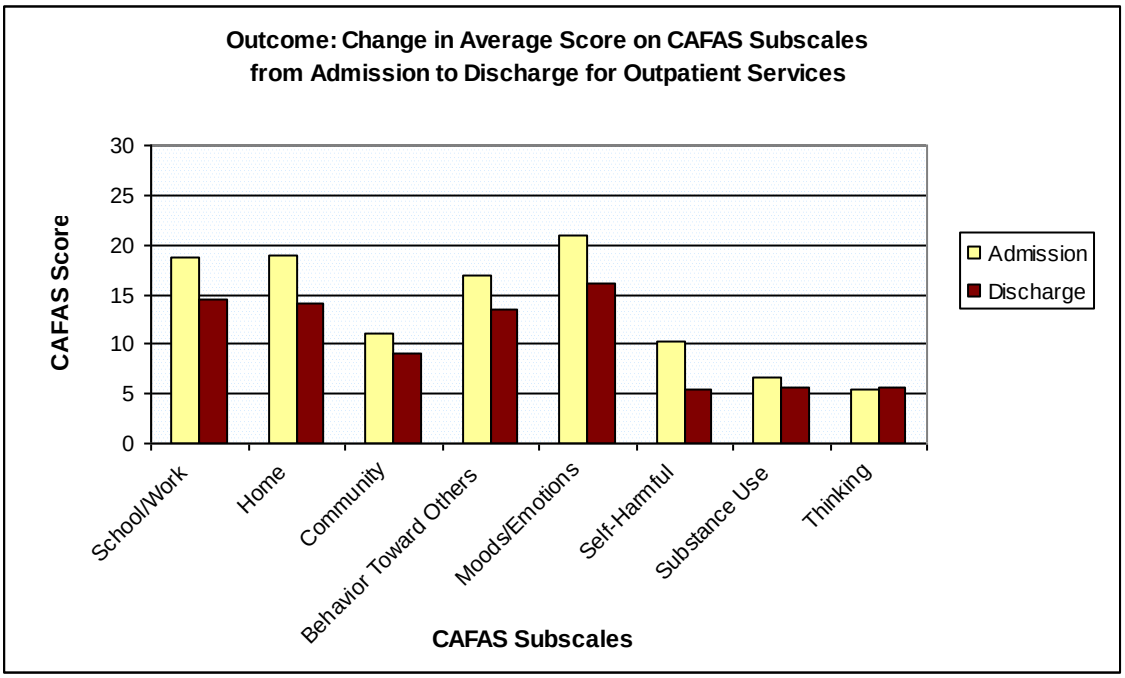
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Children's Clinical Services. The mean CAFAS score was 82.04 (SD= 37.41) at admission. At 6 months into services, the mean CAFAS score decreased to 62.82 (SD= 32.73); t (205) = 7.33, p = .000. Although 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. Children's Clinical Services nearly reaches the level for clinical significance.

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



A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Outpatient and Children's Clinical Services statewide. The mean CAFAS score was 95.26 (SD= 40.73) at admission. At discharge, the mean CAFAS score decreased to 75.69 (SD= 46.88); t (208) = 7.39, 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 statewide results nearly reach the level for clinical significance.

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

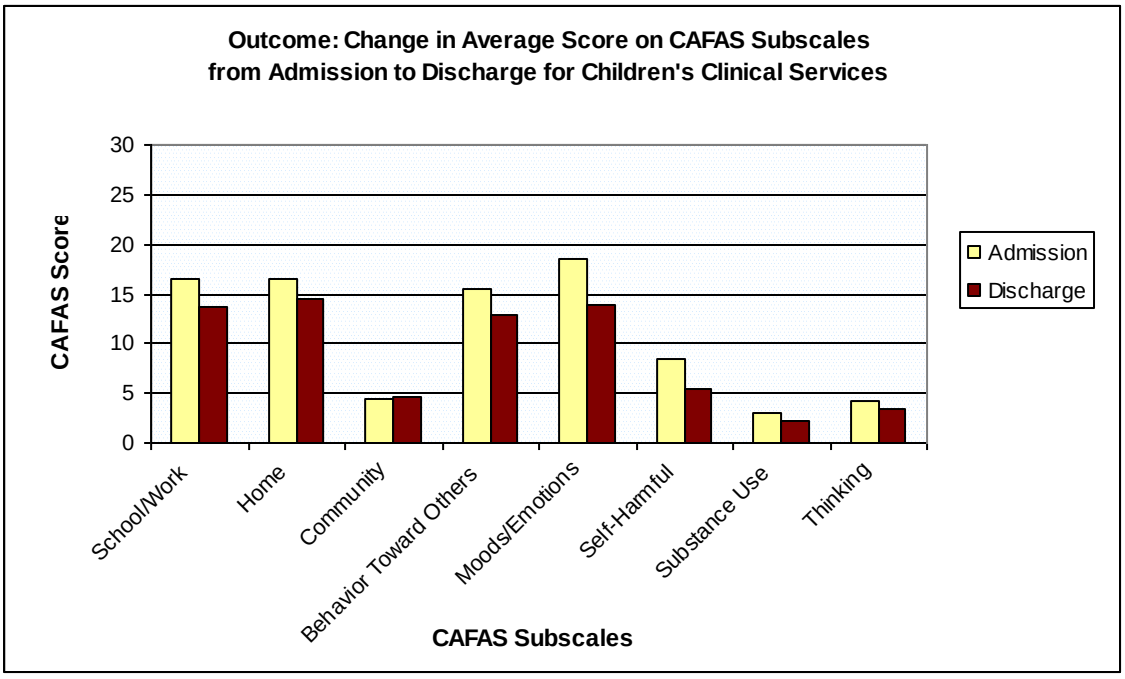


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Outpatient Services. The mean CAFAS score was 108.97 (SD= 39.92) at admission. At discharge, the mean CAFAS score decreased to 83.97 (SD= 49.34); t (77) = 5.92, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED YOUTH

Thank you for what you have done; you have changed my life forever.

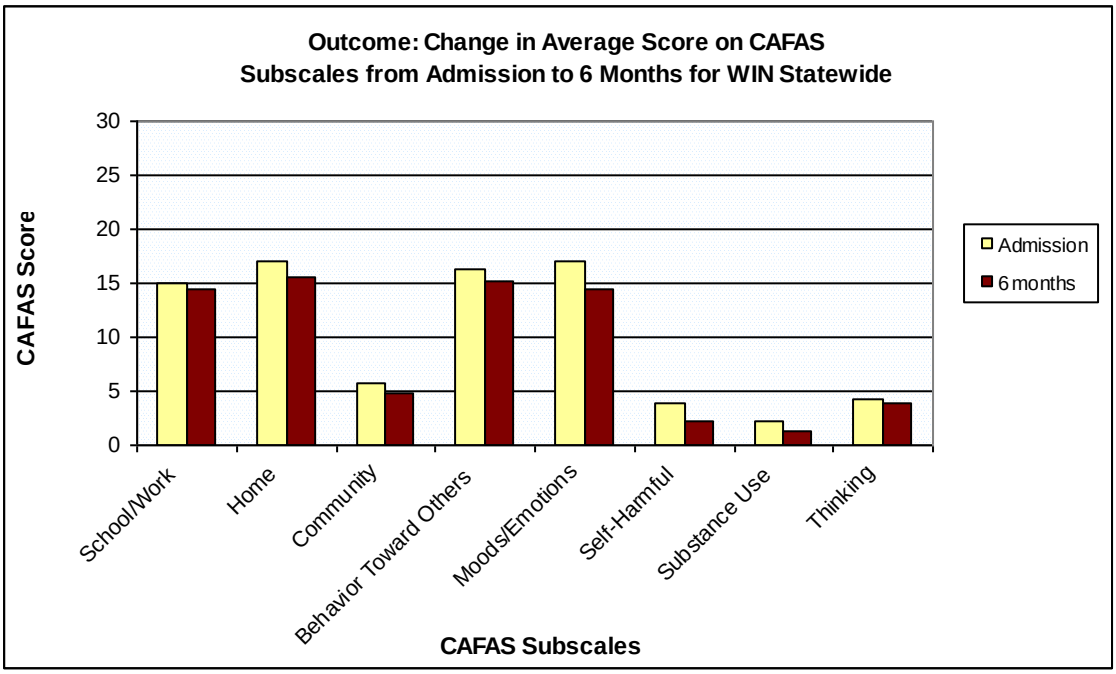
The graph below shows the admission and discharge CAFAS subscale scores for Children's Clinical Services.



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 87.10 (SD= 39.12) at admission. At discharge, the mean CAFAS score decreased to 70.76 (SD= 44.82); t (130) = 4.84, 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.

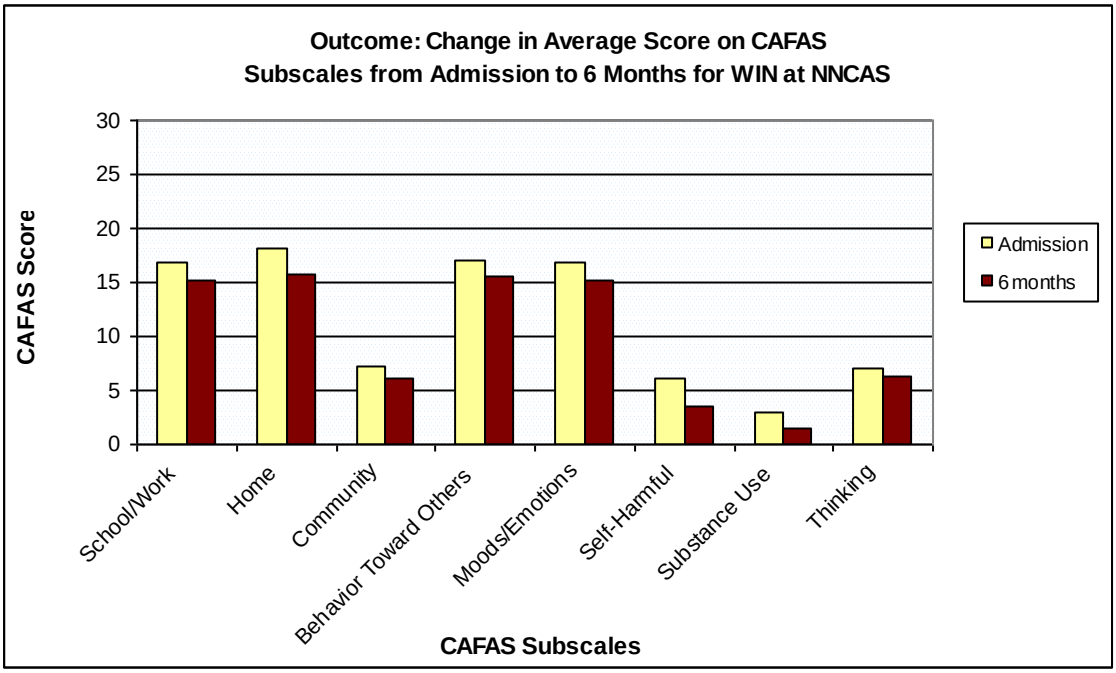
WIN

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 81.50 (SD= 33.97) at admission. At 6 months into services, the mean CAFAS score decreased to 72.00 (SD= 35.41); t (159) = 3.50, 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.

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

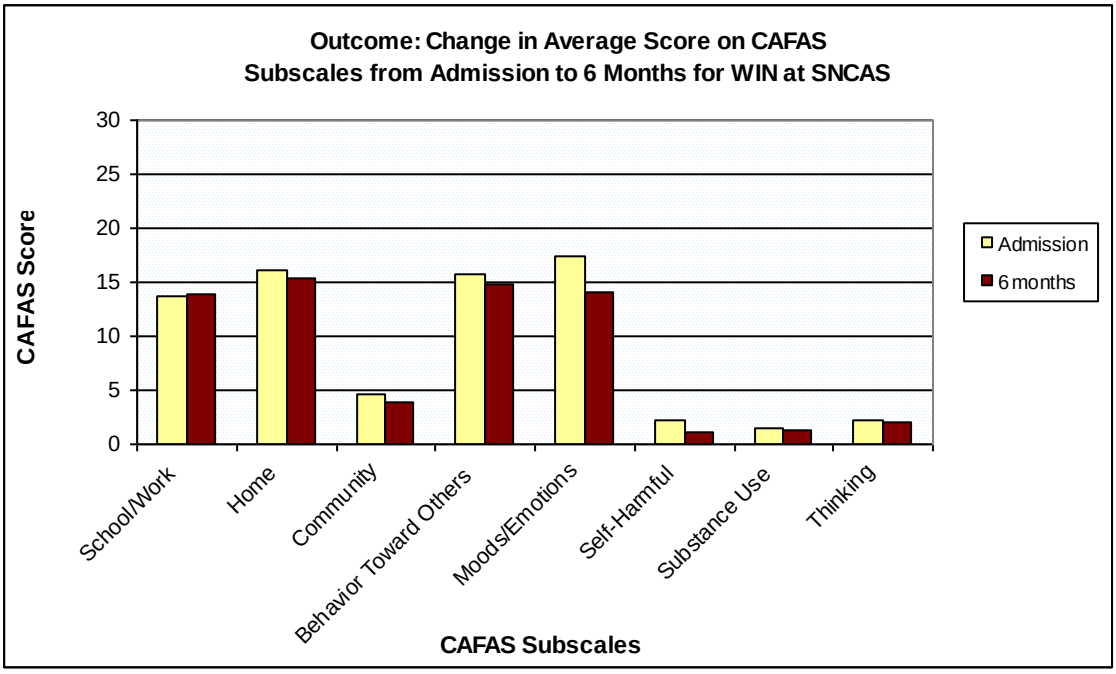


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for WIN at NNCAS. The mean CAFAS score was 92.06 (SD= 38.03) at admission. At 6 months into services, the mean CAFAS score decreased to 79.12 (SD= 37.65); t (67) = 2.64 p = .010. Although these results show 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 YOUTH

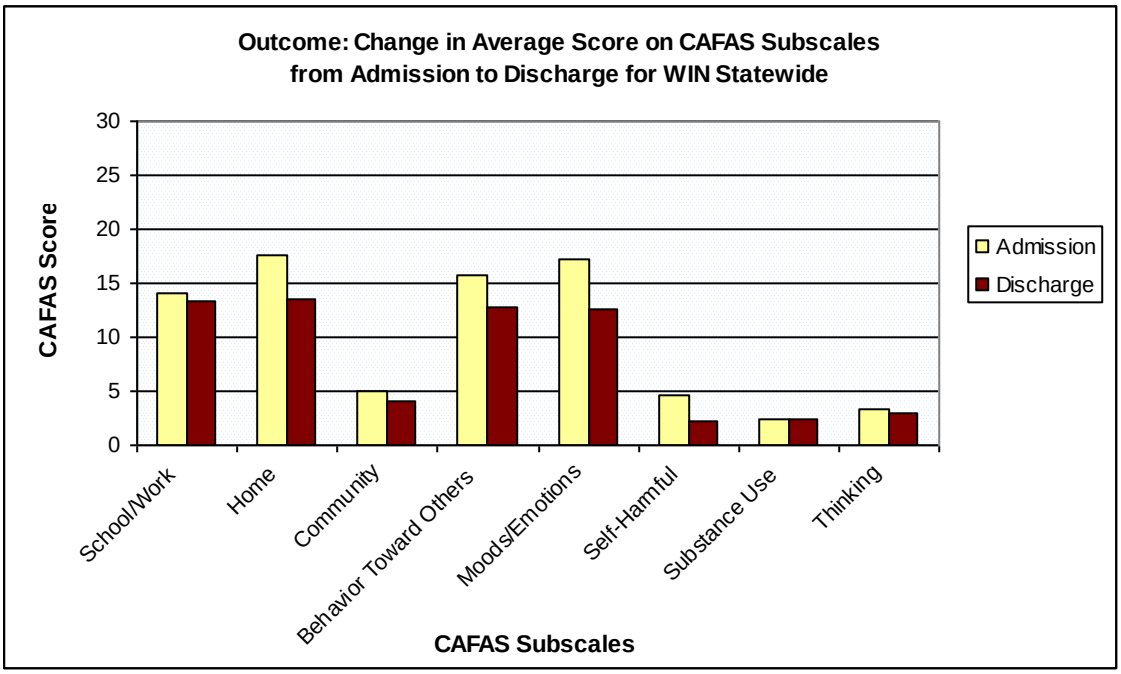
When I was freaking out, the staff would explain how to handle it better and things I could do in the future to avoid conflict.

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



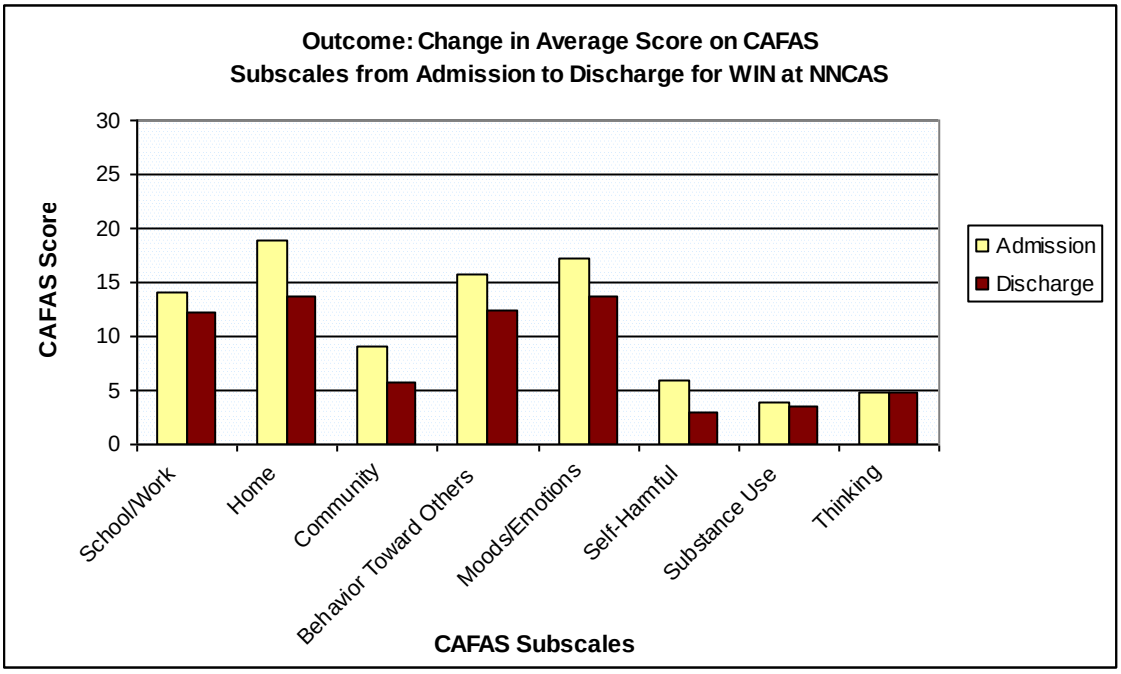
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6-months for WIN at SNCAS. The mean CAFAS score was 73.70 (SD= 28.39) at admission. At 6 months into services, the mean CAFAS score decreased to 66.74 (SD= 32.89); t (91) = 2.31, p = .023. Although these results show 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 80.07 (SD= 34.25) at admission. At discharge, the mean CAFAS score decreased to 64.25 (SD= 43.95); t (152) = 4.77, 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.

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

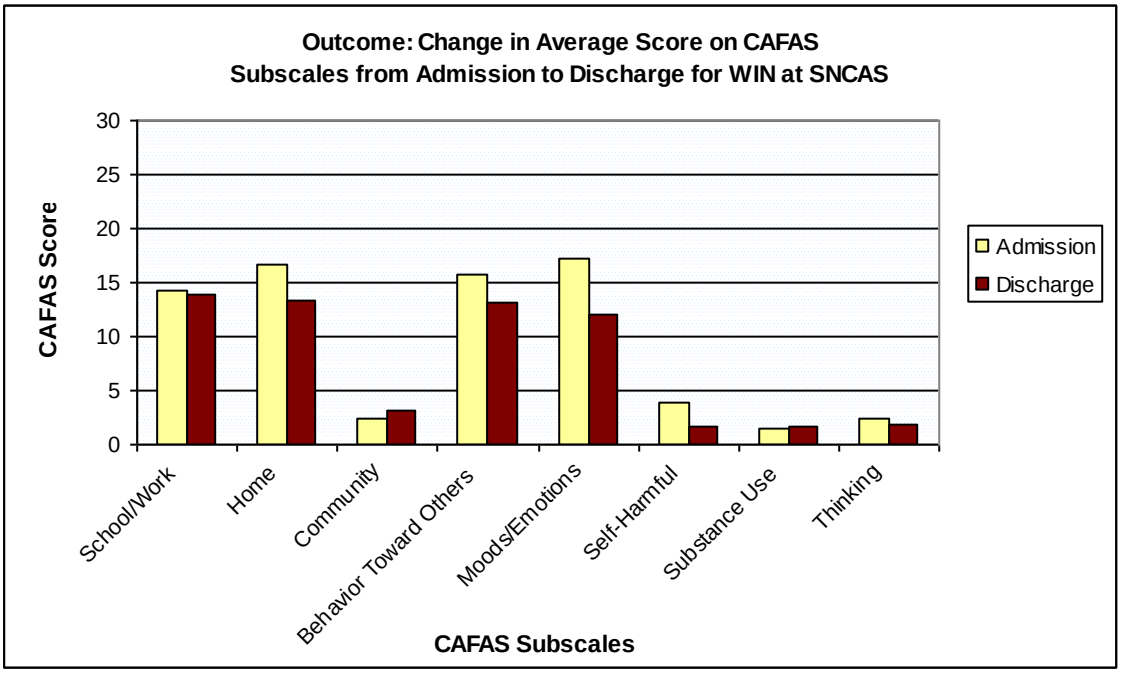


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN at NNCAS. The mean CAFAS score was 89.33 (SD= 39.22) at admission. At discharge, the mean CAFAS score decreased to 69.00 (SD= 45.46); t (59) = 3.68, p = .001. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED PARENT

Each and every one of the staff was a pleasure to be helped by and to know.

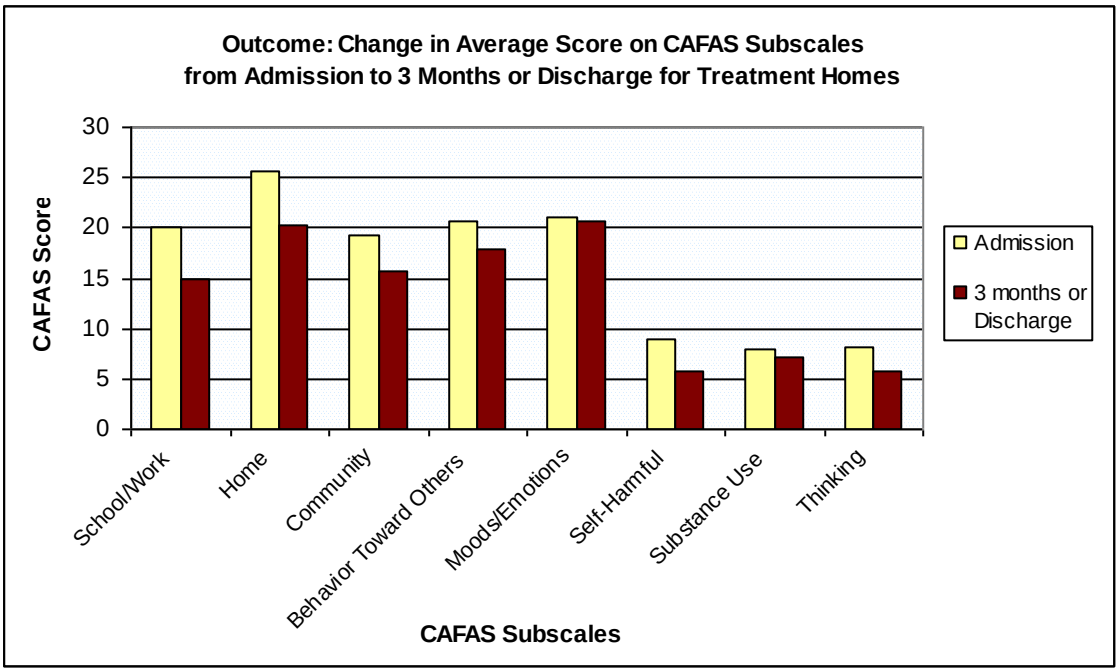
The graph below shows the admission and discharge CAFAS subscale scores for WIN at SNCAS.



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 74.09 (SD= 29.31) at admission. At discharge, the mean CAFAS score decreased to 61.18 (SD= 42.91); t (92) = 3.13, p = .002. 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

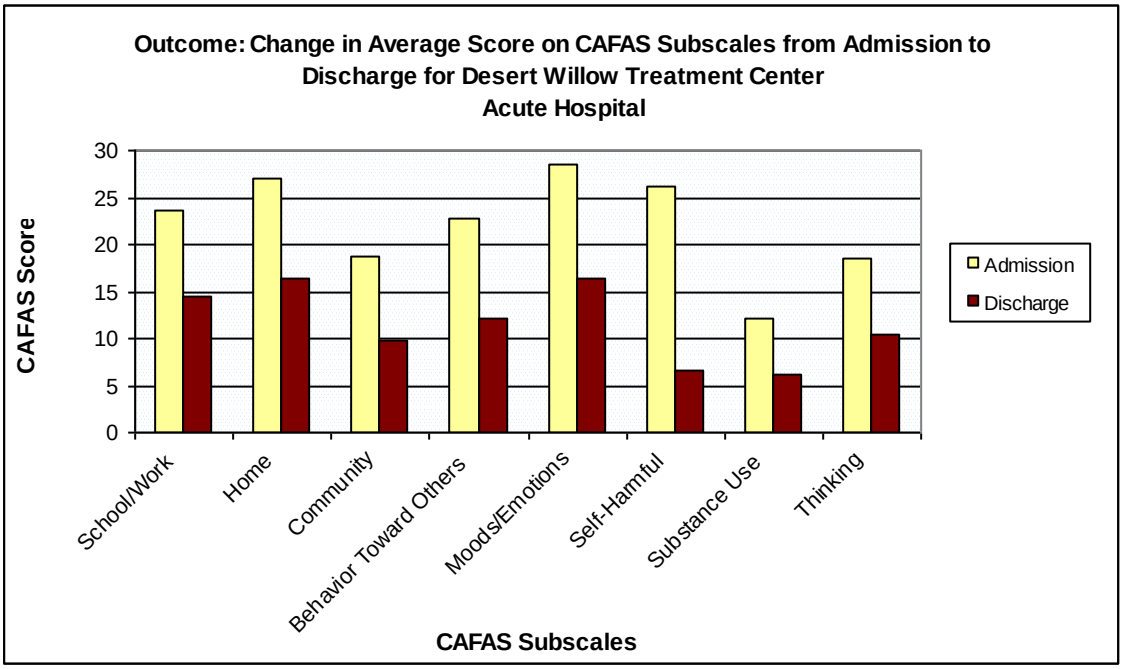
The graph below shows the admission and 3 months or discharge CAFAS subscale scores for Treatment Homes.



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 131.79 (SD= 20.74) at admission. At 3 months into services or discharge, the mean CAFAS score decreased to 108.21 (SD= 22.12); t (27) = 4.88, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 3 months or discharge.

Desert Willow Treatment Center Acute Hospital

The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Treatment Center Acute Hospital.



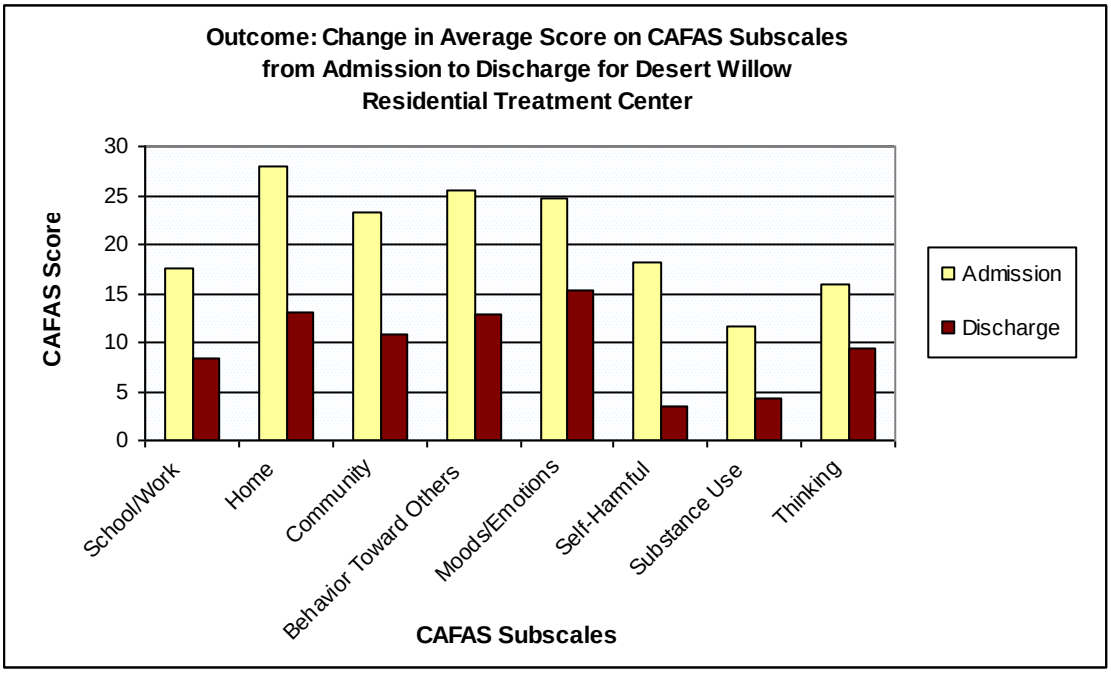
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Acute Hospital. The mean CAFAS score was 177.48 (SD= 33.76) at admission. At discharge from services, the mean CAFAS score decreased to 92.44 (SD= 32.52); t (134) = 28.49, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED YOUTH

I am learning coping and social skills.

Desert Willow Treatment Center RTC

The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Residential Treatment Center.



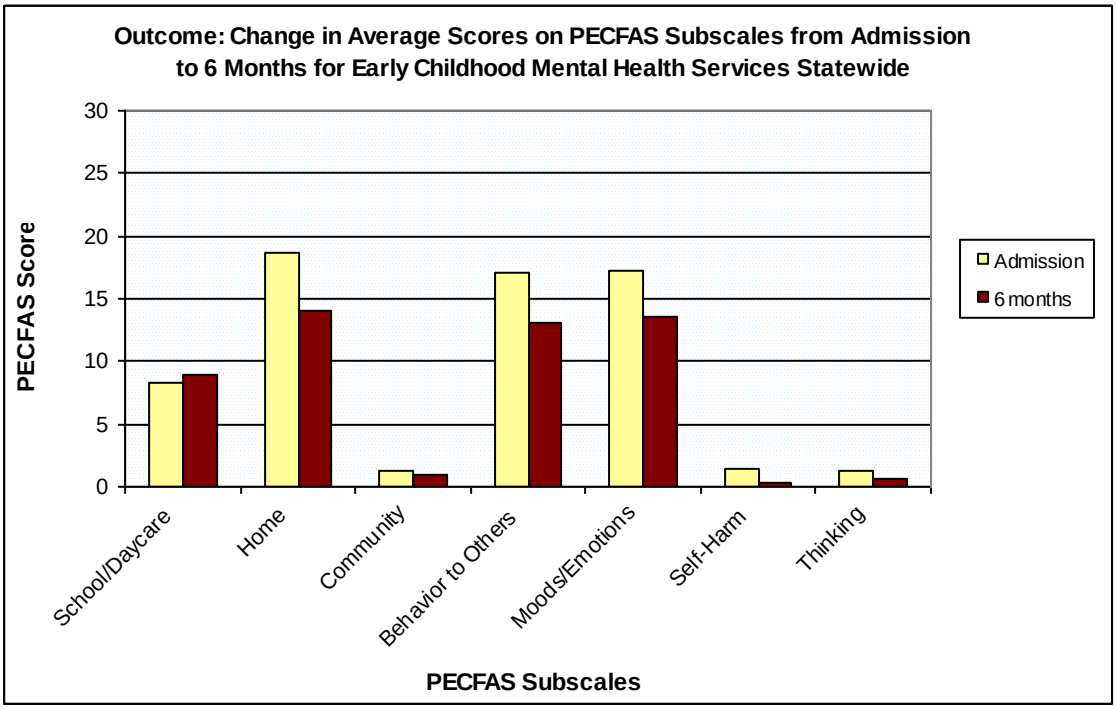
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Residential Treatment Center. The mean CAFAS score was 164.42 (SD= 33.22) at admission. At discharge, the mean CAFAS score decreased to 77.50 (SD= 43.79); t (51) = 13.48, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

They were there in our hour of need.

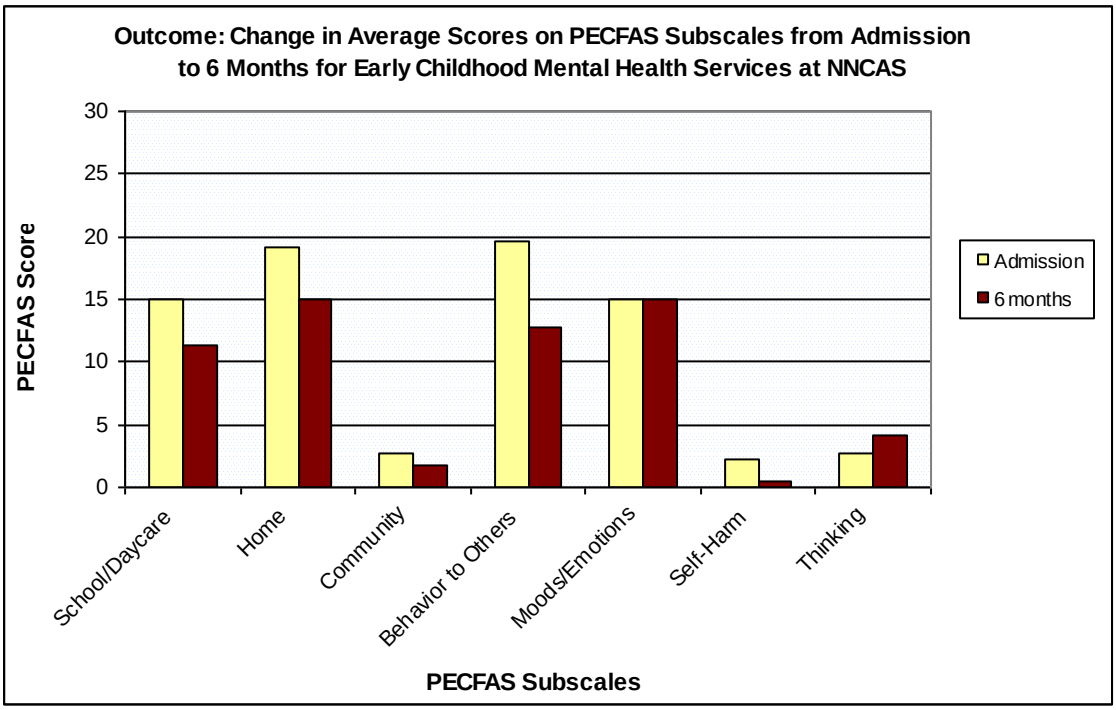
Early Childhood Mental Health Services

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



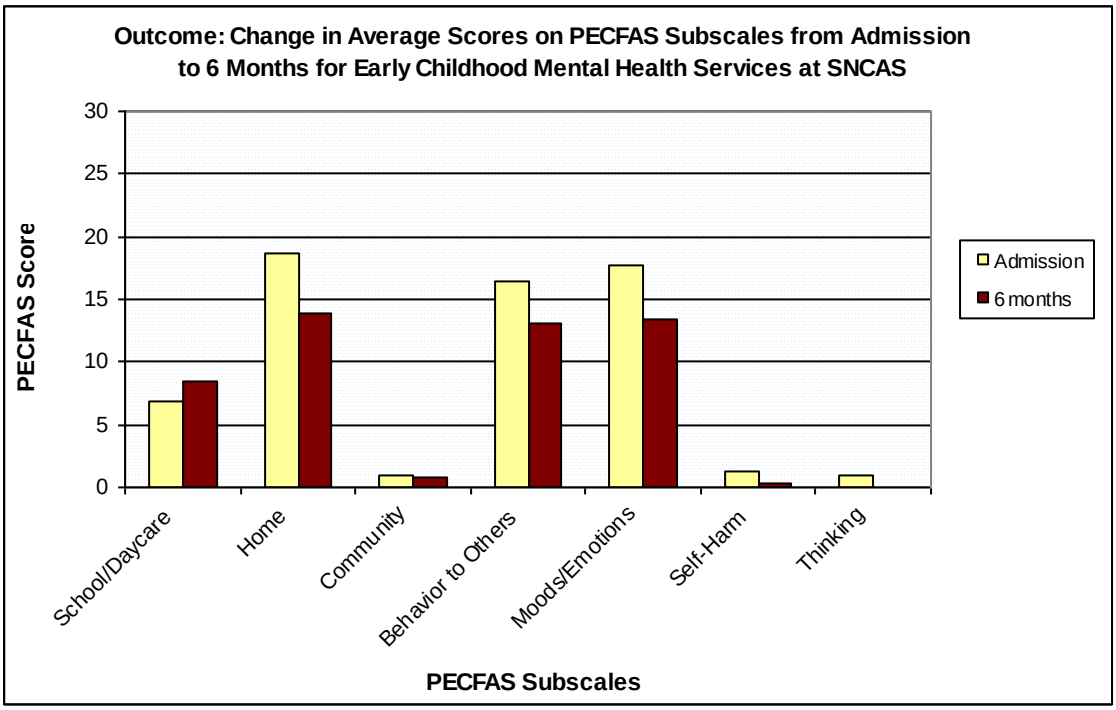
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services statewide. The mean PECFAS score was 65.43 (SD= 25.47) at admission. At 6 months into services, the mean PECFAS score decreased to 51.71 (SD= 24.50); t (128) = 5.61, 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.

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



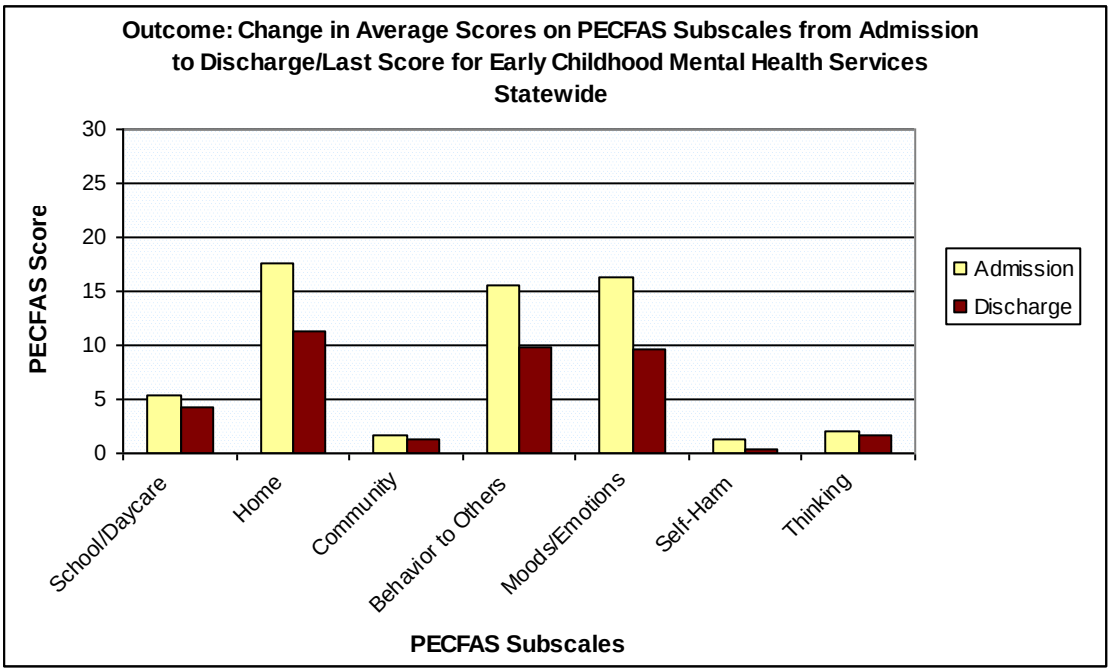
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services at NNCAS. The mean PECFAS score was 76.36 (SD= 34.72) at admission. At 6 months into services, the mean PECFAS score decreased to 60.45 (SD= 20.81); t (21) = 2.53, p = .020. 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.

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



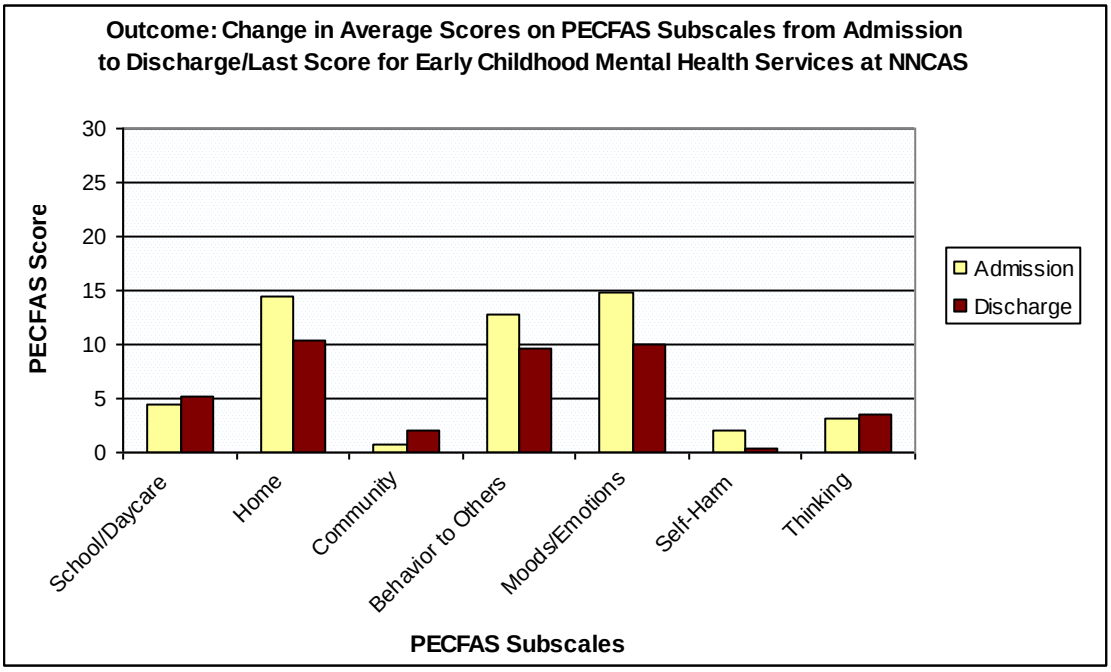
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services at SNCAS. The mean PECFAS score was 63.18 (SD= 22.68) at admission. At 6 months into services, the mean PECFAS score decreased to 49.91 (SD= 24.90); t (106) = 4.99, 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.

The graph below shows the admission to discharge/last score for PECFAS subscale scores for Early Childhood Mental Health Services statewide.



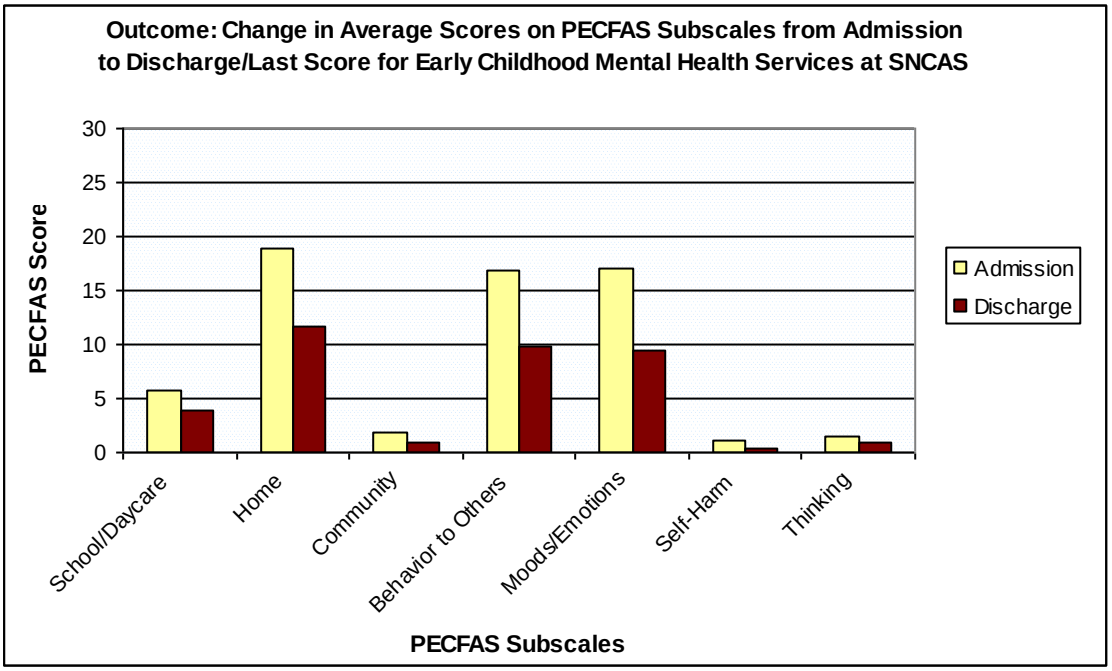
A paired-samples t-test was conducted to compare PECFAS total scores from admission to discharge or last PECFAS score for Early Childhood Mental Health Services statewide. The mean PECFAS score was 59.76 (SD= 24.64) at admission. At discharge or last score, the mean PECFAS score decreased to 38.17 (SD= 26.39); t (81) = 7.45, p = .000. These results show a clinically and statistically significant reduction in overall impairment.

The graph below shows the admission to discharge/last score for PECFAS subscale scores for Early Childhood Mental Health Services at NNCAS.



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 at NNCAS. The mean PECFAS score was 52.40 (SD= 30.73) at admission. At discharge or last score, the mean PECFAS score decreased to 41.20 (SD= 27.28); t (81) = 7.45, 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.

The graph below shows the admission to discharge/last score for PECFAS subscale scores for Early Childhood Mental Health Services at SNCAS.



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 at SNCAS. The mean PECFAS score was 62.98 (SD= 20.96) at admission. At discharge or last score, the mean PECFAS score decreased to 36.84 (SD= 26.13); t (56) = 8.42, p = .000. These results show a clinically and statistically significant reduction in overall impairment.

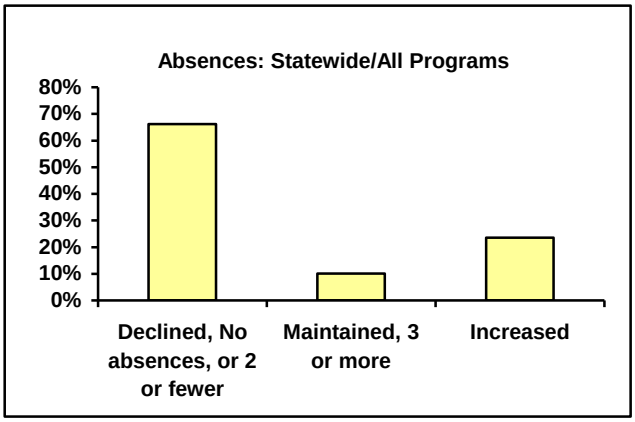
Education and Juvenile Justice Outcomes

An analysis was conducted on client's absences, suspensions/expulsions, and arrests. 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:

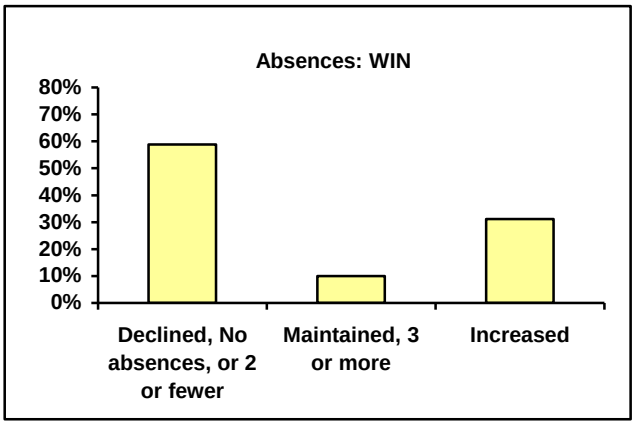
1. A client was considered to be maintaining an excellent performance or showing improvement if he or she met any one of three criteria:
   - The client had a perfect record historically and in the most recent period;
   - The client had a history of averaging no more than two absences per grade period 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).

Absences: Statewide/All Programs



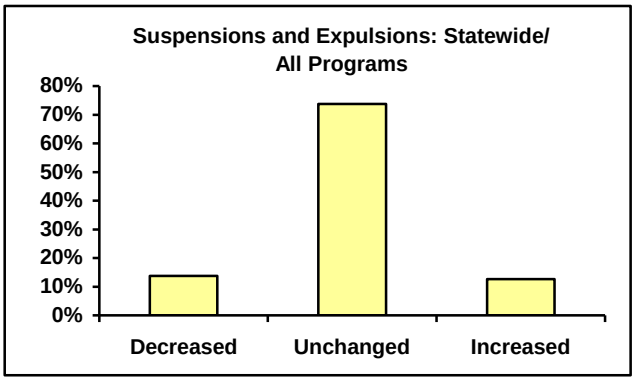
In FY2012, 554 clients had absences data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 367 (66.2%) of the clients. There were 130 (23.5%) 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 56 (10.1%) clients. Absences increased to three or more and the client average was greater than two days for 131 (23.6%) of the clients.

Absences: WIN



The WIN program accounted for 219 of the 554 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 129 (58.9%) clients. There were 21 (9.6%) 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 22 (10.0%) clients. Absences increased to three or more and the client average was greater than two days for 68 (31.1%) clients.

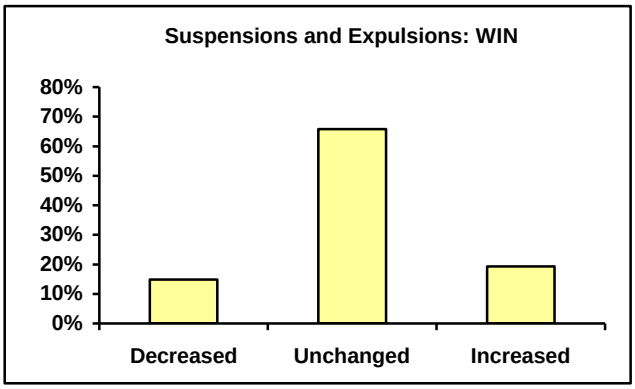
Suspensions and Expulsions: Statewide/All Programs



In FY2012, 517 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 71 (13.7%) of the clients. For 381 (73.7%) of the clients, there was no change in suspensions and expulsions versus his or her own average, and 362 (95.0%) of them had a zero average and zero

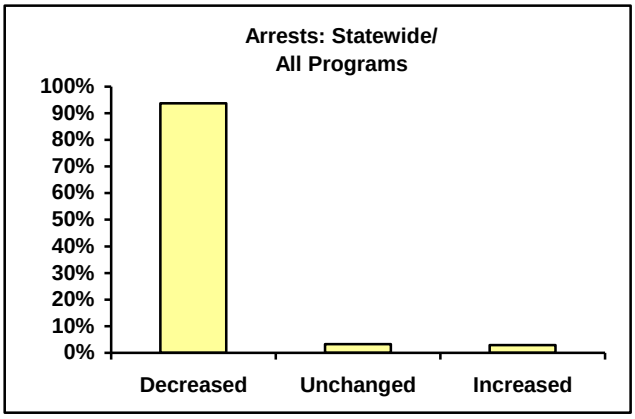
suspensions or expulsions. Suspensions and expulsions increased versus the client's own average for 65 (12.6%) of the clients.

Suspensions and Expulsions: WIN



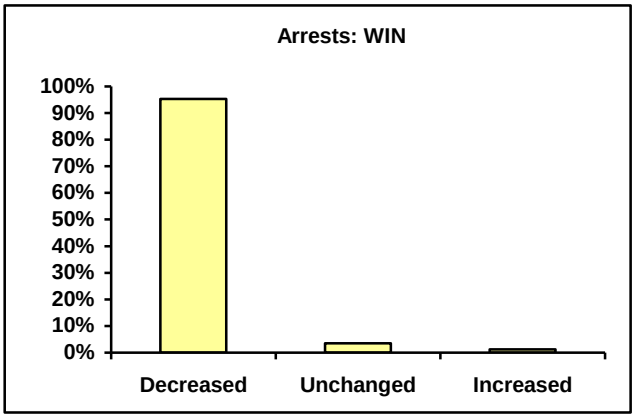
The WIN program accounted for 202 cases of the 554 cases with suspensions and expulsions data over multiple periods. Suspensions and expulsions decreased versus the client's own average for 30 (14.9%) of the clients. For 133 (65.8%) of the clients, no change occurred in suspensions and expulsions versus his or her own average, and 125 (94.0%) of them had a zero average and zero suspensions or expulsions. Suspensions and expulsions increased versus the client's own average for 39 (19.3%) of the clients.

Arrests: Statewide/All Programs



In FY2012, 629 clients had arrest data entered for at least two periods from which an average could be constructed. Of the 629 clients with arrest data, 556 (88.4%) had no arrests. Arrests decreased or remained zero versus the client's own average for 590 (93.8%) of the clients and 34 (5.4%) of the clients had fewer arrests than the client's historical average. For 21 (3.3%) 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 18 (2.9%) for the clients.

Arrests: WIN



In FY2012, WIN had 170 of the 629 clients with arrest data entered for at least two periods from which an average could be constructed. Of the 170 clients with arrest data, 145 (85.3%) had no arrests. Arrests decreased or remained zero versus the client's own average for 162 (95.3%) of the clients. For 6 (3.5%) 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 2 (1.2%) for the clients.

PROGRAM EVALUATION DEVELOPMENT: AGGRESSION REPLACEMENT TRAINING

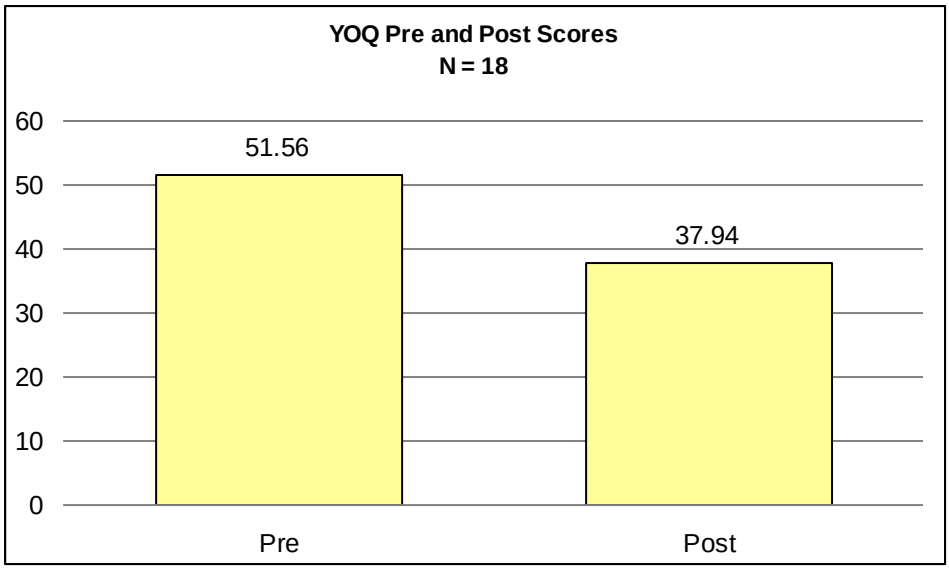
Clients served in residential treatment facilities have severe and complex needs requiring care in a structured living environment to help manage their problem behaviors. Aggression Replacement Training (ART) is a cognitive behavioral intervention program that helps youths improve their social skills and moral reasoning, better manage their anger, and reduce their aggressive behavior.[1] 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 66 youth who have participated in ART at ATC. These 66 youth were served in FY 2012.

Gender	
Male	31 (47%)
Female	35 (53%)
Race/Ethnicity	
Caucasian	45 (68.2%)
African-American	7 (10.6%)
Hispanic	13 (19.7%)
Other	1 (1.5%)
Average Age	15.02

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

[1] 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*

dolescent.[1] The YOQ-SR has 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.[2] Youth are asked to complete the YOQ-SR when they begin ART and then again when they finish the training. ATC collected pre and post YOQ-SR paired scores on 18 youth participating in ART. The graph below shows the average pre and post scores for the YOQ-SR.



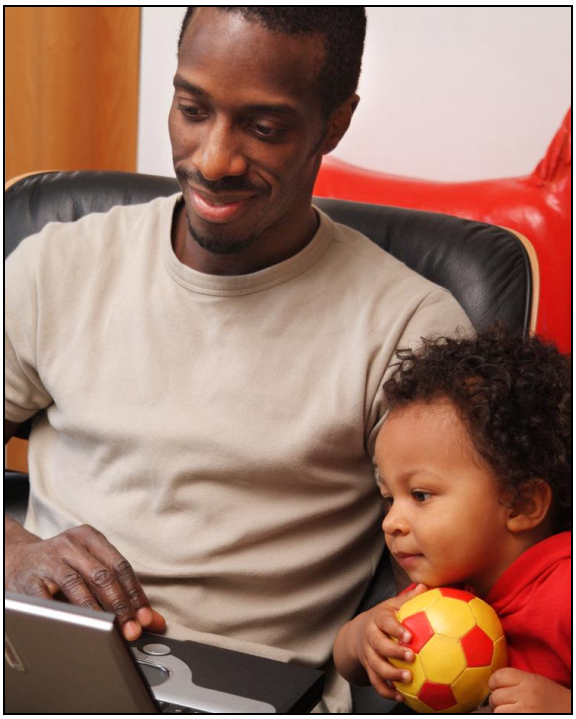
In order to draw meaningful conclusions, complete data sets need to be collected on more youth. ATC is encouraged to continue to collect data on the YOQ-SR.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

Thank you—that's all I can say—and great job!

[1] 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

[2] Burlingame, G. M., Wells, M. G., Cox, J. C., Lambert, M. J., Latkowski, M. & Justice, D. (2005, July). *Administration and scoring manual for the Y-OQ.* OQ Measures L.L.C.



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 2012	Youth % positive	Parent % positive	National Benchmark for Parent Response[7]
Services are seen as accessible and convenient regarding location and scheduling	80%	89%	83.8%
Services are seen as satisfactory and helpful	82%	89%	83.8%
Clients get along better with family and friends and are functioning better in their daily life	78%	74%	64.6%
Clients feel they have a role in directing the course of their treatment	72%	92%	86.8%
Staff are respectful of client religion, culture and ethnicity	90%	94%	92.5%
Clients feel supported in their program and in their community	87%	90%	85.3%
Clients are better able to cope and are doing better in work or school	80%	74%	66.8%
Important issues such as diagnosis, medication, treatment options, client rights and confidentiality were adequately explained by staff (community based domain)	82%	89%	NA

[7] 2010 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/dataoutcomes/urs/2011/nevada.pdf

ATTACHMENT C

DCFS Community Based Services Parent/Caregiver Youth Survey Results Statewide Spring 2012 Report

DCFS Community-Based Services Parent / Caregiver – Youth Survey Results Statewide Spring 2012

From March 12 to April 20, 2012, 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); respondents' ability to direct the course of their treatment (Participation in Treatment); whether staff were respectful of respondents' 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 a 60% or less 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 will monitor these particular items in subsequent surveys to determine if similarly low

endorsement rates re-occur. Programs will give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action should be taken. Programs will 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 312 parent/caregivers—of these 312, 18 were filled out in Spanish—and 181 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	46	501	9%	46
WIN	31	150	21%	33
Early Childhood Mental Health Services	73	468	16%	N/A
SNCAS Total	150	1,119	13%	79
NNCAS				
Outpatient Services	48	207	23%	52
WIN–Reno/Rural/Expansion	63	139	45%	50
Early Childhood Mental Health Services	51	162	31%	N/A
NNCAS Total	162	508	32%	102
Statewide Total	312	1,627	19%	181

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 2012

SNCAS
Children's Clinical Services Results

Parent/Caregiver N=46; Youth N=46 **Total Served = 501 Sample = 9%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	91	76
Services were scheduled at times that were right for us.	96	85
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	87	91
The people helping my child and family stuck with us no matter what.	89	90
I felt my child and family had someone to talk to when he/she was troubled.	91	85
The services my child and family received were right for us.	87	80
I received the help I wanted for my child.	91	93
My family got as much help as we needed for my child.	85	93
POSITIVE OUTCOMES		
My child is better at handling daily life.	77	85
My child gets along better with family members.	81	65
My child gets along better with friends and other people.	83	87
My child is doing better in school and/or work.	78	70
My child is better able to cope when things go wrong	64	80
I am satisfied with our family life right now.	68	65
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	81	58
I helped to choose my child and/or family's treatment goals.	96	80
I participated in my child's and family's treatment.	98	76
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	98
Staff respected our family's religious/spiritual beliefs.	96	93
Staff spoke with me in a way that I understood.	100	96
Staff was sensitive to my family's cultural and ethnic background.	98	89
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	91	N/A
I have people that I am comfortable talking with about my child's problems.	93	N/A
In a crisis, I would have the support I need from family or friends.	93	89
I have people with whom I can do enjoyable things.	87	89
I am happy with the friendships I have.	N/A	93

I feel I belong in my community.	N/A	80
FUNCTIONING		
My child is better at handling daily life.	77	85
My child gets along better with family members.	81	65
My child gets along better with friends and other people.	83	87
My child is able to do the things he/she wants to do.	79	78
My child is doing better in school and/or work.	78	70
My child is better able to cope when things go wrong.	64	80
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	96	84
Staff explained my child and my family's rights and confidentiality issues.	96	89
I receive support and advocacy from my Nevada PEP Family Specialist.	84	78
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	75	78
Our family is aware of people and services in the community that support us.	91	83
I am better able to handle our family issues.	85	76
I am learning helpful parenting skills while in services.	91	89
I have information about my child's developmental expectations and needs.	87	86

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ So far, nothing - very disappointed - This, alas, has proven unbeneficial all around. ♦ Someone to talk to other than family. ♦ School for him will help him evolve. ♦ How to handle certain problems. ♦ Learning how to open up her feelings instead of keeping it inside. ♦ Proper medication /dosage. Counseling. ♦ Knowing that people care about him. Learning coping skills to better deal with life and teenage emotions. ♦ Regular visits to family therapy. ♦ His medication. ♦ Coping with life. ♦ Being able to talk about their feelings and better manage their behaviors. ♦ Counseling. ♦ We are both better people because of Staff. She has taught us so many skills to better understand each other. ♦ Suggestions for coping with stress and loss. ♦ Learning coping skills. ♦ That we can have a doctor and a therapist so my kids have complete services. ♦ The opportunity to understand us and help us with our problem. ♦ Having someone to talk to. ♦ Working on the things that she does. About teaching her a different way to take care of problems. ♦ Staff's consistency and openness. ♦ It is too early to tell at this time. ♦ I like to know that there is support available if needed. ♦ She has someone whom she is able to talk to on a weekly basis for the problems she is having. ♦ My son is now able to control his temper, something he couldn't do before. ♦ Learned to balance the family better. ♦ Tips Staff gave us to try instead of what we were doing.	1. What has been the most helpful thing about the services you received? ♦ I have learned to stay calm in stressful situations. ♦ Having a safe place for my feelings and emotions. ♦ Me not to lie or to not get in trouble. ♦ The help has helped me to cope better with things that bother me. ♦ Being able to talk with my mom. ♦ Yes. ♦ Medication, the therapy. ♦ Advice. ♦ My brothers anger issues. ♦ The doctor, he is nice and the nurse. Also the medicines help me be better. ♦ Been easier to move my life along and get back on my feet and out in the world. ♦ Having someone to talk to and getting help with problem solving. ♦ Yes I had been helpful with my treatment and I thank the people for helping me. ♦ It has helped me realize not everything in my past was my fault. ♦ I am able to cope better with the problems in my family, or other problems around me. ♦ Having a helpful hand / person to talk to. ♦ I can get help with other people. ♦ Ummm… the respect. ♦ Being able to talk with Staff. ♦ Very comforting and reliable. ♦ The helpfulness is that they teach me to be confident about myself. ♦ The specialist makes me feel like I actually have someone whom I can talk to and trust ♦ Schooling. ♦ Somebody to talk to about my problems. Somebody to help me to work on my anger. ♦ Having somebody to talk to about my problems. ♦ I'm able to get out my feelings. ♦ They give me a chance to talk to about my feelings / problems. ♦ Everything.

Parent/Caregiver comments	**Youth comments**
♦ Our life has changed. I am able to go to work and know that the school won't be calling all day to have me pick up my son. ♦ They help him understand better. ♦ Learning coping skills. ♦ Support for how to handle tough situations and not being afraid to dole out consequences. ♦ It has allowed the child to transition into a new foster home and give the child the ability to once again trust adults. ♦ Answers I needed. ♦ Coping with anger. ♦ That he is learning to control himself. ♦ That my sons are learning easy rules for not fighting and obeying. ♦ That they communicate more with me. ♦ She listens to me a little more. ♦ That my daughter learned to behave better and understand family life. ♦ That he better understands his problems with behavior and aggression. ♦ The support of his counselor when he needs it, he calls her and she always listens. ♦ We have learned that her conduct is not normal and can receive more help to make her better. ♦ Having help learning to deal with my sons behavioral problems. ♦ Medication and her therapist.	♦ I learned how to cope with my emotions and it's improved my life. ♦ They help me cope better with friends and family. ♦ You guys help me to reduce my stress. ♦ Dr. has given me medication. ♦ That I don't feel lonely or mad. ♦ I control my emotions more and look forward to seeing my counselor more often. ♦ Receiving medication and having sessions every week has really helped. ♦ My medicine free is the most helpful thing about the services that I received.
2. What would improve services your child and the family received? ♦ We should be doing family sessions, not individual child therapist sessions. ♦ Dr. would actually smile and make eye contact. ♦ More parenting skills. ♦ Just being able to listen to her and try to help her with her feelings. ♦ Nothing. I'll continue bi-monthly sessions and meds to continue her well being. ♦ The services we received were perfect. ♦ The only problem is that she is getting change of the therapist 3 times already since we are coming to the clinic; I think this situation cause that my daughter feels insecure and start all over again try to feel comfortable with her therapist, too bad as of now 3-15-2012 we do not know who is going to be her therapist and I DO NOT FEEL comfortable that she is going to be seen by a man therapist; Because her issues are with man I do not know if I will continue with the services, or at least until you guys get enough personnel. ♦ Nothing right now. ♦ Availability. ♦ Bring back Staff. ♦ I have no complaints at this time. ♦ Nothing that I can see at this time. ♦ Keep doing what you are doing and thank you [happy face]. ♦ It is too early to tell at this time. ♦ Don't know at this time. The service we received seems to be working at this time. ♦ We've learned better communication. ♦ Location was very far from my home. ♦ Nothing at this time. ♦ If the kids would open up to their therapist more. ♦ Nothing I can think of. ♦ To control his anger. ♦ The continuation of the ongoing treatment plan. ♦ More family therapy. ♦ I am satisfied with my clinician because in her classes we learn how to communicate better with the children and I think she does very good work. ♦ Very good service.	2. What would improve services you received? ♦ Helping me become a better person. ♦ I don't know. ♦ Do not change therapy often. ♦ Unsure. ♦ I would need help with my problems. ♦ Nothing. Everything has been wonderful. I have seen progress. ♦ No because I like them just fine. ♦ The services is ok with me. ♦ Ummm… more knowledge. ♦ Nothing at this time. ♦ nothing it's perfect! ♦ The thing that improved in my services are social skills and thinking right with things. ♦ Nothing, this is a great service! ♦ I don't know. ♦ More strategies. ♦ More talking? I don't know. They are fine / good. ♦ Everything is good. ♦ More Spanish speaking representatives. ♦ Try and change my arrival time. ♦ Having an office in Henderson Nevada. ♦ I think if I can have a program or Medicaid insurance can would improve the services that I received.

Parent/Caregiver comments	**Youth comments**
♦ We can take care of the family better. ♦ He is in better communication and shares more time with the family. ♦ If we could dedicate more time in each session where we could talk about everything. ♦ More time with the counselor. ♦ I think if we could have an insurance program it would be better, but without insurance we have received help.	
3. Additional Comments ♦ Therapist need to involve parents in sessions because individual sessions obviously not helping and the therapist MUST communicate with family as a whole. ♦ Staff has been awesome, pleasant and very helpful. ♦ Thank you for your service to my child. ♦ Staff is a Godsend and we will forever be grateful to her and the center. Thank You. ♦ Let's hope President Obama does not cut funding for these types of services for our children because children are our future. Keep a good thing going!! ♦ We received a new counselor only to learn she is leaving also. There are no counselors to take us on. ♦ Since changing from the Henderson office, services have been much more appropriate and consistent. ♦ Only to thank them for their attention and their great help. ♦ This is a great program. ♦ Services are good. Keep up the good work that is being provided to the child in care. ♦ Thank you for not giving up [happy face]. ♦ None at this time. ♦ Just keep up the good work. ♦ We've received excellent results; thanks to the staff who have assisted us. ♦ My son is currently on the Honor Roll and has received several awards. He is also able to function at school and stay focused. My counselor is an amazing, he is patient with him and very knowledgeable in his field. We are blessed for all the services that are provided to us.. ♦ Thanks to this program, we have the necessary help for all the children with problems. ♦ Thanks for having these offices with all the nice personnel for our children who need them. ♦ Only to thank the personnel for their time and patience that they have for helping families with problems. Without them we couldn't learn to overcome these crises. Thanks, Staff (you're so special). ♦ When my son stops help with his therapist, I feel he has a lot of anxiety and gets depressed and when therapy is regular, the advice changes him or the way they work with him is very good. ♦ I am very grateful for your support and hope you open more locations so we can stay closer. ♦ Thanks for your support; you have been a blessing for us.	3. Any additional comments? ♦ Keep up the good work. ♦ No. ♦ My plan treatment. ♦ Not at this time. ♦ I do not need a PSR worker. ♦ Thanks for supporting me and my family. ♦ I'm so grateful with the services that I received.

SNCAS		
WIN Results		
Parent/Caregiver N=31; Youth N=33 **Total Served = 150 Sample = 21%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	90	75
Services were scheduled at times that were right for us.	87	85
GENERAL SATISFACTION		

SNCAS WIN Results		
Parent/Caregiver N=31; Youth N=33 Total Served = 150 Sample = 21%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
Overall, I am pleased with the services my child and/or family received.	94	81
The people helping my child and family stuck with us no matter what.	93	81
I felt my child and family had someone to talk to when he/she was troubled.	97	79
The services my child and family received were right for us.	90	85
I received the help I wanted for my child.	90	79
My family got as much help as we needed for my child.	83	79
POSITIVE OUTCOMES		
My child is better at handling daily life.	77	84
My child gets along better with family members.	74	85
My child gets along better with friends and other people.	68	91
My child is doing better in school and/or work.	61	73
My child is better able to cope when things go wrong	70	67
I am satisfied with our family life right now.	84	67
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	81	58
I helped to choose my child and/or family's treatment goals.	90	84
I participated in my child's and family's treatment.	94	75
CULTURAL SENSITIVITY		
Staff treated our family with respect.	97	97
Staff respected our family's religious/spiritual beliefs.	90	88
Staff spoke with me in a way that I understood.	97	94
Staff was sensitive to my family's cultural and ethnic background.	84	78
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	90	N/A
I have people that I am comfortable talking with about my child's problems.	90	N/A
In a crisis, I would have the support I need from family or friends.	94	88
I have people with whom I can do enjoyable things.	90	88
I am happy with the friendships I have.	N/A	81
I feel I belong in my community.	N/A	76
FUNCTIONING		
My child is better at handling daily life.	77	84
My child gets along better with family members.	74	85
My child gets along better with friends and other people.	68	91
My child is able to do the things he/she wants to do.	81	76
My child is doing better in school and/or work.	61	73
My child is better able to cope when things go wrong.	70	67

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	94	76
Staff explained my child and my family's rights and confidentiality issues.	94	88
I receive support and advocacy from my Nevada PEP Family Specialist.	90	85
My Nevada PEP Family Specialist supports me in leading my child's	97	88

treatment planning or Child and Family Team meetings.		
Our family is aware of people/ services in the community that support us.	97	73
I am better able to handle our family issues.	90	85
I am learning helpful parenting skills while in services.	93	91
I have information about my child's developmental expectations and needs.	97	76

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ The whole team, how we work well together to help child. ♦ The most helpful thing has been the extra support received with helping my child reach some of his goals. ♦ Support and advice when dealing with behavioral problems. ♦ The counseling along with PCW. The PSR workers. ♦ PSR - Counselor – Support, ♦ Client really loves going to see Staff, his therapist, he feels quite comfortable with him. ♦ Guidance, School Advocacy, tutoring etc… ♦ The support team and safety. ♦ Getting therapy for child. ♦ Child looks forward to services. ♦ Being able to talk to my children about different things. ♦ The PCW and MH2 provided cell number and an additional numbers for my son, he feels comfortable speaking to both. ♦ Learning how to deal with certain problems. ♦ I believe they feel they now can talk to someone. ♦ It gives him another outlet of confidence to have someone outside the home listen to him. He likes his worker for now. ♦ Our home visits. Our worker is very nice we look forward to seeing her. ♦ She has someone she trusts. ♦ Team work, cooperation, respect. ♦ He has given all of us a set of goals to work on with client. ♦ The support is really good. ♦ Emotional support and all other services have been good and he enjoys everything. He seems a lot happier. ♦ We are very happy with the services. ♦ The support of WIN and people of Stepping Stones. ♦ C.B.H .and WIN put everything in place. ♦ Support.	1. What has been the most helpful thing about the services you received? ♦ The education about the services. ♦ They help me with my anger issues. ♦ Everything!!! ♦ Calming me down!! ♦ Everything. ♦ My dad all about my services. ♦ Control my anger. ♦ I get the help I really need. ♦ Able to get my school music supplies. ♦ BST & PSR. ♦ Steps to skills. ♦ I have learned to cope with how I feel and talk about my life. ♦ Learning to deal with problems. ♦ I would probably say just working on the past problems. Also, talking on little problems that have been happening today or yesterday. ♦ Much respect and hard work. ♦ Everything helping me to achieve. ♦ The coping skills and knowing that I have someone to count on. ♦ Always being for me, helpful and understanding in all occasions. ♦ I learned new coping skill and I have no more thoughts of suicide. ♦ The one I have now. ♦ I have been getting along really well with my friends and family. ♦ It has helped me with my grades, in school, and in my house. ♦ I do not know. ♦ Make me feel better. ♦ They help me communicate with my family. ♦ I have people I could speak to or ask advice from.
2. What would improve services your child and the family received? ♦ The services received are ample. ♦ I feel the services are good just the way they are and slowly making progress with this child. ♦ Everything has been good for us. We have learned a lot about our selves and our family. It has made us stronger. ♦ I feel like they are receiving good services at this time. ♦ More knowledge about Nevada laws. ♦ Activity for the children during evening and weekends, even summer activity. ♦ Replacement of MH2's - is imperative! No, therapy is HORRIBLE! ♦ It would be great if a family like ours could have help without state assistance - this program is like nothing I could have had with church or family - I love them…middle class hurts too. ♦ To have the opinion of foster parent and the child heard and not be told what is policy. Instead try to find an alternate solution at times. ♦ Nothing, things are fine. ♦ None - very satisfied ♦ Surprise me! ♦ Everything is fine the way it is. ♦ Pills. ♦ No thing really because everyone has been doing a great job and we all are a team. counseling are child.	2. What would improve services you received? ♦ There is not anything I can think of that would improve them. ♦ Nothing because they are fine. ♦ I would like more services which would be… Casa, sports, big brother and big sister. ♦ Reuniting me and my family… AKA won't happen. ♦ Bring old Staff back. ♦ My dad and the rest of workers. ♦ To help me be happy by earning rewards. ♦ More ability to talk to friends outside of treatment. ♦ I don't know. ♦ Let people finish their sentences and let people (mom, brother, me) finish their sentences. ♦ Having someone being there for me. ♦ Keep working hard! ♦ To not wet the bed and not to lie. ♦ Staff is Great ♦ I believe everything is fine. ♦ I don't know. ♦ I am a better person and mom. ♦ If they helped out more with my anger. ♦ I would not improve it. ♦ Service are fine. ♦ Keep workers for more than a month. ♦ It is good.

♦ Services are good as is ♦ They got all the services they need and it's working	
3. Additional Comments ♦ My child's doing well in the home and at school. ♦ We must keep our family together. ♦ Client is a very loving young man and is excited about his new home and family. ♦ I am undecided on several issues because we have no MH-2. ♦ I get choked up when I talk about my gratitude and appreciation for what we've been provided - I've (we) needed this for SO long. I'm really worried (embarrassingly) that Staff could be gone. ♦ I hope to keep all the workers we have working with us. ♦ The WIN worker has been awesome in our services and getting him what he needs.	3. Additional Comments ♦ My WIB worker always helped me get through a lot of stuff. ♦ My counselor is Awesome. ♦ It wouldn't hurt to record or track peoples convo's, and when conversation gets carried away say "Stop and take a break". ♦ Having old therapist back. Not having a therapist and having them leave without seeing me was not cool. ♦ Thank you so much. ♦ This is really helping me a lot.

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=73; Youth = NA Total Served = 468 Sample = 16%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	85	N/A
Services were scheduled at times that were right for us.	93	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.	90	N/A
I felt my child and family had someone to talk to when he/she was troubled.	88	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.	92	N/A
My family got as much help as we needed for my child.	86	N/A
POSITIVE OUTCOMES		
My child is better at handling daily life.	78	N/A
My child gets along better with family members.	81	N/A
My child gets along better with friends and other people.	81	N/A
My child is doing better in school and/or work.	82	N/A
My child is better able to cope when things go wrong	69	N/A
I am satisfied with our family life right now.	75	N/A
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	81	N/A
I helped to choose my child and/or family's treatment goals.	89	N/A
I participated in my child's and family's treatment.	91	N/A
CULTURAL SENSITIVITY		
Staff treated our family with respect.	92	N/A
Staff respected our family's religious/spiritual beliefs.	92	N/A
Staff spoke with me in a way that I understood.	90	N/A
Staff was sensitive to my family's cultural and ethnic background.	90	N/A
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	90	N/A
I have people that I am comfortable talking with about my child's problems.	90	N/A

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=73; Youth = NA Total Served = 468 Sample = 16%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
In a crisis, I would have the support I need from family or friends.	80	N/A
I have people with whom I can do enjoyable things.	87	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.	78	N/A
My child gets along better with family members.	81	N/A
My child gets along better with friends and other people.	81	N/A
My child is able to do the things he/she wants to do.	91	N/A
My child is doing better in school and/or work.	82	
My child is better able to cope when things go wrong.	69	N/A

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	N/A
Staff explained my child and my family's rights and confidentiality issues.	89	N/A
I receive support and advocacy from my Nevada PEP Family Specialist.	88	N/A
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	88	N/A
Our family is aware of people/ services in the community that support us.	85	N/A
I am better able to handle our family issues.	82	N/A
I am learning helpful parenting skills while in services.	91	N/A
I have information about my child's developmental expectations and needs.	91	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ Having weekly therapy and also knowing I can call for advice when other behavior issues come about during the week. ♦ Having someone else that will listen to them and is concerned about them as an individual. ♦ He has been able to talk about his behavior and he handles things better. ♦ My foster daughter can cope better with her problems now. ♦ Getting him to talk about his feelings - shows compassion. ♦ The therapist explains behavior and concepts clearly and always goes the extra mile to get the services we need. ♦ My child is learning how to share and interact in a social setting! ♦ I am better able to handle his outbursts and the outbursts are happening less often. ♦ Being able to spend more time as a family. ♦ The therapist. ♦ Better bonding between child and us - our foster parents. ♦ Helping my child with his needs. ♦ Opening up the door so me and child can talk about his feelings, helping him feel safe. ♦ The people, they have been 100% all the time. I feel as if me and my child are the only patient they have. They are consistent and they care. ♦ Helping us to understand and help manage our foster child's anger issues. ♦ Helping use learn to know our foster child's personality and needs better.	1. What has been the most helpful thing about the services you received? • NA

- The consistency of having the same therapist has helped him greatly.
- I've learned helpful ways to teach my child and help her in a positive way.
- Medication.
- Demonstration of coping strategies.
- The help in understanding his behavior issues and the support of teaching him.
- When my daughter was with my cousins, they paid for her daycare.
- The training that they give him in therapy on behavior and obedience.
- The ability to handle her emotions.
- Not sure.
- He is gaining the knowledge to cope with situation… just has to learn to apply.
- School.
- Staff's ideas and thoughts on how to deal with meltdowns and things we can do to help CLIENT cope with separation from parent's issues plus helping us with behavior issues also.
- Child is aware of right and wrong.
- Learning how to build structures to handle situations when she gets mad or irritated.
- That client is able to communicate about how he is feeling, that they don't have to hit each other or hurt each other as a form of love.
- They explain everything.
- The confidence in parenting and the assurance that my child is on track developmentally.
- Just starting with these services - I believe new avenues of turning negative into positive behavior.
- Learning how to trust again.
- How to express her feelings and emotions in a positive manner.
- Being able to talk to someone and understand.
- So far he hasn't received a permanent therapist but I bring her because I know that her therapist, models growth and confidence for her.
- My son is able to talk and control his anger. Knows how to communicate.
- Just being able to talk to someone to help work together to improve negative behaviors.
- Support, understanding and guidance.
- N/A - have not gotten to this point yet.
- Having a therapist and case manager to work and talk with.
- Learning how to express and relate feelings.
- Better behavior and speech is better than ever.
- Teaching me to be calm with him.
- This service has helped my child to interact with other children.
- Learning way to speak and show how to behave to the kids and results are amazing.
- Very supportive I like it when I call, always helpful.
- Dealing and learning ways of helping me with their behavioral problems.
- Staff is most help in modify his behavior, and, she has help me other services. She is always there to help with any problems.
- I have someone to talk with about child. Very sensitive problems that she has since foster care.
- My child is learning new skills to help her cope with difficult situations.
- One on one counseling.
- Counseling, medications, and support.
- He can receive services weekly and on a one on one basis.
- She's better following directions.
- Learning new skills to gain compliance from my children.
- The therapist has not changed. She has been with my foster child since she came into care over 2 years ago.
- Educated me on what to do when client has her tantrums.
- The provider is very caring.

♦ Although we have just begun, I can see and understand how treatment will be helpful.	
2. What would improve services your child and the family received? ♦ Staff was great especially my Staff, she was very attentive to our family and she respected us. ♦ Putting him in a group setting and working on getting along with others - follow rules. ♦ More self help services and independency. ♦ Daily life skills, eating, going to the bathroom, getting dressed etc… ♦ No improvements needed. ♦ Keep services as is. ♦ Nothing, everything is good. ♦ Pick up from school for Day Treatment. ♦ We're ok ♦ Very satisfied with current services, wouldn't change a thing. ♦ I'm not sure. ♦ Nothing to mention. ♦ Very satisfied with plan for child. She is making progress. ♦ Somebody to get busy and do what I ask. ♦ If he could apply what he is learning. He can state what he needs to do. ♦ The services we have received and continue to receive are fine. ♦ Child care services. ♦ Services are great. I wouldn't trade Staff for the world! ♦ I think the services that client and the family receive is wonderful, that you can only take little steps at a time, and with any process it can only get better. ♦ The service is great the way it is. ♦ Having a more specific agenda in regards to activities etc… ♦ I will see as we progress. ♦ Sometimes an outdoor setting when the weather is nice. ♦ More consistent behavior feedback. ♦ Everything received from them was fantastic and continues to help us in every way. ♦ We haven't reached that point yet. ♦ Help that my child needed. ♦ Staff is good. ♦ I wouldn't change the service, it is great for my foster son. ♦ N/A Everything great. ♦ I would just like to keep family service's because my children improve with the more they work with Staff. ♦ Transportation. ♦ None all great. ♦ Behavior. ♦ Her behavior. Her bondage issues. ♦ Right now, the services are wonderful and I wouldn't change anything. ♦ I would like to see when child is being asked questions from therapist that its to much playing with toys and the focus on the questions are being distracted by playing with the toys, and most question do not get answered! ♦ Counseling. ♦ The continuation of the weekly, one on one services. ♦ I believe for her to have real one on one therapy. ♦ Nothing I can think of. ♦ Handouts or homework for parents and family. ♦ I think my therapy has been real help for us. ♦ Too early to tell.	2. What would improve services you received? • NA
3. Additional Comments ♦ Staff has been wonderful. ♦ Out therapist is doing a great job with my foster daughter. ♦ Thank for helping my son he is a happy boy from Day Treatment. ♦ Thank You! From my heart. ♦ Only to give thanks to God and you for putting them in my path. ♦ Staff has been a very positive role model and she is very calm	3. Any additional comments? • NA

which has actually helped even more. She is very professional and when she speaks to us she makes the conversation clear. ♦ Staff is outstanding and listens to everything whether it's about client or anything else we talk about. ♦ Gratitude for the kindness of the staff for us, they know what they are doing. Thanks. ♦ I love the ladies that are working with us, Staff have been a lot of help. ♦ Thanks for all you do! Awesome Support! ♦ Keep up the good work. You help young children to deal with issues that they have. ♦ I love my worker she is awesome. ♦ I thank God every time I pray for my counselor, I hope that she will always be a part of lives. ♦ My counselor goes with me to all appointment with the children and her and I then able to see what's next all what is best for the children. I need that. ♦ I am happy with the help given to my children. ♦ Our therapist is wonderful. She explains things to me in a way I understand. It allows me to be able to talk and work things out with him. ♦ No. Dr. was exceptionally good and I trusted her and valued her input. ♦ Thanks for all the support your agency gives to my family and especially to my counselor. ♦ So far, everyone concerned is Great!!!	

NNCAS Outpatient Services Results		
Parent/Caregiver N=48; Youth N=52 Total Served = 207 Sample = 23%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	77	71
Services were scheduled at times that were right for us.	90	86
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	89
The people helping my child and family stuck with us no matter what.	92	80
I felt my child and family had someone to talk to when he/she was troubled.	88	77
The services my child and family received were right for us.	85	83
I received the help I wanted for my child.	83	89
My family got as much help as we needed for my child.	81	89
POSITIVE OUTCOMES		
My child is better at handling daily life.	71	80
My child gets along better with family members.	71	83
My child gets along better with friends and other people.	69	80
My child is doing better in school and/or work.	62	71
My child is better able to cope when things go wrong	67	74
I am satisfied with our family life right now.	56	83
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	84	60
I helped to choose my child and/or family's treatment goals.	92	88
I participated in my child's and family's treatment.	96	74
CULTURAL SENSITIVITY		

NNCAS

Outpatient Services Results

Parent/Caregiver N=48; Youth N=52 Total Served = 207 Sample = 23%	Parent/Caregiver Positive Response %	Youth Positive Response %
Staff treated our family with respect.	94	94
Staff respected our family's religious/spiritual beliefs.	96	97
Staff spoke with me in a way that I understood.	96	91
Staff was sensitive to my family's cultural and ethnic background.	92	88
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	88	N/A
I have people that I am comfortable talking with about my child's problems.	83	N/A
In a crisis, I would have the support I need from family or friends.	85	89
I have people with whom I can do enjoyable things.	90	97
I am happy with the friendships I have.	N/A	89
I feel I belong in my community.	N/A	74
FUNCTIONING		
My child is better at handling daily life.	71	80
My child gets along better with family members.	71	83
My child gets along better with friends and other people.	69	80
My child is able to do the things he/she wants to do.	77	77
My child is doing better in school and/or work.	62	71
My child is better able to cope when things go wrong.	67	74

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	83	80
Staff explained my child and my family's rights and confidentiality issues.	92	97
I receive support and advocacy from my Nevada PEP Family Specialist.	76	83
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	84	77
Our family is aware of people/ services in the community that support us.	77	83
I am better able to handle our family issues.	83	79
I am learning helpful parenting skills while in services.	88	89
I have information about my child's developmental expectations and needs.	90	69

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ They helped me find a diagnostic, so that my son would obtain the adequate treatment. ♦ He has greatly improved his behavior, and he has learned to deal with routine or everyday problems. ♦ That when I need answers I can discuss it with the therapist. ♦ The treatments provided are geared toward the child, my daughter is treated like a person, not just her diagnosis. ♦ Consistent ♦ Having support with questions and concerns. ♦ Steady, on-going visits and consultations and having the	1. What has been the most helpful thing about the services you received? ♦ Helping coping with my emotions. ♦ I don't know. ♦ Someone to listen to me. ♦ I have someone to talk to about problems. ♦ They explain things to me that I need help on. ♦ Better coping skills and a better ability to understand other points of view for situations I am in. ♦ Good counseling. ♦ That I take searquil it helps me sleep but I need a higher dose. ♦ Just about everything.

proper medications prescribed. ♦ She is able to cope a little better, but still regresses. ♦ Just him being able to acknowledge any issues and discuss them with us. ♦ We are just breaking the ice here. I believe that my daughter needs to be truly honest with the counselor that she sees or she may not be able to get the help she really needs. ♦ Learning more ways to understand him / feeling and emotions. ♦ Structure and continuity. ♦ Assisting in parenting decisions. ♦ Coping skills. ♦ It helps his grades. ♦ Giving me as much understanding as possible. ♦ She is talking more and plays with kids. ♦ Finally getting a mix of medication and therapy that works together. ♦ The skills she has been taught in order to better handle her anxiety. ♦ I now think different about life. ♦ A focus on my son. He is learning that many of his problems were caused by his actions / choices. ♦ Setting goals with children's behavior and school. Learning new ways of parenting skills and techniques. ♦ His worker is wonderful and tries very hard to help us, but there is too little service available, and they are taking so very long to get. But yet, his worker is not giving up and keeps working hard to help us. That's an encouragement. ♦ About him getting along with his family. ♦ Coping skills. ♦ Being able to set up incentive programs with child to make him strive to do better. ♦ Counseling. ♦ Attempting to get her to admit fault for her actions. ♦ My child has a place to voice his concerns about school bullying. He can vent his feelings. ♦ The great support my counselor is giving to all of us. ♦ No payment - but then I guess you get what you pay for, right? ♦ Counseling - The Learning Home with parental guidance and consequences. ♦ The communication. ♦ Everything, we've been coming here for 4 years. ♦ Counseling and medicine. ♦ His therapist listens and provides helpful information. ♦ Our therapist has been there every step of the way. ♦ Getting the kids on the medication they need. ♦ I would have to say coping with daily life	♦ The counseling. ♦ Learned how to handle my emotions. ♦ Being sent to West Hills Hospital. ♦ I get a lot of tips on how to control my behavior. ♦ I have learned to cope and accept things that have happened and will continue to do so. ♦ I'm learning better coping skills. ♦ David gave a skill and more to me. ♦ It's helped me get back on track with my life and made me feel somewhat normal. ♦ The help. ♦ Having to talk about my feelings. ♦ Learning how to deal with my family and my self and my problems and understand what to do in life. ♦ The most helpful services I have received have been the support and help from others. ♦ It helps me get along with my family better. ♦ I feel like I have someone to talk to at anytime that I need to talk and I get along better with my family and friends because I know how to deal with difficult situations ♦ In the foster care plus the love that I need!! Thanks to my counselor, Sis, mamma, grandma, grandpa. Auntie - Uncle! ♦ The knowledge of knowing that people, such as friends and family, are truly there for me when I need guidance and/or advice. ♦ My coping skills. ♦ Don't know! ♦ All of it has been really helpful. ♦ That I am happy more than I was before I came here. ♦ Counseling. ♦ Counseling to understand my problems better.
2. What would improve services your child and the family received? ♦ I have nothing at this time ♦ More time allotted to appt. ♦ I feel at this time we are being helped to the best of your ability and would not expect more than that. ♦ Continue as is, periodical updates and forecasts of his condition/situation. ♦ I think we are receiving the best treatment for my child and family. ♦ I need to have more time to answer this question - I am getting upset about being late for our appointment. ♦ Maybe anger session [1 hour] a week [1 time], some weeks don't seem long enough get insurance issues straightened out. ♦ Assistance with gas. I have two children being seen at this location. ♦ If the entire family was involved which impossible since we have important family whom refused to participate.	2. What would improve services you received? ♦ I'm happy with the services. ♦ I don't care. ♦ I like what help I get now. ♦ Nothing that I can currently think of. ♦ Attitude. ♦ Good support and privileges. ♦ I don't think anything needs to be improved. ♦ It's all good. ♦ Nope. ♦ If the West Hills staff was less grouchy. ♦ I don't know. Everything seems perfectly fine to me. ♦ Teaching your people to be more polite. ♦ My services have altogether been great and very helpful. ♦ More time - more minutes. ♦ Some one on one time. ♦ I think I want to come very week here. ♦ They are great just the way they are.

♦ Nothing. ♦ I have no idea. ♦ The counselor is very nice to us and talks to her. ♦ I don't understand the question. ♦ The services that are provided to us have been extremely helpful. I would not change anything. ♦ More services for children that are so out of control; and not having to wait so long to receive them. Services that can step in and help before he kills someone, or seriously hurts someone. ♦ For him to get along better with his sister. ♦ More communication between the family. ♦ Seems to be OK as is. ♦ Don't know. ♦ getting this counseling finished ♦ I think it is all great - I thank Staff for their outstanding support- they are just great! Thank you with all my heart. [signed and printed his name] ♦ Better staffed with knowledgeable MFT's. ♦ More counseling sessions with therapist. ♦ Frequent Saturday hours. ♦ If they actually read the file on my child, which I have provided, before we are seen. ♦ Nothing. ♦ If the kids would start listening to what Marcy has to say and talk to her. ♦ Not sure, don't know. ♦ More contact and financial support	♦ Me helping with my skills as well. ♦ No improvement needed. ♦ By loving plus caring about other people. ♦ I don't understand the question. ♦ I don't know. Everything seems perfectly fine to me. ♦ Don't know. ♦ Services received is good, no improvement needed right now.
3. Additional Comments ♦ I can't say enough good about this facility. ♦ Appreciate the help very much. ♦ Thank you for all your efforts and support. ♦ We need more information about anger management and helpful ways to defuse explosive situations. I also believe that we can do a lot here. ♦ The person that has been paired up with my son, counselor, has been outstanding! ♦ The staff is very understanding of my graveyard work hours. ♦ Thank you for everything. ♦ None ♦ The services we do have, have helped and we very much like our worker, it's the system that needs more help. ♦ Good job! ♦ Thanks to my counselor for being so patient to my daughter when at times it's difficult ♦ I am very grateful for everyone's help. ♦ Thank you!	3. Any additional comments? ♦ No one cares because it's STUPID. ♦ Thank you for Stafffor helping me when I most needed it. ♦ Love my service. ♦ They do a good job. ♦ Thank you for all the things you did for me and my family! ♦ This whole experience not only helped me, but everyone that surrounds me.

NNCAS WIN Results		
Parent/Caregiver N=63; Youth N=50 **Total Served = 139 Sample = 45%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	90	81
Services were scheduled at times that were right for us.	97	83
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	79
The people helping my child and family stuck with us no matter what.	86	75
I felt my child and family had someone to talk to when he/she was	89	74

NNCAS WIN Results		
Parent/Caregiver N=63; Youth N=50 Total Served = 139 Sample = 45%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
troubled.		
The services my child and family received were right for us.	90	60
I received the help I wanted for my child.	90	71
My family got as much help as we needed for my child.	86	81
POSITIVE OUTCOMES		
My child is better at handling daily life.	75	93
My child gets along better with family members.	79	76
My child gets along better with friends and other people.	73	90
My child is doing better in school and/or work.	76	79
My child is better able to cope when things go wrong	63	81
I am satisfied with our family life right now.	75	68
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	90	62
I helped to choose my child and/or family's treatment goals.	98	81
I participated in my child's and family's treatment.	97	71
CULTURAL SENSITIVITY		
Staff treated our family with respect.	95	83
Staff respected our family's religious/spiritual beliefs.	95	88
Staff spoke with me in a way that I understood.	98	90
Staff was sensitive to my family's cultural and ethnic background.	95	81
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	94	N/A
I have people that I am comfortable talking with about my child's problems.	95	N/A
In a crisis, I would have the support I need from family or friends.	86	80
I have people with whom I can do enjoyable things.	92	83
I am happy with the friendships I have.	N/A	90
I feel I belong in my community.	N/A	100
FUNCTIONING		
My child is better at handling daily life.	75	93
My child gets along better with family members.	79	76
My child gets along better with friends and other people.	73	90
My child is able to do the things he/she wants to do.	68	86
My child is doing better in school and/or work.	76	79
My child is better able to cope when things go wrong.	63	81

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	92	74
Staff explained my child and my family's rights and confidentiality issues.	97	79
I receive support and advocacy from my Nevada PEP Family Specialist.	92	93
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	95	93
Our family is aware of people/ services in the community that support us.	97	88
I am better able to handle our family issues.	83	83
I am learning helpful parenting skills while in services.	90	79

I have information about my child's developmental expectations and needs.	90	71

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ Help with transporting and supervising sibling visits. ♦ Availability. ♦ Team meeting planning, accountability for clients. ♦ The child's problems and the child - Is improving. ♦ Availability. ♦ The services provided have helped us manage the many tasks -"extras" that are necessary to care for our child - especially the coordination at other services like ILP, of attendance at special functions focused on her such as "Queen for you". ♦ Lots of support. ♦ I am able to get the support and help right away. ♦ Collaboration of services on a consistent basis. ♦ Support for both of us. ♦ The team helpful and we feel that we can talk to them. ♦ Making sure his needs are being met and checking with the foster home every week. ♦ I am able to call my Staff whenever I have a problem for help. ♦ Tania is very helpful when I need someone to talk to or are having problems. ♦ WIN Staff is great! She keeps the team updated on everything. ♦ Talking to my worker about anything. ♦ My child is doing much better with his behavior and coping skills. Helping me to get housing is very important also, thank you. ♦ School and therapy support. ♦ Staff is a strong support for her and always there with an open ear and full of suggestions. Love [heart] her. ♦ IEP so that he knows he has an escape. ♦ WIN. ♦ I am able to go to his meeting. ♦ Wrap Around. ♦ Therapy and Dr - alliance (PSR). ♦ Alliance office PSR Therapy and Dr. ♦ Things are better coordinated. ♦ Referral to an inpatient treatment center by the WIN Worker. ♦ It is helping me also be able to better help my child. My child is improving a lot. ♦ Support from WIN worker keeps us informal and very helpful. ♦ Visit and getting out! ♦ Undecided. ♦ I got two new beds for the boys. We were able to have a wonderful Christmas. The boys have received new clothes. She has paid our utility bill. ♦ Community resources and WIN support. ♦ Therapy - workers support - clothing - X-mas items - food baskets - help with utilities and rent. ♦ Support from WIN and my team and community services. ♦ Girls got bikes - Help me get Medicaid for girls - got food pantry and clothes - information for resources. ♦ Services (WIN) goes to my home. ♦ Helping her get the things she needs. ♦ That we have a support system - we have people to go to for help. ♦ Knowledge and help getting to needed appointments.	1. What has been the most helpful thing about the services you received? ♦ When we talk about stuff. ♦ Staying in school, emotional support and such. ♦ Lot's of people who support me. ♦ Begin boxing. ♦ School, grades and homework ♦ I receive help in ways I understand and learn new skills. ♦ Don't know! ♦ My behavior has gotten somewhat better and I am able to talk about my problems with someone close. ♦ They taught me good things. ♦ Transportation. ♦ I feel I am supported. ♦ I don't know yet. ♦ The most helpful thing about the services I received are the services. ♦ The structure. ♦ Learning to do taxes. ♦ Getting liking better with family and expressing how I feel and am happier and enjoy more things. ♦ I am safe. ♦ My staff. ♦ Getting all services - going home to mom. ♦ Everything they have done. ♦ The emotional support. ♦ New friends. ♦ Pretty much everything. ♦ That I am able to communicate my problem better. ♦ I get heard and can organize my life. ♦ OK. ♦ I learned how to separate friendships from romance. Abuse vs. love. ♦ They've made sure we can make ends meet and support us through tough times. ♦ I don't know.

Parent/Caregiver comments	Youth comments
♦ Consistency with WIN program. ♦ PSR & PEP. ♦ Support. ♦ Learning different ways in handling situations with my children. ♦ Helping me to deal with problems my daughter has and giving me hope that we'll make it through and complete goals that we have. ♦ To have better communication. ♦ I don't know. ♦ Overall care and concern for the children, communication and resources. ♦ Michelle listens - even though she can't change the laws that apply in this situation she makes me feel as if she would! ♦ For now he is behaving much better in school. ♦ He is not so mad to where he is breaking things in my home and hurting my family. ♦ The services are helpful because it shows the child that someone other than us is concerned and helpful. Good Back-Up! ♦ The services are helpful because it shows the child that someone other than us is concerned about her and willing to help. It keeps her on the straight and narrow! ♦ The support ♦ Worker being there for myself and child to talk with when needed. ♦ Someone to talk with and get suggestions from. ♦ They give me better ideas of way to deal with my child and help me find resources I need for my family. ♦ Still not sure we have gotten that far yet. ♦ Consistency.	
2. What would improve services your child and the family received? ♦ Everything is good right now. ♦ Nothing - this team is doing everything needed for this child. ♦ Things are going pretty good at this time. ♦ None - they respected my wishes ♦ As foster parents we appreciate the support system we receive. ♦ ATC ♦ Medicaid. ♦ Nothing. ♦ Help special education learning school. ♦ Having workers closer and better available would be helpful. ♦ I had to wait for a year for these services. ♦ Nothing I am happy with the services I receive. ♦ More workers like G. Dorian. ♦ Undecided. ♦ I wouldn't change anything about my case worker. She has been an angel. Thank you ♦ Educational supplies clothing - community activities in Silver Springs area - food pantries. ♦ Very happy with WIN services but wish therapy is closer to state line. ♦ Money would help a lot. ♦ I live in rural Nevada and it would be really nice to have more services available to meet my families needs ♦ Everything is good. ♦ I don't see any problems or things that need to be improved with him. I think she, WIN worker, has been amazing and done everything she could possibly do for us. ♦ More important information in writing. ♦ Everything and everyone was helpful.	2. What would improve services you received? ♦ I don't have stuff to talk about. ♦ Continuing helping me. ♦ Letting me see my family. ♦ If I could check in with my family and friends more often and my dog. ♦ I don't know. ♦ What would improve services that I received is… I really don't know. ♦ People being easier to reach. ♦ More money. ♦ For everybody to be on the same page with what's going on. ♦ If I wasn't taken to begin with. ♦ More information. ♦ Nothing, they're fine [drew a happy face] ♦ I OK. ♦ I feel like I'm not very active.

Parent/Caregiver comments	Youth comments
♦ I don't know. ♦ Nothing I can think of. ♦ Have CPS listen to WIN. ♦ I don't have anything at this time. ♦ Too bad there aren't more services or programs available in this very rural area. ♦ We need more services and programs available to us in this VERY rural area. ♦ Wish there was better counselors in our area. ♦ For me to have classes with Alice. ♦ New to program so not sure yet.	
3. Additional Comments ♦ Thank you for being so consistently on top of things! You've been an extraordinary support to us all. ♦ Thank you for the support you give to foster parents. They make our job easier. ♦ More training on what to expect from different programs ♦ Wrap Around is Awesome ♦ All persons in this case are nice and helpful. ♦ I had to wait too long for treatment with my son - if service were rendered 2 yrs ago. ♦ I enjoy my WIN worker very much and have received a lot of important information. ♦ Great Job! ♦ We appreciate WIN and all the staff. Thank You. ♦ We love and appreciate Staff. We know they go to bat for our family as a whole and not JUST for the welfare of the child. ♦ Thanks to Staff for helping me with my son and listening to me with my son. ♦ I'm thankful for the help I have gotten here.	3. Any additional comments? ♦ I want to thank Staff for helping me all this time and helping me get through crises and problems! ♦ Hi! I Love football, I'm 11 years old. Bye!!!!!!! ♦ I need to see my family. ♦ I would like to be out of foster care as soon as possible. ♦ Thank you. ♦ Awesome person. ♦ BAM - More SNICKERS!! Please, and thank you BAM! ♦ Drew a happy face. ♦ Thanks all of you for what you did for me and [2 names]. ♦ No man! ♦ Have a nice day [drew a happy face]. ♦ Thank You!

NNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=51; Youth N=NA **Total Served = 162 Sample = 31%**	**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.	92	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	NA
The people helping my child and family stuck with us no matter what.	94	NA
I felt my child and family had someone to talk to when he/she was troubled.	92	NA
The services my child and family received were right for us.	92	NA
I received the help I wanted for my child.	90	NA
My family got as much help as we needed for my child.	87	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	77	NA
My child gets along better with family members.	75	NA
My child gets along better with friends and other people.	67	NA
My child is doing better in school and/or work.	69	NA
My child is better able to cope when things go wrong	61	NA

NNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=51; Youth N=NA Total Served = 162 Sample = 31%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I am satisfied with our family life right now.	71	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	88	NA
I helped to choose my child and/or family's treatment goals.	94	NA
I participated in my child's and family's treatment.	96	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	96	NA
Staff respected our family's religious/spiritual beliefs.	92	NA
Staff spoke with me in a way that I understood.	94	NA
Staff was sensitive to my family's cultural and ethnic background.	94	NA
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	92	NA
I have people that I am comfortable talking with about my child's problems.	92	NA
In a crisis, I would have the support I need from family or friends.	94	NA
I have people with whom I can do enjoyable things.	90	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.	77	NA
My child gets along better with family members.	75	NA
My child gets along better with friends and other people.	67	NA
My child is able to do the things he/she wants to do.	81	NA
My child is doing better in school and/or work.	69	NA
My child is better able to cope when things go wrong.	61	NA

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	88	NA
Staff explained my child and my family's rights and confidentiality issues.	96	NA
I receive support and advocacy from my Nevada PEP Family Specialist.	83	NA
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	78	NA
Our family is aware of people/ services in the community that support us.	87	NA
I am better able to handle our family issues.	78	NA
I am learning helpful parenting skills while in services.	90	NA
I have information about my child's developmental expectations and needs.	92	NA

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ The improvement with behavior due to meds, even the school is seeing improvement. ♦ We are still very new - only one second visit - we haven't seen a lot of progress yet .n/a. ♦ We have just started services, what little we have received	1. What has been the most helpful thing about the services you received? • NA

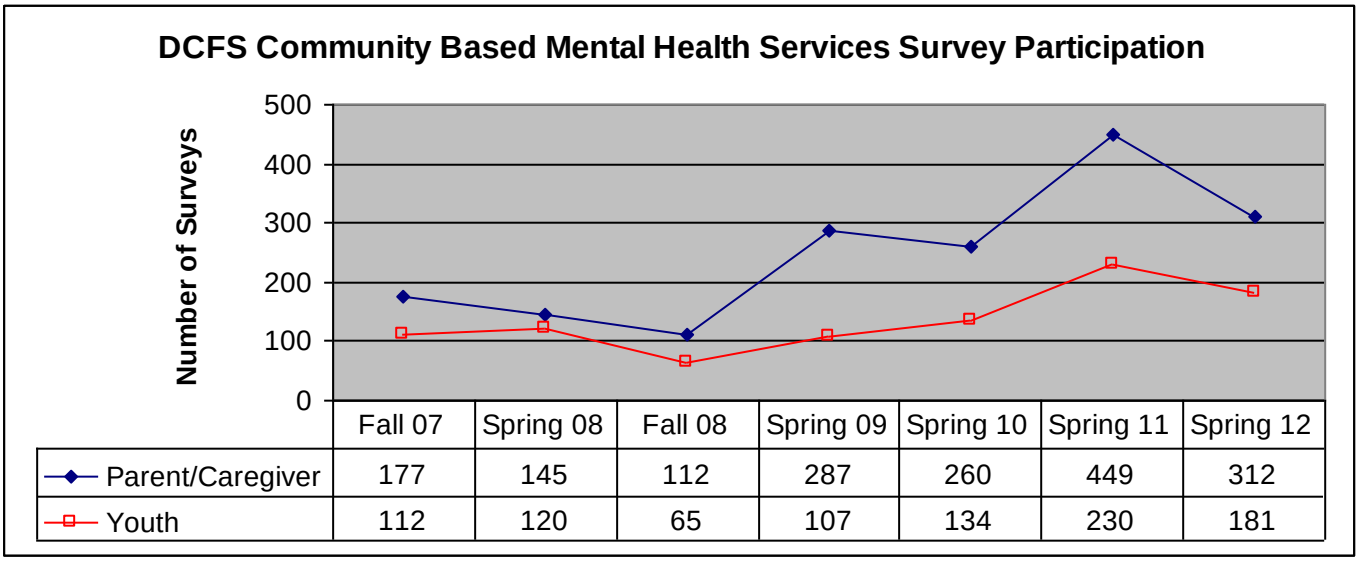
we are still adapting to our lives. ♦ My daughter is doing better since she has been seeing her new Counselor in Reno. ♦ Learning how to communicate better with my children before a disagreement turns into something worse. ♦ Learning how to cope with day to day problems and how to make better choices. ♦ That the program help me pay for my son's medication ♦ Help me understand why they do what they do and my interventions are more appropriate ♦ Understanding, support and ideas to help him and other family members in regards to his behavior. ♦ Services help us as a family to be there for her and to come in our home as Foster, and for Adoption. ♦ He is a little more well mannered and polite especially to females. ♦ He has turned 180 degrees from when we first had him in our home. ♦ Seeing weekly ♦ He has increased attention span and is learning how to express his emotions appropriately ♦ consistent therapists. ♦ Having the support and being able to communicate with Staff whenever needed. ♦ Learning behavior modification techniques. ♦ Learning his behavior could change. ♦ Coping skills, boundaries. ♦ My therapist has been our rock. She has supported us and guided us to the best interest of our child. Also the day treatment program. ♦ The counselor wants to help in every way and is very accommodating to my schedule. ♦ Having a safe, non-judgmental person to talk to about behaviors and techniques used. A place to be honest. ♦ The support and services we have received over the last few years is irreplaceable. Dr.is and has been an integral part of my daughter's progress and ability to handle the world around her. ♦ Can communicate w/counselor his feelings and concerns Therapist gives many positives ♦ My therapist helps me to better understand my kids and what to do to help them ♦ Her psychologist knew exactly how to advise and guide my daughter, as well as her doctor. ♦ He is learning what is acceptable in society and he is also on meds to help him. He has a good relationship with Staff and Dr. so it works for him. ♦ Staff has had a lot of helpful advice and parenting ideas. ♦ Staff. ♦ Explanation of why things are done, how to apply, how to set and obtain goals. ♦ Learning how to deal with my kids, being more patient with them. ♦ Too early to tell. ♦ Support and new ideas. ♦ A good plan of action. ♦ Gives him another adult he can trust to talk about his feelings. ♦ Controlling my temper while dealing with my son. ♦ He is overcoming huge emotional obstacles leading to a greater chance for successful living. ♦ Having questions answered about the boys. ♦ Working with my grandson on anger issues and problems with acceptance. ♦ Helps us understand why she does what she does. ♦ Communication and social skills. ♦ Knowing the girls are comfortable with their counselor. ♦ Learning to talk about hard topics in a productive way.	

♦ Validation of our discipline techniques and validation of the long road to attachment with an adopted toddler. ♦ My discussion with counselor	
2. What would improve services your child and the family received? ♦ More interaction from the doctor. We see him once every 3 months, or more. ♦ Help with transportation to and from the site. ♦ That they would open more facilities and help more families like my family. ♦ More one on one time with therapist occasionally ♦ Everything is good. ♦ Time and practice of behavioral modification skills. ♦ None - she was fabulous. ♦ None that I can think of. ♦ More interaction with my child during a session teaching. ♦ Telephone calls with a reminder of appointments, especially to see the psychiatrist, Dr. as it can be difficult to remember all appointments. ♦ Group sessions. Peer sessions for child. ♦ Not much. ♦ Everything's okay so far. ♦ If I could take Staff closer to home. ♦ Parenting work shops. ♦ Not sure, don't know. ♦ Too early to tell. ♦ Nothing. ♦ Wish there were written resources for us to turn to. Nevada PEP seems to be geared towards older children, and we don't have use for that yet. ♦ I'm totally satisfied. ♦ If our case worker would push more to get what I believe would benefit the boys, like sports, me being able to talk to teachers etc… ♦ Services are great - no need for improvement. ♦ Continued appointments.	2. What would improve services you received? • NA

3. Additional Comments ♦ Everyone is kind and respectful. ♦ Staff is helping my daughter a lot, it helps that my daughter likes her. ♦ My kids enjoy coming here. Not only have they learned how to use their words better but so have I. We function a lot better and have less physical outbursts. ♦ Thanks for all the support and help you have gave me and my son and family. ♦ I think you do a wonderful job at children's services. ♦ Thank you for these services and for the children. ♦ Great staff. ♦ We have had nothing but great experiences from the Day Treatment and Therapy with our adoptive child, also with children we fostered! Thank you for your great services for our children. ♦ I know some of my marks are low, but I am at a point of not knowing what to do next with my child. My therapists have been a blessing, but I'm not seeing how to move forward now. ♦ I couldn't be more grateful. Although there is no cure for my daughters mental health impairment, the therapy and medication management have been an absolute blessing with our everyday lives! Thank You! ♦ The new front receptionist is very nice, polite and if you ask her a question she will answer or find the answer out without acting like it's a hassle. ♦ The staff here is always kind to my family. ♦ I and my child, his siblings and my husband [great grand-parent and adoptive parent] would have struggled to find our way through the emotional trauma and unexpected life changes. The children's therapist has been a life-saver! ♦ Dr. has helped my grandson deal with all the issues he had from being in a drug situation. ♦ Thank you for all you do, I have found all the staff here very caring and considerate. ♦ Thank You!	3. Any additional comments? • NA

Survey participation

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



	Fall 07	Spring 08	Fall 08	Spring 09	Spring 10	Spring 11	Spring 12
Parent/Caregiver	177	145	112	287	260	449	312
Youth	112	120	65	107	134	230	181

The current survey shows a statewide decrease (31%) in parent/caregiver participation and a corresponding decrease (21%) in youth participation when compared to the same survey conducted in the spring of last year.
Statewide there was a combined total of 493 agency parent/caregiver and youth survey participants. There was an overall statewide participation decrease of (27%) from the Spring 11 survey.

A Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 312 parent/caregiver surveys returned statewide, 18 were in Spanish.

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

Youth Version of the Youth Survey

DCFS COMMUNITY BASED SERVICES
YOUTH SURVEY – NNCAS
(Youth 11 years and older)

Today's Date: _____

Please help our Agency improve itself by answering some questions about the services you receive. Your answers are confidential and anonymous.

Where do you receive services? (Mark one box only)	**Outpatient Services**	**Wraparound In Nevada (WIN)**
Reno: Northern Nevada Child & Adolescent Services – Enterprise Rd.	□	
Reno: WIN – Holcomb Lane		□
Rural: WIN		□
Wraparound Washoe Expansion		□

1. How long have you been in the services indicated above?

Less than 2 months □ 3-5 months □6 months – 1 year □ More than 1 year

2. Are you currently living with one or both of your parents? □Yes □No

3. Your Age: _____

4. Your Gender: □ Male □ Female

5. Your Race: **(Mark all that apply)**

Am. Indian/Alaskan Native □ Asian □ White (Caucasian)

African American □ Native Hawaiian/Other Pacific Islander □ Other _____

6. Are your birth parents of Spanish, Hispanic, Mexican or Latino Origin? □ Yes □ No

7. Do you have Medicaid insurance? □Yes □ No □Uncertain

8. Have you lived in any of the following places in the last 6 months? **(Mark all that apply)**

□ With one or more parents □ Homeless shelter □ State correctional facility
□ With another family member □ Group Home Runaway / homeless / on the streets
□ Foster Home Residential treatment center □ Hospital Therapeutic foster home □ Crisis shelter Local jail or detention facility Other:_____

Thank you for taking the time to complete the survey on the following pages. Your opinions are important, so please be frank and tell us what you think about the services you receive.

Please indicate if you Strongly Disagree, Disagree, are Undecided, Agree, or Strongly Agree with each of the statements below. Put a mark (X) in the box that best describes your answer. Should a statement not apply to you, you may mark the Does Not Apply box.

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Does Not Apply
9.	Overall, I am pleased with the services I receive.						
10.	I helped to choose my services.						
11.	I help to choose my treatment goals.						
12.	The people helping me stick with me no matter what.						
13.	I feel I have someone to talk to when I am troubled.						
14.	I participated in my own treatment planning.						
15.	The services I receive are right for me.						
16.	Staff explained my diagnosis, medication and treatment options.						
17.	Staff explained my rights and confidentiality issues.						
18.	The location of services is convenient for me and my family.						
19.	Services are scheduled at a time that is right for me and my family.						
20.	I get the help I want.						
21.	I get as much help as I need.						
22.	Staff treat me with respect.						
23.	Staff respect my family's religious and spiritual beliefs.						
24.	Staff speak with me in a way that I understand.						
25.	Staff are sensitive to my cultural and ethnic background.						
26.	I receive support and advocacy from my NV PEP Family Specialist.						
27.	My NV PEP Family Specialist makes sure my voice is heard during the treatment planning meetings.						

As a result of the services I receive:

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Does Not Apply
28.	I am better at handling daily life.						
29.	I get along better with family members.						
30.	I get along better with friends and other people.						
31.	I am better able to do the things I want to do.						
32.	I am doing better in school or work.						
33.	I am better able to cope when things go wrong.						
34.	I am satisfied with my family life right now.						
35.	I am aware of people and services in the community that support me.						
36.	I am better able to handle family issues.						
37.	I am learning helpful skills while in services.						
38.	I have information about my developmental expectations and needs.						

As a result of the services I receive… (please answer for relationships with persons other than your mental health providers)

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Does Not Apply
39.	In a crisis, I would have the support I need from family or friends.						
40.	I have people with whom I can do enjoyable things.						
41.	I am happy with the friendships I have.						
42.	I feel I belong in my community.						

43. In the last twelve months, did you see a medical doctor (or nurse) for a health checkup or because you were sick?

(Mark one box)

□No

□Yes, in a clinic or office

□Yes, but only in a hospital emergency room

□Do not remember

44. Are you on medication for emotional/behavioral problems? □Yes □No

44 - a. If yes, did the doctor or nurse tell you what side effects to watch for? □Yes □No

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

_____

_____

_____

46. What would improve services you received?

_____

_____

_____

Any additional comments?

_____

_____

_____

Thank you for taking the time to answer the Survey. We will be happy to share the results of this survey with you. Please call the Division of Child and Family Services' Planning and Evaluation Unit at 775-688-1645 extension 305 if you have any questions or comments regarding this survey.

ATTACHMENT E

DCFS Residential Discharge Survey Report Parent/Caregiver
Youth Survey Results Statewide

DCFS Residential Discharge Survey Report Parent / Caregiver – Youth Survey Results Statewide FY 2012

From July 1, 2011 to June 30, 2012, DCFS collected residential discharge surveys from children's residential 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 upon discharge. Participants were asked to disagree or agree with a series of statements relating to six of the seven areas or "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness. The seventh domain pertaining to "Social Connectedness" was omitted because of the constrained social context of children in residential programs. An eighth domain surveyed select items of interest to residential service program managers.

The 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); respondents' ability to direct the course of their treatment (Participation in Treatment); whether staff were respectful of respondents' religion, culture and ethnicity (Cultural Sensitivity); and how well respondents seem to be doing in their daily lives (Functioning). The last 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, residential services survey results are in table format and are presented by type of service: Oasis On Campus Treatment Homes under the Southern Nevada Child and Adolescent Services (SNCAS), and the Adolescent Treatment Center and the Family Learning Homes 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.

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 a 60% or less 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. Oasis On Campus Treatment Homes, the Adolescent Treatment Center or the Family Learning Homes having courtesy highlighted items will monitor these particular items in subsequent surveys to determine if similarly low endorsement rates re-occur. Programs will give special attention to a highlighted statement's subject matter when considering if any programmatic or other corrective action should be taken.

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, what would improve client safety and any additional comments they might have had. Lastly, a section on survey participation concludes the report.

Survey Participants

Parents or caregivers with children receiving residential mental health treatment and the children themselves, when age appropriate, were participants in this survey. Responding to the survey were 22 parent/caregivers and 40 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, sent to DCFS' Planning and Evaluation Unit contact. 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 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				
Oasis On Campus Treatment Homes	3	49	6%	5
SNCAS Total	3	49	6%	5
NNCAS				
Adolescent Treatment Center	5	56	9%	19
Family Learning Homes	14	56	25%	16
NNCAS Total	19	112	17%	35
Statewide Total	22	161	14%	40

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

DCFS Residential Based Services
Parent / Caregiver – Youth Survey Results
Statewide FY2012

SNCAS

Oasis On Campus Treatment Homes

Parent/Caregiver N=3; Youth N=5 Total Served = 49 Sample = 6%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	100
Visitation rooms were comfortable and provided privacy with my child.	67	100
Services were scheduled at times that were right for us.	100	100
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	80
The people helping my child and family stuck with us no matter what.	100	80
I felt my child and family had someone to talk to when troubled.	100	100
The services my child and family received were right for us.	67	100
My family got the help we wanted for my child.	33	100
My family got as much help as we needed for my child.	33	100
POSITIVE OUTCOMES		
My child's educational needs were met during residential services.	67	100
My child is better at handling daily life.	33	100
My child gets along better with family members.	67	80
My child gets along better with friends and other people.	67	100
My child is doing better in school and/or work.	33	100
My child is better able to cope when things go wrong	67	100
I am satisfied with our family life right now.	0	80
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	67	80
I helped to choose my child and/or family's treatment goals.	67	100
I participated in my child's and family's treatment.	100	100
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	100
Staff respected our family's religious/spiritual beliefs.	100	100
Staff spoke with me in a way that I understood.	100	80
Staff was sensitive to my family's cultural and ethnic background.	67	100
FUNCTIONING		
My child is better at handling daily life.	33	100
My child gets along better with family members.	67	80
My child gets along better with friends and other people.	67	100
My child is doing better in school.	33	100
My child is better able to cope when things go wrong.	67	100
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	100	60
Staff explained my child and family's rights, safety and confidentiality issues.	100	100
Our family is aware of people and services in the community that support us.	67	100

I am better able to handle our family issues.	67	N/A
I am learning helpful parenting skills while in services.	67	N/A
I have information about my child's developmental expectations and needs.	100	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ I learned that single departments act differently depending on the staff. ♦ She is really trying to understand what is going on and to cope with her peers and grownups and being more respectful to others.	1. What has been the most helpful thing about the services you received? ♦ The staff. ♦ When I got to talk about how I feel with another peer. ♦ Therapy. ♦ It was all good. ♦ Getting along with my peers and with other homes, and I do go everyday.
2. What would improve services your child and the family received? ♦ Provide services in a more uniform way, that way child and family can expect the same answer from different staff on different days. ♦ Having family visits at home sooner so you can see how the child is really coping.	2. What would improve services you received? ♦ Better appliances for household / 11 West. ♦ Be a little more stricter on the kids. ♦ It was all good. ♦ I think everything was good and the best.
3. What would improve client safety? ♦ This is a question that can best be answered by staff rather than me. As far as I'm concerned, my child's safety was never compromised. ♦ Everything was good.	3. What would improve client safety? ♦ Cameras. ♦ I think that they should see what kids come in with. ♦ God help. ♦ Keeping the back doors locked. ♦ Nope.
4. Additional Comments ♦ I would like to thank everyone at Oasis and building 14 for providing, these past 49 weeks, the best possible living environment for my child!	4. Any additional comments? ♦ Evaluate clients thoroughly for roommate selection/placement. ♦ I just want to say thanks for everything. ♦ Everything was great. ♦ No thank you.

NNCAS

Adolescent Treatment Center

Parent/Caregiver N=5; Youth N=19 Total Served = 56 Sample = 9%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	84
Visitation rooms were comfortable and provided privacy with my child.	100	94
Services were scheduled at times that were right for us.	100	89
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	89
The people helping my child and family stuck with us no matter what.	100	74
I felt my child and family had someone to talk to when troubled.	100	89
The services my child and family received were right for us.	100	95
My family got the help we wanted for my child.	100	95
My family got as much help as we needed for my child.	80	89
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	80	84
My child is better at handling daily life.	80	100
My child gets along better with family members.	80	94
My child gets along better with friends and other people.	80	83
My child is doing better in school and/or work.	80	94
My child is better able to cope when things go wrong	75	100

NNCAS Adolescent Treatment Center		
Parent/Caregiver N=5; Youth N=19 Total Served = 56 Sample = 9%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I am satisfied with our family life right now.	80	89
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	75	89
I helped to choose my child and/or family's treatment goals.	100	95
I participated in my child's and family's treatment.	100	89
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	84
Staff respected our family's religious/spiritual beliefs.	100	83
Staff spoke with me in a way that I understood.	100	100
Staff was sensitive to my family's cultural and ethnic background.	100	88
FUNCTIONING		
My child is better at handling daily life.	80	100
My child gets along better with family members.	80	94
My child gets along better with friends and other people.	80	83
My child is doing better in school.	80	94
My child is better able to cope when things go wrong.	75	100
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	100	89
Staff explained my child and family's rights, safety and confidentiality issues.	80	79
Our family is aware of people and services in the community that support us.	60	89
I am better able to handle our family issues.	100	N/A
I am learning helpful parenting skills while in services.	100	N/A
I have information about my child's developmental expectations and needs.	100	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ Therapy for daughter and medication. Staff friendly and respectful. ♦ My child and I have learned to communicate better with each other. ♦ Counseling, learning to cope with life's challenges, focus on academics. ♦ The structure and different classes to help strengthen skills.	1. What has been the most helpful thing about the services you received? ♦ My team leader or staff always listened to me, and gave good advice. ♦ Learning how to communicate with my family. ♦ Learning coping and social skills. ♦ The staff help me when I got in trouble and they talk to me. ♦ Learning ways to solve situations I have been in or might happen. ♦ My grade, management (A.R.T.) ♦ When the staff helped me out with using self control and when I needed help I got help. ♦ I got the help that I wanted and needed. ♦ Art. ♦ The most helpful thing is the therapy groups and individual. ♦ That I can control myself and not freak out on the littlest things. ♦ I didn't get taken out of state. ♦ The most helpful services were talking to my therapist. ♦ They have taught me how to cooperate with my family and others my age and showed me how to properly act like a teenager that respects herself and others, and can do anything. ♦ Complaints but nothing happen so. ♦ Art. ♦ The skills that I was taught and the groups. ♦ I was able to reflect upon myself without outside interference or

	influence.
2. What would improve services your child and the family received? ♦ More communication with the Doctor. ♦ I feel the ATC program has met our needs and goals. ♦ No improvements come to mind.	2. What would improve services you received? ♦ Being able to get a hug when necessary. ♦ Staff be more open minded to others religious beliefs. ♦ People wouldn't have relationships here. Everyone got treated the way they wanted to be treated. ♦ My actions to stay the way I want them to… ♦ If staff cracked down and got more into the drama and tried to stop H. ♦ Nothing, it was perfect. ♦ Nothing, everything was great. ♦ My parents understanding me and where I'm coming from. ♦ Do something when a complaint is filed. ♦ I Don't Know. ♦ Staff not pushing their religion. ♦ Family anger management, counseling.
3. What would improve client safety? ♦ I do not feel there was a safety issue. ♦ I never felt my child 's safety was in harms way.	3. What would improve client safety? ♦ Follow through with complaint forms. ♦ Sit down with new client and explain what they should expect. ♦ Body searches for carvings. ♦ Everything was perfect ♦ Try not to keep talking about running. ♦ Find ways to tell us not to do things to where we can listen, where we will want to. I think you guys should find ways to tell us not to do the things that we can't do here and the things that are going to get us into trouble here, in a way to where we will listen and take it in. Telling us "No, don't do that, that's an MPL". It doesn't work like that some of us don't care. Maybe try "Don't punch this person because you'll go to JUVI for a while and have a ?% chance to come back, do you wanna be out of state? Plus wouldn't that hurt your hand? (add some humor, then go back and get them to understand.) Your parents and maybe your P.O. would be so disappointed, then it'll ruin your night sitting in the hospital, what if you have to pay the bill, what if you're old enough to be charged as an adult." A teenager will react to something like this, so why don't you try it sometime. ♦ Teach us Kung Fu. ♦ Not putting gay or bi kids together. ♦ IDK, ATC does a great job at that.
4. Additional Comments ♦ I received these papers at last minute from my daughter, not enough time. Overall I'm happy with the service provided to us. I feel that more doctor participation is very important. Medication is a serious matter and should be addressed by the Doctor directly to the parent. ♦ I am so grateful for all services made available to us and appreciate the professionalism of the entire ATC staff. ♦ This program has made a large improvement in my child. An improvement I did not think was going to happen. The staff has worked so hard I do not feel I am dissatisfied with any experiences.	4. Any additional comments? ♦ Thank you. ♦ I like the helpfulness. ♦ I had great service here, it changed my life thank you ATC. ♦ Thank you for what you have done, you have changed my life forever. ♦ Switch relaxation from Friday to Monday. ♦ Don't remind us that we're in a treatment center, we already know. ♦ Don't make it seem like we are just one in a bunch of bad because everyone can show good. ♦ Keeping a better eye on the gang activity. ♦ ATC is a great environment for the kids who need it.

NNCAS

Family Learning Homes

Parent/Caregiver N=14; Youth N=16 **Total Served = 56 Sample = 25%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	93	69
Visitation rooms were comfortable and provided privacy with my child.	79	79

NNCAS Family Learning Homes		
Parent/Caregiver N=14; Youth N=16 Total Served = 56 Sample = 25%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
Services were scheduled at times that were right for us.	86	94
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	71	88
The people helping my child and family stuck with us no matter what.	71	81
I felt my child and family had someone to talk to when he/she was troubled.	79	75
The services my child and family received were right for us.	79	88
My family got the help we wanted for my child.	79	88
My family got as much help as we needed for my child.	64	81
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	93	93
My child is better at handling daily life.	79	81
My child gets along better with family members.	64	93
My child gets along better with friends and other people.	79	87
My child is doing better in school and/or work.	64	93
My child is better able to cope when things go wrong	71	88
I am satisfied with our family life right now.	57	87
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	93
I helped to choose my child and/or family's treatment goals.	100	75
I participated in my child's and family's treatment.	100	94
CULTURAL SENSITIVITY		
Staff treated our family with respect.	64	75
Staff respected our family's religious/spiritual beliefs.	92	92
Staff spoke with me in a way that I understood.	93	94
Staff was sensitive to my family's cultural and ethnic background.	100	92
FUNCTIONING		
My child is better at handling daily life.	79	81
My child gets along better with family members.	64	93
My child gets along better with friends and other people.	79	87
My child is doing better in school.	64	93
My child is better able to cope when things go wrong.	71	88
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	79	94
Staff explained my child and family's rights, safety and confidentiality issues.	93	100
Our family is aware of people and services in the community that support us.	64	88
I am better able to handle our family issues.	77	N/A
I am learning helpful parenting skills while in services.	77	N/A
I have information about my child's developmental expectations and needs.	85	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ Weekly parent training meetings with staff. ♦ Support structure.	1. What has been the most helpful thing about the services you received? ♦ Receiving counseling, individually and as a family. ♦ Art group. ♦ How staff were always persistent when it came to getting what I

Parent/Caregiver comments	Youth comments
♦ They were there in our hour of need. ♦ His attitude has changed. He's better at exception feedback. ♦ Addressing his interaction with other people, then he handles it. ♦ Learning how to talk to each other. Trying to understand his thinking process. ♦ Staying on top of him until school is right and everybody working together. ♦ Not too much of anything. ♦ Everyone at the Home 3 was so helpful, they all went out of their way. Counselors great job! Thank you for having them employed. ♦ The counseling. ♦ Getting respite, cooling down period, education. ♦ Having strangers reinforce the same things we have told our child. ♦ Getting along better with family.	needed to do done. ♦ Getting up and hygiene. ♦ Got friends and a room. A lot of caring people. ♦ Friendships and controlling my anger. ♦ Learning to control my anger. Dealing with other people who aren't safe. ♦ Family visits!! ♦ A lot of things helped me. ♦ Learning to cope with issues. ♦ Learning to take space away when I am angry. ♦ Learned how to control my anger. ♦ Structure ♦ When I was freaking out, the staff would explain how to handle it better and I should do things in the future to avoid conflict. ♦ The staff listened to my problems and helped me with them. ♦ Nothing was helpful about the services I received.
2. What would improve services your child and the family received? ♦ For my child to complete the program and have time to practice with rules, consequences and rewards. ♦ Nothing, they did the job. ♦ Having more therapist willing to do games/basketball while doing therapy. ♦ To keep coming here on an outpatient basis. ♦ When starting was new to this program it felt as if we were all on the same page. Also in beginning he was not seeing his therapist. ♦ If parent were listened to, and taken serious about how bad problem really was. ♦ Maybe have them take their jackets off and bra, that's where my daughter would stash her cell phone. ♦ My child's temper and for me to understand her better. ♦ A better environment - less distractions other behaviors. ♦ Better communications and consistent follow through from and between staff members, also with family. ♦ Better communication.	2. What would improve services you received? ♦ Having staff take the reigns to communicate at the beginning, then, relying on us to make appts etc. We felt we didn't know what to do and had to "push" to start and receive services at the beginning. ♦ Being able to feel like there's at least one staff that I can freely talk to. ♦ If one of the kids could rake outside for one of the jobs. ♦ More groups to help kids more. ♦ If I had no therapy. ♦ Nothing really. ♦ More allowance. ♦ Being in a better environment and staff talking to us like we are humans. ♦ I would not know if I would improve - I received.
3. What would improve client safety? ♦ Show videos on child/teenage shows on teens who runaway. ♦ When the problem happened they took charge so safety wasn't an issue. ♦ It would require each youth having own room but know this isn't feasible. ♦ Things are good the way they are. ♦ Listen to parent "much more" ♦ Do a few more shakedowns.	3. What would improve client safety? ♦ When kids been constantly freaking out send them some where else. ♦ None, it's safe. ♦ They need to control kids who aren't safe. ♦ You could be calmer and treat older kids like young adults because it helps people my age understand. ♦ By putting people on loss when someone pushes you! ♦ Keep unsafe clients in their room. ♦ Watching kids better so you knew if people are getting hit or talked to rudely. ♦ I think they do a really good job with safety! ♦ I do not know what it means both this one and the next one.
4. Additional Comments ♦ I'm not satisfied because my child didn't complete the program persons CFT and that no probation officer was appointed to assist us at home. My child has received 17 citations, most for running, and this state does nothing to assist families who want to keep their child safe and who care and love their child. Also, my child was not provided with a job or volunteer upon her dismissal of the program. Nothing was offered either. ♦ All of the staff was very helpful with the positive outcome we experienced. We give a lot of thanks for the extra time given to this case! They had to deal with a biological mom and the adoptive Mom and Dad. Their input was exceptional.	4. Any additional comments? ♦ We received false promises by our senior case worker in this house - no follow through at all. ♦ I never liked the way rules were. I felt sometimes they were made up. ♦ The program really helped my life get better and made me a more mature and responsible person!

Parent/Caregiver comments	Youth comments
♦ Thank you for all helping my child. May of not agreed on the way things happened but it turned out in the end. No problems!! ♦ Each and every one of the staff at this home was a pleasure to be helped by, and to know. Thank-you to each and everyone of them, please let them know this. ♦ Thank You ♦ My daughter manipulated the system. I told staff. No one would hear me. I'm back at square one. My daughter is out roaming the streets, shooting heroin in her arm. Her probation officer gave her a two days "heads up" for her drug tests and said he "just wants her out of the system, and wants to close her case!! ♦ Thank you, that's all I can say, and Great Job.	

Survey participation

This report is the first statewide children's Residential Discharge Survey report conducted by DCFS based solely on collecting surveys at discharge. In the past, the surveys were collected but not at discharge and the outcomes were included in statewide satisfaction reports. This survey report is intended to be on-going and will show parent/caregiver and youth participation trends collected at discharge of the client.

A Spanish version of the parent/caregiver survey instrument was available for this project, and usage of this survey will be tracked in following years.

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 F

Risk Measures / Departure Conditions Report
Oasis

Division of Child and Family Services
OASIS ON-CAMPUS TREATMENT HOMES (OASIS)
Risk Measures and Departure Conditions Report – 2012

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 2012 report is the fifth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2012 through December 2012. Oasis submitted a complete data set in 2012. Oasis is to be commended for their willingness to share this very important information.

All of the risk measures and departure conditions data are self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2012 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. 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:

- Suicidal behavior
- 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 (CFT) decision making

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

OASIS ON-CAMPUS TREATMENT HOMES PROGRAM INFORMATION

This report for Oasis is the analysis of risk measures and departure conditions data collected from January 2012 though December 2012.

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 four reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2012	25.83	2012	16.67
	Range: 22 to 28		Range: 10 to 25
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

Suicidal Behavior

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

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

Suicide attempts and completions reported by Oasis for five reporting periods are noted in Table 2.

Table 2

SUICIDAL BEHAVIOR INCIDENTS		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2012	1	0
2011	0	0
2010	0	0
2009	1	0
2008	4	0

The one incident of suicide attempt reflects the following information: the 13 year old male Caucasian youth of non-Hispanic ethnicity attempted to harm himself by scratching and biting himself. The youth stated that he would jump off a two story building, drink cologne or gasoline, and he would stuff his shirt down his throat until he choked. The youth has a diagnosis of Bipolar Disorder. This youth does have a history of suicide attempts; the outcome of this attempt is that the youth was admitted to a psychiatric hospital. The specialized foster care parents/staff followed the suicide attempt protocol, and they received suicide training as well as a suicide refresher course.

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 Oasis for five reporting periods are noted in Table 3.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of Errors
2012	4
2011	13
2010	22
2009	11
2008	7

The 4 incidents of medication errors reflect the following descriptive information:

- 3 (75%) were child welfare custody and 1 (25%) was parental custody and no juvenile probation involvement.

Clinical and Medication Error Information:

- The most frequent diagnosis was Bipolar Disorder (2 or 50% of youth).
- Type of medication error
  - 4 (100%) other medication error:

  - Client threw his medication down the sink at school. He did take another dose of medication at school; however, the dose that he threw down the drain had to be replaced from the home stock of medication causing a pill shortage in the medication count.
  - Client was discharged from medical hospital with only 3 pills of Ziprasidone. Staff had to wait for physician to authorize medication to the pharmacy. Client missed one dose.
  - Client ran out of medication without any refills. Staff unable to reach physician until Monday.
  - Documentation error – medication was administered on time.
- All medication errors were with psychotropic medication.
- Medication error outcome
  - 2 (50%) were errors that occurred but did not reach the patient.
  - 2 (50%) were errors that occurred that reached the patient but did not cause patient harm.
- Medication error day
  - Each of the four medication errors occurred on a separate day (Sunday, Monday, Thursday, and Friday).

- Medication error time
  - 3 (75%) of the medication errors occurred at 7:00pm.

Highlights:

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

Practice Guidelines and Opportunities for Improvement:

- Specialized Foster Care managers or supervisors or the agency's Quality Assurance staff should confer with the staff member involved in the error and thoroughly document how the error occurred and how its recurrence can be prevented. Medication errors are sometimes the result of system problems rather than exclusively from staff performance or environmental factors; thus error reports should be encouraged and not used for punitive purposes but to achieve correction or change (American Society of Hospital Pharmacists, 1993).
- Ensure medication logs are periodically reviewed for quality assurance by someone other than the person who administered the medication.
- Agencies need to maintain detailed individual education records which include the date and duration of training. Staff should be evaluated using the following checklist:
  1. Demonstrates proper storage of medication
  2. Sets-up medication administration properly (i.e., clean, designated space with needed supplies available)
  3. Reads and follow directions on medicine labels
  4. Identifies the client by name
  5. Demonstrates clean technique for administering Medications
  6. Observe as client takes medication
  7. Demonstrates correct recording of medication given
  8. Demonstrates correct recording of medications not given

9. Demonstrates proper action to take if medication not taken or given either by refusal/unavailable medication or other contraindications
10. Describes proper action to take if medication not taken or given
11. Describes resources to be used in an emergency or when problems arise
12. Describes procedure for medication errors

- Consistent and accurate reporting is a positive step toward identifying and eliminating medication errors and ensuring the safety and well-being of all clients. By identifying medication error trends and problem areas, programs will be able to prevent future errors and reduce patient harm and injuries. Planning and Evaluation Unit (PEU) staff are working with Oasis staff through initial and annual medication administration and management training as well as conducting monthly medication reviews to help identify 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 (AWOL).

AWOL incidents reported by Oasis in the five reporting periods are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	Number of AWOLs
2012	4
2011	21
2010	7
2009	15
2008	5

The 4 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 3 (75%) were male and 1 (25%) was female.
- Average age was 15.25 with an age range of 13 to 17 years.
- 3 (75%) were child welfare custody and 1 (25%) was parental custody and no juvenile probation involvement.
- 2 (50%) were Caucasian, 1 (25%) was African American, and 1 (25%) was Unknown.
- 2 (50%) were Hispanic.

Clinical and AWOL Information:

- The most frequent diagnosis for the youth was Mood Disorder (1 or 25% of youth), Bipolar Mood Disorder (1 or 25% of youth), Attention Deficit Hyperactivity Disorder (1 or 25% of youth), and Schizoaffective Disorder (1 or 25% of youth).
- Average number of AWOL days was 3 days with a range of 3 days to 3 days.

- All of youth had a history of AWOL.
- Type of supervision at AWOL
  - 3 (75%) youth left from school or work
  - 1 (25%) youth left from specialized foster care home during the day
- Behavior during AWOL
  - All of the youth's behavior during AWOL was unknown.
- Outcome
  - 3 (75%) absent indefinitely
  - 1 (25%) other:
    - The youth left the program, was returned to the program on 11/23/12 then left again after fifteen minutes, the youth was then found by police and taken to Sunrise overnight and returned to the program on 11/25/12. The youth was admitted to Spring Mountain on 11/25/12.

Highlights:

- Oasis experienced a significant decrease in AWOLs in 2012 from 2011.
- All of the AWOLs occurred between 1:25PM and 5:15PM.

Practice Guidelines and Opportunities for Improvement:

- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005).
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety (Courtney et al., 2005)
  - schedule regular visitation with family members
  - promote family ties such as placement with siblings
  - nurture other positive relationships in the youth's life, such as a mentor
  - offer activities and recreational opportunities that will interest youth
  - provide personal safety training
  - inform youth of risks of and alternatives to running
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).
- Ensure that a complete runaway history of each youth is shared with providers as early in the pre-placement process as possible.
- Develop protocols regarding supervision between the school and the treatment home.

Restraint and Manual Guidance

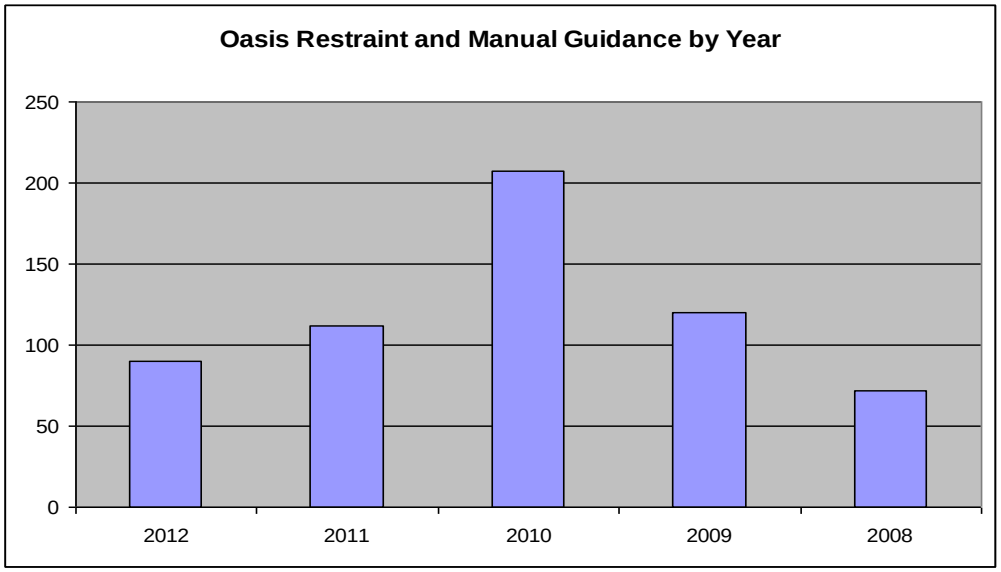
Specialized foster care providers were asked to track and report on restraint and manual guidance used on children and adolescents. As it is stated in the monthly data collection report for Risk Measures and Departure Conditions, restraint and manual guidance is a method of restricting a child's freedom 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 CPAR for the restraint method.

The 90 restraint and manual guidance incidents reported by Oasis in five reporting periods are noted in Table 5 below.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	Number of Restraint / Manual Guidance Incidents
2012	90
2011	112
2010	207
2009	120
2008	72



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

- 50 (56%) were male and 40 (44%) were female.
- Average age was 9.7 with an age range of 7 to 17 years.
- 60 (67%) were child welfare custody, 27 (30%) were parental custody and no juvenile probation involvement, 2 (2%) were parental custody on probation, and 1 (1%) was DCFS youth parole custody/supervision.
- 67 (75%) were Caucasian, 19 (21%) were African American, 2 (2%) were Asian, 1 (1%) was American Indian/Alaska Native, and 1 (1%) was Other.
- 10 (11%) were Hispanic.

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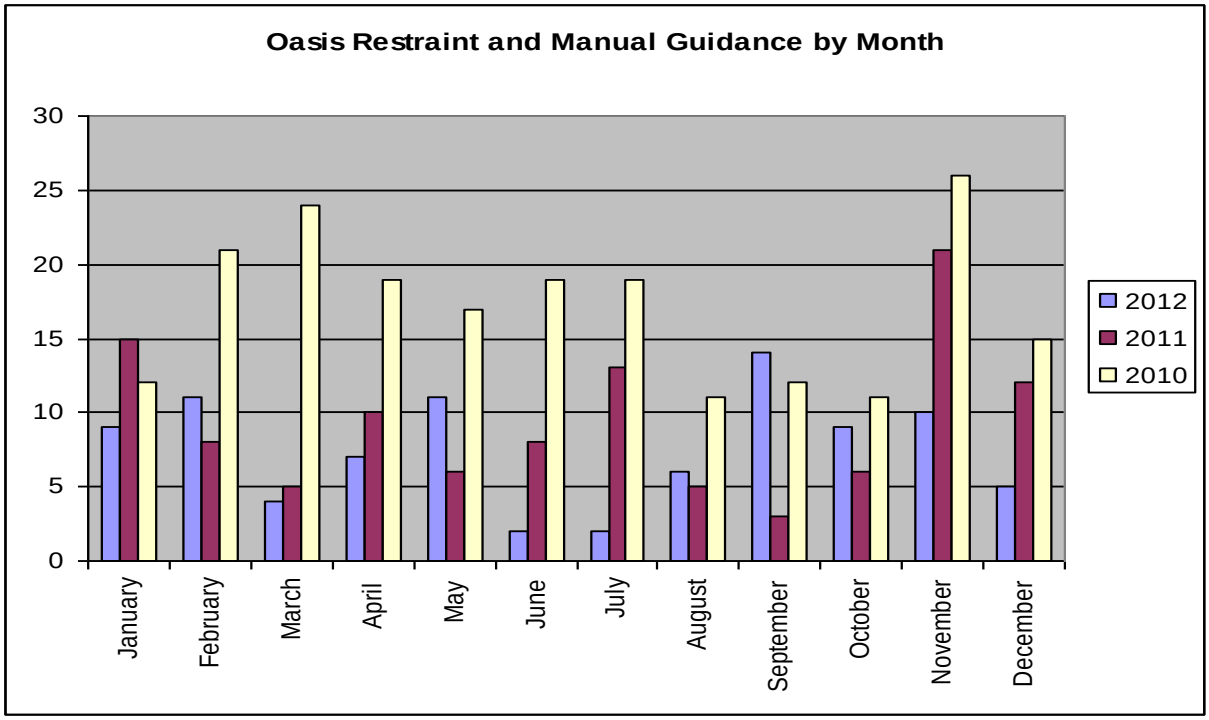
2012 SUMMARY

Clinical and Restraint/Manual Guidance Information:

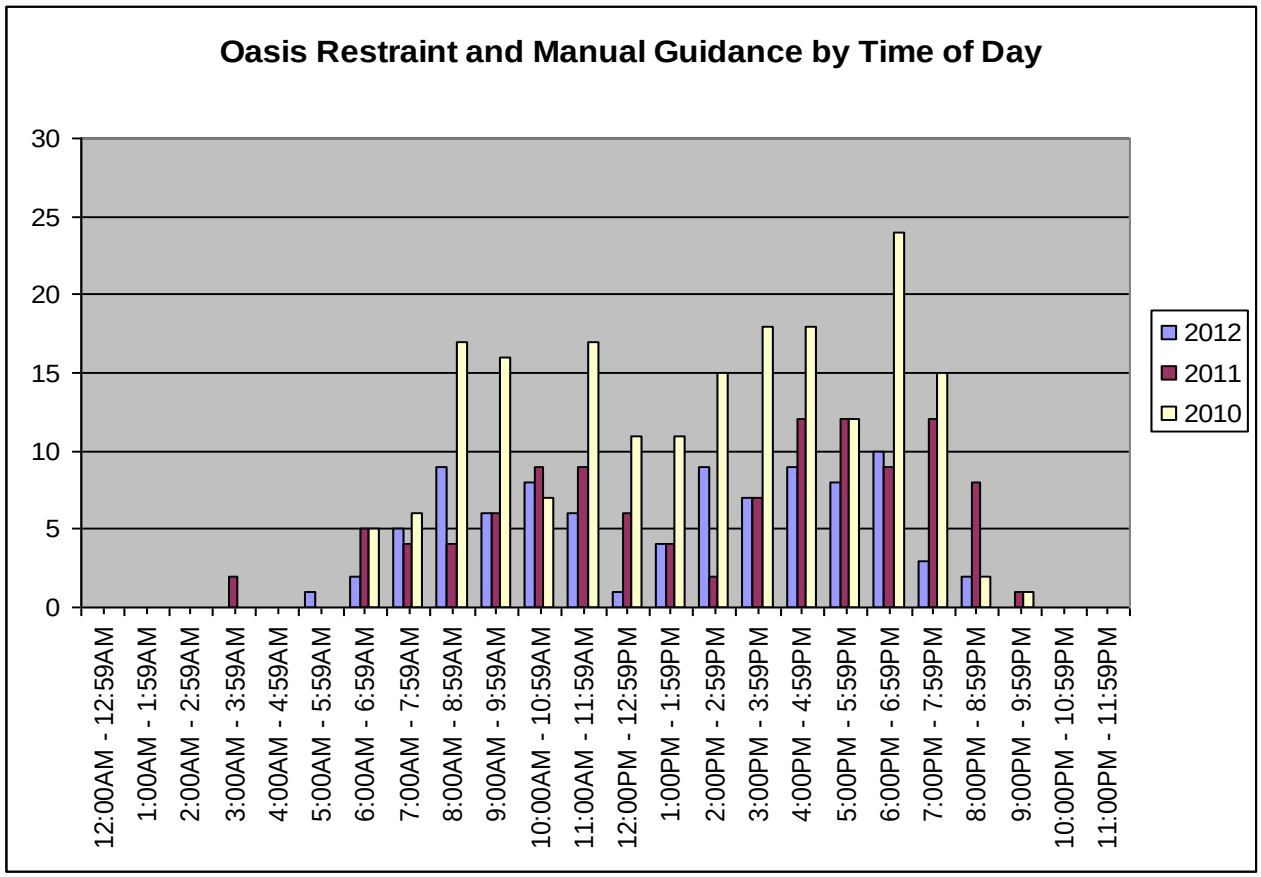
- The most frequent diagnosis was Mood Disorder (56 or 62% of youth).
- Average length of restraint and manual guidance was 15.3 minutes, ranging from zero to 135 minutes.
- 87 (97%) of the youth had a history of restraint and manual guidance.
- Restraint and Manual Guidance Event
    - 34 (38%) physically assaultive toward adult
    - 17 (19%) youth putting self at "risk" of harm
    - 14 (15%) youth putting others at "risk" of harm
    - 8 (9%) other:
        - 3 (3%) Client was hurting self and staff and destruction of property.
        - 2 (2%) Client was harming self and threatening to harm others.
        - 1 (1%) Client was running around and refusing to take direction. The client was escorted to the bedroom.
        - 1 (1%) Client was hurting self and staff.
        - 1 (1%) Client was running away, threatening to kill self, kicking, hitting and biting staff.
    - 7 (8%) youth running away
    - 5 (6%) physically assaultive toward another youth
    - 5 (6%) property destruction
- Restraint and Manual Guidance Supervision
    - 50 (56%) group of 2 or 3
    - 32 (35%) group – 4 or more
    - 7 (8%) one-on-one
    - 1 (1%) other:
        - Client had one-on-one staff attention but then staff left the room to attend to another client.
- Restraint and Manual Guidance Injury
    - 58 (65%) no one injured
    - 29 (32%) client injured
    - 3 (3%) staff injured

Highlights:

- The staff received initial and refresher training.
- In the past two reporting periods Oasis has shown a reduction in the use of restraint and manual guidance; however, the program has also averaged fewer clients served. Still, on average in 2012, there were 7.5 incidents of restraint and manual guidance per month as compared to 9.3 incidents per month in 2011 and 17.5 incidents per month in 2010. The bar graph below shows the incidents of restraint and manual guidance by month for 2010 through 2012.



- The bar graph below shows the incidents of restraint and manual guidance by time of day for 2010 through 2012. In 2012, 51% (46) of the restraint and manual guidance incidents occurred in the hours after school and into the early evening. During the same time of day in 2010 and 11, there were 52% and 48% incidents of restraint and manual guidance respectively.



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 restraint 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. Since many youth have experienced trauma, training staff and treatment parents in de-escalation techniques to avoid restraint and manual guidance incidents is especially important since restraint incidents can result in retraumatization of youth.

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.

Child on child physical and sexual incidents reported by Oasis in the two reporting periods noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2012	0
2011	2

No physical and/or sexual incidents (child on child) were reported in 2012.

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.
- 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)
- Since foster youth have likely experienced traumatic events, a physical or sexual incident may result in retraumatization. Teach staff and supervisors about the importance of acknowledging and addressing the traumatic experience and how to provide support to youth concerning the disclosure of the physical and/or sexual incident (World Health Organization, 2006).
- In fact, other youth in the home may be retraumatized simply by witnessing an incident between peers. A trauma informed system should establish a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact. (Trauma and Retraumatization Proceedings, 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 35 discharges in the 2012 reporting period.

The 35 departures reflect the following descriptive information.

- 25 (71%) were male and 10 (29%) were female.
- Average age was 13 with an age range of 8 to 18 years.
- 21 (60%) were Caucasian, 11 (31%) were African American, 1 (3%) was American Indian/Alaska Native, 1 (3%) was Asian, and 1 (3%) was Unknown.
- 3 (9%) of youth were of Hispanic origin.
- Custody Status
    - 23 (66%) were in child welfare custody
    - 6 (17%) were in parental custody and no juvenile probation involvement
    - 4 (11%) were in parental custody and on probation
    - 1 (3%) was in DCFS youth parole custody/supervision
    - 1 (3%) was Tribal
- 34 (97%) were Medicaid or SCHIP recipients
- The average length of stay at Oasis in 2012 was 179.91 days, ranging from 15 days to 497 days (1.36 years).

  The average lengths of stay reported by Oasis in the five reporting periods are noted in Table 7.

Table 7

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	179.91
2011	168.44
2010	161.46

Clinical and Departure Information:

- The most frequent diagnosis at admission was Mood Disorder (15 or 43% of youth) followed by Bipolar Disorder (5 or 14% of youth).
- The most frequent diagnosis at discharge was Mood Disorder (14 or 40% of youth) followed by Bipolar Disorder (5 or 14% of youth).
- The average CASII composite score at admission was 23.26.
- The average CASII composite score at discharge was 21.94.
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 8.

Table 8

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting	Restrictiveness	Setting

Period	Score	
2012	12	Individual home – emergency shelter
2011	11	Between regular foster care and individual home – emergency shelter
2010	11	Between regular foster care and individual home – emergency shelter
2009	11	Between regular foster care and individual home – emergency shelter
2008	11	Between regular foster care and individual home – emergency shelter

In 2012, ROLES score resulted in an average score of 12, which equals the restrictiveness score of individual home – emergency shelter.

- 3 (8%) unknown: Youth were AWOL. The departure setting is unknown.
- 3 (8%) home of parents, 18 year old
- 5 (14%) home of parents, child
- 2 (6%) home of relative
- 2 (6%) supervised independent living
- 2 (6%) regular foster care
- 9 (26%) group treatment home
- 1 (3%) county detention center
- 8 (23%) state and private mental hospital

- 19 (56%) youth completed treatment prior to discharge.
- Transition plan appropriate
  - 22 (63%) yes
  - 13 (37%) no
  - ➢ Explanations:

1. 4 (31%) Client was AWOL.
2. 3 (23%) Client was hospitalized.
3. 3 (23%) Client did not have a transition plan.
4. 2 (15%) Client transitioned too fast from the program.
5. 1 (8%) Client was arrested, no transition plan.

- Discharge plan appropriate
  - 31 (89%) yes
  - 4 (11%) no
  - ➢ Explanations:

1. 2 (50%) Client did not have a transition plan.
2. 1 (25%) Client was AWOL.
3. 1 (25%) Client was not ready for discharge.

- Who recommended departure
  - 21 (60%) CFT
  - 5 (14%) child's mental health practitioner
  - 4 (11%) N/A; youth went AWOL
  - 3 (9%) other:
    - 2 (66%) Client aged out of program and was transferred to Adult Mental Health Services.
    - 1 (33%) Client was arrested.

- 1 (3%) child welfare case manager
- 1 (3%) parent

Youth in Child Welfare Custody

Of the 35 discharges reported by Oasis in the 2012 reporting period, 23 (66%) were in the custody of a public child welfare agency.

The 23 departures reflect the following descriptive information.

- 15 (65%) were male and 8 (35%) were female.
- Average age was 13 with an age range of 8 to 18 years.
- 13 (57%) were Caucasian, 8 (35%) were African American, 1 (4%) was Asian, and 1 (4%) was Unknown.
- 3 (13%) youth were of Hispanic origin.
- All were Medicaid recipients
- The average length of stay at Oasis in 2012 was 193.78 days, ranging from 15 days to 497 days (1.36 years).

The average lengths of stay reported by Oasis in the three reporting periods are noted in Table 9.

Table 9

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	193.78
2011	187.43
2010	195.40

Clinical and Departure Information:

- The most frequent diagnosis at admission was Mood Disorder (11 or 48% of youth) followed by Bipolar Disorder (3 or 13% of youth) and Oppositional Defiant Disorder (3 or 13% of youth).
- The most frequent diagnosis at discharge was Mood Disorder (11 or 48% of youth) followed by Bipolar Disorder (3 or 13% of youth) and Oppositional Defiant Disorder (3 or 13% of youth).
- The average CASII composite score at admission was 23.26.
- The average CASII composite score at discharge was 21.94.
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 10.

Table 10

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2012	11	Between regular foster care and individual

		home – emergency shelter
2011	12	Individual home – emergency shelter
2010	13.60	Group Treatment Home

In 2012, ROLES score resulted in an average score of 11, which equals the restrictiveness score of between regular foster care and individual home – emergency shelter.

- 3 (13%) unknown: Client was AWOL.
- 2 (9%) supervised independent living
- 1 (4%) home of parents, 18 year old
- 1 (4%) home of parents, child
- 2 (9%) home of relative
- 1 (4%) regular foster care
- 9 (39%) group treatment home
- 4 (17%) state and private mental hospital

- 14 (64%) youth completed treatment prior to discharge.
- Transition plan appropriate
  - 15 (65%) yes
  - 8 (35%) no
  - Explanations:

1. 4 (50%) Client was AWOL.
2. 2 (25%) Client did not have a transition plan
3. 2 (25%) Client transitioned too fast from the program.

- Discharge plan appropriate
  - 20 (87%) yes
  - 3 (13%) no
  - Explanations:

1. 1 (33%) Client was AWOL.
2. 1 (33%) Client was did not have a transition plan.
3. 1 (33%) Client was not ready to transition from the program.

- Who recommended departure
  - 14 (61%) CFT
  - 4 (17%) N/A; youth went AWOL
  - 2 (9%) child's mental health practitioner
  - 2 (9%) other:
    - Client aged out of program and was transferred to Adult Mental Health Services.
  - 1 (4%) child welfare case manager

Overall Highlights:

- In 2012, the average length of stay is almost 6 months. In 2010 and 2011, the average length of stay was approximately 5 months.
- There is a slight increase of the ROLES score in 2012 as compared to previous years. The ROLES score in 2012 is individual home – emergency shelter while in previous years the ROLES score was between regular foster care and individual home – emergency shelter.
- Upon discharge, 40% (14) of the youth were placed in less restrictive settings. Also, 29% (10) of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- 61% (14) of the departures were recommended by the CFT.

MEDICAID REPORT 2013
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2012 SUMMARY

Children in Child Welfare Custody Highlights:

- In 2012, the average length of stay is 6 months. In 2010 and 2011, the average length of stay was approximately 5 months.
- There is a slight decrease of the ROLES score in 2012 as compared to 2011. The ROLES score in 2012 is between regular foster care and individual home – emergency shelter while in 2011 the ROLES score was individual home – emergency shelter.
- Upon discharge, 7 (30%) of youth returned to a less restrictive environment.
- Upon discharge, 17% (4) of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- Of the 23 departures for children in the custody of a child welfare agency, 61% (14) were recommended by a CFT.

Practice Guidelines and Opportunities for Improvement:

- Only 14 (61%) of the 23 departures for children in the custody of a child welfare agency were recommended by a CFT. In 2011, 68% of departures for children in the custody of a child welfare agency were recommended by a CFT. While in 2010, 76% of departures for children in the custody of a child welfare agency were recommended by a 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. Providers should consider 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.
- Ensure staff and treatment parents receive training in trauma informed care. By recognizing the impact of trauma on children's lives or viewing behaviors through the "lens" of their traumatic experiences, their behaviors begin to make more sense (Grillo and Lott, 2010). Using an understanding of trauma as a foundation, the CFT can then formulate effective strategies to address challenging behaviors and help children develop new, more positive coping skills.

Summary

Oasis submitted all of its 2012 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 2012 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. In addition to training the Oasis staff on the statewide Medication Administration and Management policy,

the PEU has begun a review of the administration, record keeping, and medication practices of Oasis. Since Oasis reported fewer than expected medication errors in 2012, the monthly medication reviews conducted by PEU will help Oasis staff accurately report medication errors. It is anticipated that these reviews will foster an environment of medication administration best practices. While OASIS did report fewer restraint and manual guidance incidents in 2012 than in previous years, it is recommended that the provider agency continue to work with staff in practicing de-escalation techniques as well as 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, structured therapeutic environment, 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 2012 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

Risk Measures / Departure conditions Report
Adolescent Treatment Center

Division of Child and Family Services
DCFS ADOLESCENT TREATMENT CENTER (ATC)
Risk Measures and Departure Conditions Report – 2012

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 2012 report is the fifth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2012 through December 2012. ATC submitted a timely and complete data set in 2012. ATC is to be commended for their willingness to share this very important information.

All of the risk measures and departure conditions data are self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2012 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. 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:

- Suicidal behavior
- 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 (CFT) decision making

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

ADOLESCENT TREATMENT CENTER PROGRAM INFORMATION

This report for ATC is the analysis of risk measures and departure conditions data collected from January 2012 though December 2012.

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 four reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2012	15.5	2012	18.92
	Range: 14 to 16		Range:16 to 22
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

Suicidal Behavior

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

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

Suicide attempts and completions reported by ATC for five reporting periods are noted in Table 2.

Table 2

SUICIDAL BEHAVIOR INCIDENTS		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2012	1	0
2011	0	0
2010	1	0
2009	0	0
2008	0	0

The one incident of a suicide attempt reflects the following descriptive information:

The youth was a Caucasian non-Hispanic female and 17 years old. She is in the custody of her parents and is not on probation. She attempted suicide by wrapping a string around her neck and stated she wanted to die. This youth has a history of previous suicide attempts. She is diagnosed with Bipolar I Disorder. The suicide protocol was followed and the youth was admitted to a psychiatric hospital. The staff received both initial and refresher suicide prevention training.

Highlights:

- Staff received initial and refresher suicide prevention training.

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 for five reporting periods are noted in Table 3.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of Errors
2012	7
2011	2
2010	0
2009	1
2008	0

The 7 incidents of medication errors reflect the following descriptive information:

- 1 (14%) was in child welfare custody, 4 (57%) were parental custody on probation, and 2 (28%) were parental custody and no juvenile probation involvement.

Clinical and Medication Error Information:

- The most frequent diagnosis was Posttraumatic Stress Disorder (2 or 29% of youth).
- Type of medication error
  - 4 (57%) omission or missed dose error
  - 1 (14%) unauthorized drug error
  - 2 (28%) other medication error:
    - 1 (14%) Client's medication ran out before new order arrived. Staff needed to order earlier. One dose missed.
    - 1 (14%) Pharmacy error.
- All 7 of the medication errors were with psychotropic medication.
- Medication error outcome
  - 7 (100%) were errors that occurred that reached the patient but did not cause patient harm
- Medication error day
  - 3 (43%) Saturday
  - 2 (29%) Monday
  - 1 (14%) Thursday
  - 1 (14%) Friday
- Medication error time
  - 4 (57%) occurred in the evening
  - 3 (43%) occurred in the morning

Highlights:

- The staff administering the medications received initial and refresher medication administration and management training.
- Errors are being documented and reported. When errors are consistently documented and reviewed, procedural improvements can be made to minimize future errors.

Practice Guidelines and Opportunities for Improvement:

- Workplace distraction is a leading factor contributing to medication errors (American Society of Hospital Pharmacists, 1993). 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.

- Ensure medication logs are periodically reviewed for quality assurance by someone other than the person who administered the medication.
- Pre-service and annual training in medication administration and management is a requirement. 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.
- Agencies need to maintain detailed individual education records which include the date and duration of training. Staff should be evaluated using the following checklist:

1. Demonstrates proper storage of medication
2. Sets-up medication administration properly (i.e., clean, designated space with needed supplies available)
3. Reads and follow directions on medicine labels
4. Identifies the client by name
5. Demonstrates clean technique for administering Medications
6. Observe as client takes medication
7. Demonstrates correct recording of medication given
8. Demonstrates correct recording of medications not given
9. Demonstrates proper action to take if medication not taken or given either by refusal/unavailable medication or other contraindications
10. Describes proper action to take if medication not taken or given
11. Describes resources to be used in an emergency or when problems arise
12. Describes procedure for 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 (AWOL).

AWOL incidents reported by ATC in the five reporting periods are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	Number of AWOLs
2012	1
2011	8
2010	4
2009	8
2008	0

The 1 incident of child and adolescent absence of more than 24 hours reflects the following descriptive information:

- The youth who went AWOL for 3 days was a 17 year old Caucasian female of Hispanic descent. She is in parental custody and on probation. Her diagnosis is Bipolar I Disorder. She went AWOL while on a weekend pass with her father. Her behavior during AWOL was unknown. The youth was discharged after 3 days of being absent indefinitely.

Highlights:

- Only one AWOL incident occurred in 2012.

Practice Guidelines and Opportunities for Improvement:

- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005).
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety (Courtney et al., 2005)
    - schedule regular visitation with family members
    - promote family ties such as placement with siblings
    - nurture other positive relationships in the youth's life, such as a mentor
    - offer activities and recreational opportunities that will interest youth
    - provide personal safety training
    - inform youth of risks of and alternatives to running
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).
- Ensure that a complete runaway history of each youth is shared with providers as early in the pre-placement process as possible.

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). ATC staff use CPAR for the restraint method.

The 8 restraint and manual guidance incidents reported by ATC in five reporting periods are noted in Table 5 below.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	Number of Restraint / Manual Guidance Incidents
2012	8
2011	4
2010	6
2009	3
2008	4

The 8 incidents of restraint and manual guidance reflect the following descriptive information:

- All 8 were female
- Average age was 15.4 with an age range of 14 to17 years
- 6 (75%) were child welfare custody, 1 (12.5%) was parental custody on probation, and 1 (12.5%) was parental custody and no juvenile probation involvement
- All 8 were Caucasian
- None were Hispanic

Clinical and Restraint/Manual Guidance Information:

- The most frequent diagnosis was Posttraumatic Stress Disorder (4 or 50% of youth).
- Average length of restraint and manual guidance was 11.8 minutes, ranging from 4 to 24 minutes.
- 3 (38%) of the youth had a history of restraint and manual guidance.
- Restraint and Manual Guidance Event
    - 8 (100 %) were physically assaultive toward an adult
- Restraint and Manual Guidance Supervision
    - 8 (100%) group of 2 or 3
- Restraint and Manual Guidance Injury
    - 1 (12.5%) client injured (rug burn on knee)
    - 1 (12.5%) staff injured (staff was bitten)
    - 6 (75%) no one injured

Highlights:

- The staff received initial and refresher training.

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 restraint 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. Since many youth have experienced trauma, training staff and treatment parents in de-escalation techniques to avoid restraint and manual guidance incidents is especially important since restraint incidents can result in retraumatization of youth.

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.

Child on child physical and sexual incidents reported by ATC in the two reporting periods are noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2012	0
2011	2

Highlights:

- There were no incidents during this reporting period.

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 40 discharges in the 2012 reporting period.

The 40 departures reflect the following descriptive information.

- 17 (42.5%) were male and 23 (57.5%) were female
- Average age was 15.6 with an age range of 13 to 17 years
- 37 (93%) were Caucasian, 2 (5%) were African American, 1 (3%) was Mixed
- 12 (30%) of youth were of Hispanic origin
- Custody Status
    - 16 (40%) were in child welfare custody
    - 15 (38%) were in parental custody and on probation
    - 9 (23%) were in parental custody and no juvenile probation involvement
- 35 (88%) were Medicaid or SCHIP recipients
- The average length of stay at ATC in 2012 was 148.3 days, ranging from 29 days to 262 days.

The average lengths of stay reported by ATC in the last three reporting periods are noted in Table 7.

Table 7

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	148
2011	131
2010	116

Clinical and Departure Information:

- The most frequent diagnoses at admission were Depressive Disorders (15 or 37.5% of youth) followed by Posttraumatic Stress Disorder (12 or 30% of youth).

- The most frequent diagnoses at discharge were Depressive Disorders (13 or 32.5% of youth) followed by Posttraumatic Stress Disorder (12 or 30% of youth).
- The average CASII composite score at admission was 24.
- The average CASII composite score at discharge was 21.08.

Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 8.

Table 8

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2012	8.6	Supervised Independent Living
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

In 2012, ROLES score resulted in an average score of 8.6, which equals the restrictiveness score of supervised independent living.

- Setting in which each child will live
  - 1 (2.5%) unknown
  - 21 (52.5%) home of parents, for a child
  - 2 (5%) regular foster care
  - 3 (7.5%) family-based treatment home
  - 9 (22.5%) group treatment home
  - 3 (7.5%) residential treatment center
  - 1 (2.5%) county detention center
- 31 (77.5%) youth completed treatment prior to discharge.
- Transition plan appropriate
  - 36 (90%) yes
  - 4 (10%) no
  - ➢ Explanations:
  6. Pulled against medical advice.
  7. Adoptive mother decided to take her home from West Hills.
  8. Against medical advice discharge with no transition plan.
- Discharge plan appropriate
  - 36 (90%) yes
  - 4 (10%) no
  - ➢ Explanations:
  1. Pulled against medical advice.
  2. Adoptive mother decided to take her home from West Hills.
  3. Against medical advice discharge with no transition plan.
- Who determined departure

- 2 (5%) parole/probation officer
- 4 (10%) parent
- 34 (85%) CFT

Youth in Child Welfare Custody

Of the 40 discharges reported by ATC in the 2012 reporting period, 16 (40%) were in the custody of a public child welfare agency.

The 16 departures reflect the following descriptive information.

- 5 (31.3%) were male and 11 (68.8%) were female
- Average age was 15.3 with an age range of 13 to 17 years
- 15 (93.8%) were Caucasian and 1 (6.3%) was African American
- 2 (12.5%) youth were of Hispanic origin
- 16 (100%) were Medicaid recipients
- The average length of stay at ATC in 2012 was146 days, ranging from 29 days to 262 days.

The average lengths of stay reported by ATC in the three reporting periods are noted in Table 9.

Table 9

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	146
2011	156
2010	110

Clinical and Departure Information:

- The most frequent diagnosis at admission was Posttraumatic Stress Disorder (8 or 50% of youth) followed by Depressive Disorders (4 or 25% of youth).
- The most frequent diagnosis at discharge was Posttraumatic Stress Disorder (8 or 50% of youth) followed by Depressive Disorders (5 or 31.25% of youth).
- The average CASII composite score at admission was 24.00.
- The average CASII composite score at discharge was 21.08.

Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 10.

Table 10

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2012	11.4	Regular Foster Care
2011	11.6	Specialized Foster Care
2010	12.9	Family Based Treatment Home

In 2012, ROLES score resulted ted in an average score of 11.4, which equals the restrictiveness score of regular foster care.

- Setting in which each child will live
  - 4 (25%) home of parents, for a child
  - 2 (12.5%) regular foster care
  - 3 (18.8%) family-based treatment home
  - 4 (25%) group treatment home
  - 3 (18.8%) residential treatment center
- 12 (75%) youth completed treatment prior to discharge
- Transition plan appropriate
  - 15 (93.8%) yes
  - 1 (6.3%) no
  - ➢ Explanations:
  4. Against medical advice discharge with no transition plan.
- Discharge plan appropriate
  - 15 (93.8%) yes
  - 1 (6.3%) no
  - ➢ Explanations:
  4. Against medical advice discharge.
- Who recommended departure
  - 1 (6.3%) parent
  - 15 (93.8%) CFT

Overall Highlights:

- 85% of the discharges were recommended by CFTs.
- 78% of the youth completed treatment at discharge.
- Upon discharge, 65% of youth were going to a less restrictive environment. In the 2011 reporting period, 72% of youth were going to a less restrictive environment.

Children in Child Welfare Custody Highlights:

- Upon discharge, 25% of the youth reached permanency. In the 2011 reporting period, 30% of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- 75% of youth completed treatment.
- 94% of the discharges were recommended by CFTs.

Practice Guidelines and Opportunities for Improvement:

- 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.
- Ensure staff and treatment parents receive training in trauma informed care. By recognizing the impact of trauma on children's lives or viewing behaviors through the "lens" of their traumatic experiences, their behaviors begin to make more sense (Grillo and Lott, 2010). Using an understanding of trauma as a foundation, the CFT can then formulate effective strategies to address challenging behaviors and help children develop new, more positive coping skills.

Summary

ATC submitted all of its 2012 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 2012 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of suicide, medication errors, AWOL, restraint and manual guidance, and departure conditions.

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, structured therapeutic environment, 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 2012 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 H

Risk Measures / Departure Conditions Report
Family Learning Homes

Division of Child and Family Services
DCFS FAMILY LEARNING HOMES (FLH)
Risk Measures and Departure Conditions Report – 2012

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 2012 report is the fifth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2012 through December 2012. FLH submitted a timely and complete data set in 2012. FLH is to be commended for their willingness to share this very important information.

All of the risk measures and departure conditions data are self-reported by each specialized foster care provider which presents some risk that a true count of incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2012 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. 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:

- Suicidal behavior
- 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 (CFT) decision making

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

FLH PROGRAM INFORMATION

This report for FLH is the analysis of risk measures and departure conditions data collected from January 2012 through December 2012.

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 four reporting periods are reflected in Table 1.

Table 1

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
Bed Capacity		**Youth Served**	
2012	20	2012	21.67
	Range: 20 to 20		Range: 20 to 24
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

Suicidal Behavior

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

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

Suicide attempts and completions reported by FLH for five reporting periods are noted in Table 2.

Table 2

SUICIDAL BEHAVIOR INCIDENTS		
Reporting Period	**Attempted Suicides**	**Completed Suicides**
2012	0	0
2011	3	0
2010	0	0
2009	0	0
2008	1	0

Practice guidelines in an effort to maintain low incidents of suicidal behavior:

- 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 for five reporting periods are noted in Table 3.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of Errors
2012	29
2011	9
2010	3
2009	3
2008	0

The 29 incidents of medication errors reflect the following descriptive information:

- 12 (41.38%) were child welfare custody, 5 (17.24%) were parental custody on probation, and 12 (41.38%) were parental custody with no juvenile probation involvement.

Clinical and Medication Error Information:

- The most frequent diagnosis was PTSD (7 or 24.14% of youth).
- Type of medication error
  - 20 (68.97%) omission or missed dose error
  - 4 (13.79%) prescribing error
  - 2 (6.9%) wrong time error
  - 2 (6.9%) other medication error: one pharmacy error and the other incident involved the medication being administered in an inappropriate area where the medication rolled into the sink drain and was unable to be retrieved.
  - 1 (3.45%) deteriorated drug error

- 28 or 96.55% of medication errors were made with non-psychotropic medication. 1 or 3.45% medication errors involved psychotropic medication.
- Medication error outcome
    - 18 (62.07%) were errors that occurred that reached the patient but did not cause patient harm.
    - 11 (37.93%) were errors that occurred but did not reach the patient.
- Medication error day
    - 8 (27.59%) Monday
    - 6 (20.69%) Saturday
    - 5 (17.24%) Sunday
    - 4 (13.79%) Thursday
    - 3 (10.34%) Tuesday
    - 2 (6.9%) Wednesday
    - 1 (3.45) Friday
- Medication error time
    - 6 (20.69%) occurred at 2:00 PM
    - 6 (20.69%) occurred at 8:00 AM
    - 3 (10.34%) occurred at 7:00 PM
    - 2 (6.9%) occurred at 9:30 PM
    - 2 (6.9%) occurred at 3:30 PM
    - 1 (3.45%) occurred at 10:30 PM
    - 1 (3.45%) occurred at 9:00 PM
    - 1 (3.45%) occurred at 8:00 PM
    - 1 (3.45%) occurred at 7:40 PM
    - 1 (3.45%) occurred at 6:50 PM
    - 1 (3.45%) occurred at 6:00 PM
    - 1 (3.45%) occurred at 5:30 PM
    - 1 (3.45%) occurred at 5:00 PM
    - 1 (3.45%) occurred at 10:30 AM
    - 1 (3.45%) occurred at 7:00 AM

Highlights:

- The staff administering the medications received initial and refresher medication administration and management training.
- Errors are being documented and reported. When errors are consistently documented and reviewed, procedural improvements can be made to minimize future errors.
- In 2012, a statewide medication administration and management policy was implemented for residential programs. The policy outlined what constitutes medication errors. The policy also required ongoing quality assurance for medication administration and management. In response, a nurse began weekly reviews of the Medication Administration Record on FLH clients. The increased numbers of medication errors reported in 2012 are likely the result of these quality assurance activities. The increased numbers of medication errors are probably a more accurate reflection of the true occurrence of errors.

Practice Guidelines and Opportunities for Improvement:
For Omission Errors:

- Workplace distraction is a leading factor contributing to medication errors (American Society of Hospital Pharmacists, 1993). 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

General Opportunities for Improvement:

- Ensure medication logs are periodically reviewed for quality assurance by someone other than the person who administered the medication.
- Pre-service and annual training in medication administration and management is a requirement. 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.
- Agencies need to maintain detailed individual education records which include the date and duration of training. Staff should be evaluated using the following checklist:
    1. Demonstrates proper storage of medication
    2. Sets-up medication administration properly (i.e., clean, designated space with needed supplies available)
    3. Reads and follow directions on medicine labels
    4. Identifies the client by name
    5. Demonstrates clean technique for administering Medications
    6. Observe as client takes medication
    7. Demonstrates correct recording of medication given
    8. Demonstrates correct recording of medications not given
    9. Demonstrates proper action to take if medication not taken or given either by refusal/unavailable medication or other contraindications
    10. Describes proper action to take if medication not taken or given
    11. Describes resources to be used in an emergency or when problems arise
    12. Describes procedure for 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 (AWOL).

AWOL incidents reported by FLH in the five reporting periods are noted in Table 4.

Table 4

AWOL INCIDENTS	
Reporting Period	Number of AWOLs
2012	8
2011	6
2010	7
2009	8
2008	3

The 8 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 4 (50%) were male and 4 (50%) were female.
- Average age was 16.38 with an age range of 16 to 17 years.
- 1 (12.5%) was child welfare custody, 5 (62.5%) were parental custody on probation, and 2 (25%) were parental custody with no juvenile probation involvement.
- 7 (87.5%) were Caucasian, and 1 (12.5%) were African American.

Clinical and AWOL Information:

- The most frequent diagnosis for the youth was PTSD (4 or 50% of youth).
- Average number of AWOL days was 8.5 days with a range of 1 to 16 days.
- 4 (50%) of youth had a history of AWOL.
- Type of supervision at AWOL
    - 6 (75%) left from school or work
    - 1 (12.5%) left from specialized foster care home during the day
    - 1 (12.5%) other – left during home visit with mother
- Behavior during AWOL
    - 6 (75%) unknown
    - 2 (25%) substance abuse
- Outcome
    - 6 (75%) absent indefinitely
    - 1 (12.5%) returned through juvenile detention or law enforcement
    - 1 (12.5%) returned voluntarily to specialized foster care home within 72 hours

Highlights:

- 75% of AWOLs occurred during school hours.
- None of the runs were from FLH (remaining 25% ran on home visit)

Practice Guidelines and Opportunities for Improvement:

- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005).
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety (Courtney et al., 2005)
    - schedule regular visitation with family members
    - promote family ties such as placement with siblings
    - nurture other positive relationships in the youth's life, such as a mentor
    - offer activities and recreational opportunities that will interest youth
    - provide personal safety training
    - inform youth of risks of and alternatives to running
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her reasons for running away, what led to running away, ask about behaviors during the runaway, types of places he/she goes to, and the people he/she has contact with while on runaway. This may help gauge risk of future runaways and help provide appropriate responses. Also, once a youth has run away once, it is highly likely that the youth will run away again after they re-enter care and the likelihood of a youth running away

increases the more times a youth has previously run away (Children Missing From Care Proceedings, 2004).
- Ensure that a complete runaway history of each youth is shared with providers as early in the pre-placement process as possible.

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). FLH staff used Conflict Prevention and Response (CPAR) for the restraint method.
The restraint and manual guidance incidents reported by FLH in five reporting periods are noted in Table 5 below.

Table 5

RESTRAINT AND MANUAL GUIDANCE INCIDENTS	
Reporting Period	Number of Restraint / Manual Guidance Incidents
2012	63
2011	21
2010	6
2009	7
2008	2

The incidents of restraint and manual guidance reflect the following descriptive information:
- 29 (46.03%) were male and 34 (53.97%) were female.
- Average age was 8.02 with an age range of 6 to 14 years.
- 52 (82.54%) were child welfare custody, and 11 (17.46%) were parental custody and no juvenile probation involvement.
- 60 (95.24%) were Caucasian, and 3 (4.76%) were American Indian/Alaska Native.

Clinical and Restraint/Manual Guidance Information:
- The most frequent diagnoses were ADHD (20 or 31.75% of youth) and PTSD (19 or 30.16% of youth).
- Average length of restraint and manual guidance was 10.92 minutes, ranging from 1 to 50 minutes.
- 56 (88.89%) of the youth had a history of restraint and manual guidance.
- Restraint and Manual Guidance Event
    - 33 (52.38%) physically assaultive toward adult
    - 20 (31.75%) physically assaultive toward another youth
    - 6 (9.52%) youth putting others at "risk" of harm
    - 4 (6.35%) youth putting self at "risk" of harm

- Restraint and Manual Guidance Supervision
  - 52 (82.54%) one-on-one
  - 8 (12.7%) group – 4 or more
  - 3 (4.76%) group of 2 or 3
- Restraint and Manual Guidance Injury
  - 61 (96.83%) no one injured
  - 2 (3.17%) client injured

Highlights:

- There were only two minor injuries (~3% of incidents) to youth during the restraint incidents. No staff or other peer injuries occurred during the incidents.
- The staff received initial and refresher training

Practice Guidelines and Opportunities for Improvement:
Given the threefold increase in restraint incidents from 2011, evaluating the training and oversight of staff is critical to improving intervention and de-escalation tactics. The following evidence-based suggestions are recommended for improving staff-youth interactions and work to avoid incidents involving restraint:

- At the time of admission, an assessment of relevant risk factors and the youth's history with restraint should be explored as this will inform the treatment planning and services provided; therefore, the provider should focus on obtaining a complete restraint 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. Since many youth have experienced trauma, training staff and treatment parents in de-escalation techniques to avoid restraint and manual guidance incidents is especially important since restraint incidents can result in retraumatization of youth.

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.

Child on child physical and sexual incidents reported by FLH in the two reporting periods noted in Table 6.

Table 6

PHYSICAL AND/OR SEXUAL INCIDENTS (CHILD ON CHILD)	
Reporting Period	Number of Physical and/or Sexual Incidents
2012	2
2011	4

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

- Victim
  - Both victims were male.
  - Average age was 12 with an age range of 8 to 16 years
  - 1 (50%) was parental custody with juvenile probation involvement, and 1 (50%) was parental custody with no juvenile probation involvement.
- Initiator
  - Both victims were male.
  - Average age was 12.5 with an age range of 9 to 16 years
  - 1 (50%) was child welfare custody, and 1 (50%) was parental custody with no juvenile probation involvement.

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

- Physical and/or sexual incidents

  - One of the incidents was of a physical nature
  - One of the incidents was of a sexual nature.
- History of physical or sexual incidents
  - One of the two victims
  - One of the two initiators
- One of the two initiator youth had a history of initiating against other children.
- Type of supervision for the incident
  - Both incidents occurred in the home during the day, staff awake
- FLH reported the incident to the legal guardian in one of the two cases.
- Neither incident was reported to Child Protective Services.

Highlights:

- Of the two incidents, only one was reported to the legal guardian.
- Neither incident was reported to Child and 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.
- 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)
- Focus on developing protocols regarding supervision in the home as both incidents reported by FLH occurred when staff was awake and presumably available for supervision.
- Develop a protocol for documenting and reporting sexual incidents to Child and Protective Services.
- Since foster youth have likely experienced traumatic events, a physical or sexual incident may result in retraumatization. Teach staff and supervisors about the importance of acknowledging and addressing the traumatic experience and how to provide support to youth concerning the disclosure of the physical and/or sexual incident (World Health Organization, 2006).
- In fact, other youth in the home may be retraumatized simply by witnessing an incident between peers. A trauma informed system should establish a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact. (Trauma and Retraumatization Proceedings, 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 43 discharges in the 2012 reporting period.

The 43 departures reflect the following descriptive information.

- 27 (62.79%) were male and 16 (37.21%) were female.
- Average age was12.44 with an age range of 6 to 18 years.
- 36 (83.72%) were Caucasian, 4 (9.3%) were African American, 1 (2.33%) was American Indian/Alaska Native, 1 (2.33%) was Asian, and 1 (2.33%) was Mixed.
- 2 (4.65%) of youth were of Hispanic origin.
- Custody Status
    - 19 (44.19%) were in parental custody and no juvenile probation involvement
    - 14 (32.56%) were in child welfare custody
    - 10 (23.26%) were in parental custody and on probation
- 40 (93.02%) were Medicaid or SCHIP recipients
- The average length of stay at FLH in 2012 was143.77 days, ranging from 20 days to 312 days.

The average lengths of stay reported by FLH in the three reporting periods are noted in Table 7.

Table 7

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	143.77 days (range of 20 to 312)
2011	162.5 days (range of 9 to 233)
2010	116 days (range of 3 to 209)

Clinical and Departure Information:

- The most frequent diagnosis at admission was Mood Disorder, NOS (10 or 23.26% of youth) followed by PTSD (8 or 18.6% of youth).
- The most frequent diagnosis at discharge was Bipolar Disorder, NOS (7 or 16.28% of youth) followed by PTSD (6 or 13.95% of youth).
- The average CASII composite score at admission was 22.7.
- The average CASII composite score at discharge was 21.37.
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 8.

Table 8

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2012	9.74	Regular foster care
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:

- 1 (2.33%) unknown (youth ran)
- 3 (6.98%) home of parents, 18 year old
- 14 (32.56%) home of parents, child
- 5 (11.63%) home of relative
- 1 (2.33%) adoptive home
- 1 (2.33%) supervised independent living
- 1 (2.33%) regular foster care
- 1 (2.33%) individual home emergency shelter
- 4 (9.30%) family-based treatment home
- 3 (6.98%) group treatment home
- 1 (2.33%) group emergency shelter
- 2 (4.65%) medical hospital (inpatient)
- 6 (13.95%) county detention center

- 33 (76.74%) youth completed treatment prior to discharge.
- Transition plan appropriate
  - 42 (97.67%) yes
  - 1 (2.33%) no
  - ➢ Explanations:
  9. Parents prematurely pulled youth from FLH.
- Discharge plan appropriate
  - 42 (97.67%) yes
  - 1 (2.33%) no
  - ➢ Explanations:
  4. Recent change in medication for youth; was not in FLH program long enough to learn and internalize new skills. Youth still very impulsive.
- Who recommended departure
  - 1 (2.33%) provider agency
  - 1 (2.33%) parent
  - 39 (90.70%) child and family team
  - 2 (4.65%) N/A; youth went AWOL
- 4 (100%) of the departures recommended by the provider agency gave 14 calendar days notice

Youth in Child Welfare Custody

Of the 43 discharges reported by FLH in the 2012 reporting period, 14 (32.56%) were in the custody of a public child welfare agency.

The 14 departures reflect the following descriptive information.

- 10 (71.43%) were male and 4 (28.57%) were female.
- Average age was 11.36 with an age range of 6 to 16 years.
- 12 (85.71%) were Caucasian, 1 (7.14%) was African American, and 1 (7.14%) was American Indian/Alaska Native.
- 2 (14.29%) youth were of Hispanic origin.
- 14 (100%) were Medicaid recipients
- The average length of stay at FLH in 2012 was 181.57 days, ranging from 37 days to 312 days.

The average lengths of stay reported by FLH in the three reporting periods are noted in Table 9.

Table 9

AVERAGE LENGTH OF STAY	
Reporting Period	Average Length of Stay
2012	181.6 days
2011	173.8 days
2010	109.6 days

Clinical and Departure Information:

- The most frequent diagnosis at admission was PTSD (3 or 21.43% of youth) along with Mood Disorder NOS (3 or 21.43% of youth).
- The most frequent diagnosis at discharge was PTSD (4 or 28.57% of youth) followed by Mood Disorder NOS (2 or 14.29% of youth).
- The average CASII composite score at admission was 22.7.
- The average CASII composite score at discharge was 21.37.
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in restrictiveness score and setting noted in Table 10.

Table 10

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2012	11.5	Specialized foster care
2011	11.3	Specialized foster care
2010	12.9	Family based treatment home

Setting in which child/adolescent will live:

- 1 (7.14%) home of parents, child

  - 2 (14.29%) home of relative
  - 1 (7.14%) adoptive home
  - 1 (7.14%) regular foster care
  - 1 (7.14%) individual home emergency shelter
  - 3 (21.43%) group treatment home
  - 3 (21.43%) family based treatment home
  - 1 (7.14%) group emergency shelter
  - 1 (7.14%) medical hospital (inpatient)
- 13 (92.86%) youth completed treatment prior to discharge.
- Transition plan appropriate
  - 14 (100%) yes
  - 0 (0%) no
- Discharge plan appropriate
  - 14 (100%) yes
  - 0 (0%) no
- Who recommended departure
  - 14 (100%) child and family team
- 2 (100%) of the departures recommended by the provider agency gave 14 calendar days notice

Overall Highlights:

- Upon discharge, 27 (of the 43) youth were placed in less restrictive settings.

Children in Child Welfare Custody Highlights:

- Upon discharge, 9 (of the 14) youth returned to a less restrictive environment.
- Upon discharge, 4 (of the 14) youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- All 14 of the departures for children in the custody of a child welfare agency were recommended by a 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. Providers should always consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.

Practice Guidelines and Opportunities for Improvement:

- 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.

- Ensure staff and treatment parents receive training in trauma informed care. By recognizing the impact of trauma on children's lives or viewing behaviors through the "lens" of their traumatic experiences, their behaviors begin to make more sense (Grillo and Lott, 2010). Using an understanding of trauma as a foundation, the CFT can then formulate effective strategies to address challenging behaviors and help children develop new, more positive coping skills.

Summary

FLH submitted all of its 2012 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 2012 Risk Measures and Departure Conditions report reflects opportunities for improvement. The area of greatest concern is the use of physical restraint. The numbers increased three-fold for physical restraints (21 in 2011 to 63 in 2012). With the increase in physical restraints from last year, it is recommended that administration meet with staff to ensure the aggression reduction training principles are being implemented. While there are many potential reasons for the increase (i.e., one youth needed to be restrained repeatedly for his or her safety and to protect other youth and staff, staff turnover, etc.), PEU would strongly suggest a close review of these areas and discuss the issues with FLH and PEU staff to create a strategy for decreasing physical restraints. While there is always room for improvement and growth, one area where FLH should be strongly commended is in the emphasis and work with the CFT. It is apparent that the CFTs are highly involved in the lives of the youth, are incorporated in the discharge and reunification plans, and are highly valued. As documented, this practice on the part of FLH will serve the child and child's family well.

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, structured therapeutic environment, 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 2012 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 I

Wraparound Washoe Expansion Report

WRAPAROUND WASHOE EXPANSION

The Wraparound Washoe Expansion (WWE) is a collaborative effort through a memorandum of understanding, to expand wraparound services to children and adolescents with severe emotional and behavioral disturbance who are in parental custody. The following agencies joined together to create this Collaborative:

- Division of Child and Family Services
- Washoe County Juvenile Services
- Washoe County School District
- Division of Mental Health and Developmental Services/Sierra Regional Center
- University of Nevada School of Social Work
- Washoe County Children's Mental Health Consortium
- Nevada Parents Encouraging Parents (Nevada PEP)

It was important to the members of the Collaborative that the WWE be evaluated. Members met to develop a logic model in which indicators were selected that matched desired outcomes. The following tables show the outcomes and indicators identified by the Collaborative.

Child and Family Outcomes

Short Term Outcomes	Indicators
Youth will have *increased school attendance*	Track number of days absent in school
Youth will have *improved behavior in school*	Track the number of disciplinary actions; days of expulsion and suspension in school
Youth will have *improved school achievement*	Track grades in school
Youth will have *improved pro-social behaviors.*	Track number of re-arrests
Youth will have *increased or achieved stability in living situations*	Track number of moves and restrictiveness of placements through the Restrictiveness of Living Environment Scale (ROLES) Track time to permanency/reunification Count number of Youth achieving permanency
Youth will have *improved day-to-day functioning*	Child and Adolescent Functional Assessment Scale (CAFAS)
Families will have *improved functioning and reduced caregiver strain*	Caregiver Strain Questionnaire

System Outcomes

Short Term Outcomes	Indicators
Child and family *satisfaction with services is improved*	Youth Services Survey (parent/caregiver and youth versions)
Families *received parent support*	Track the number of families receiving family support services
Families will have *knowledge to navigate the system*	
Child and Family Teams will have *increased natural supports participation on teams*	Track the number/ratio of natural supports to professionals on Child and Family Teams

Youth will have *shorter stays in detention facilities*	Track the number of days youth are in detention before release to appropriate services and supports

Child and Family Outcomes

Medium Term	Long Term
Youth will make meaningful progress in school	Youth will be productive (workforce ready)
Youth will be law abiding	Youth will become safe, law abiding adults
Youth will have a safe, stable living situation in which to grow	Youth will be connected to and have healthy ties to their families and caregivers
Youth will have improved ability to function at home, at school, and in their community	Youth will have the ability to function at their highest capacity at home, in the workplace, and in their community as adults.

The WWE program began serving children and their families in October 2010. Data were collected on children and adolescents receiving services starting in October 2010 through June 2012 by WWE staff. Evaluation selection criteria were clients that received a minimum of 90 days of service and were age 6 or older. An unduplicated total of 53 children and their families received WWE services during this timeframe. The table below shows the number of referrals by agency.

Agency	Number of Children Served
Washoe County Juvenile Justice (WCJJ)	26 (49.1%)
MHDS Sierra Regional Center (SRC)	11 (20.8%)
DCFS Wraparound in Nevada (WIN)	11 (20.8%)
Washoe County School District (WCSD)	5 (9.4%)

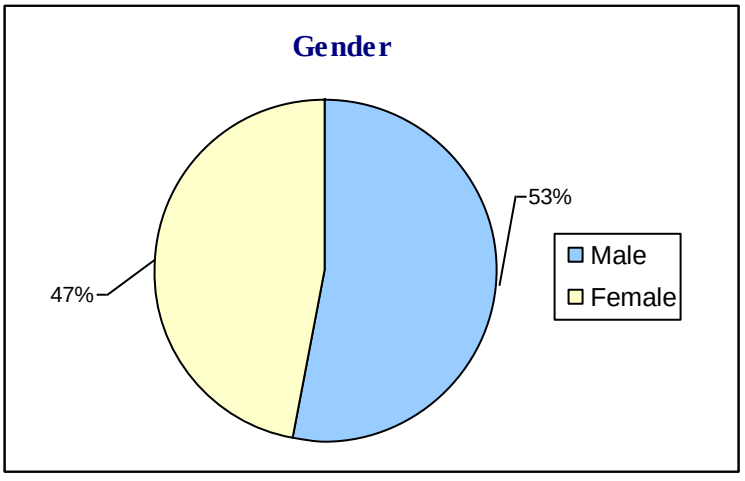
The table below shows the number of families receiving family support services through Nevada PEP.

Nevada PEP Referrals	
Number of families receiving family support	7

Demographic Information at Admission

At admission into services demographic information is collected on gender, race, ethnicity, custody status, and age.

Gender	
Male	28 (52.8%)
Female	25 (47.2%)



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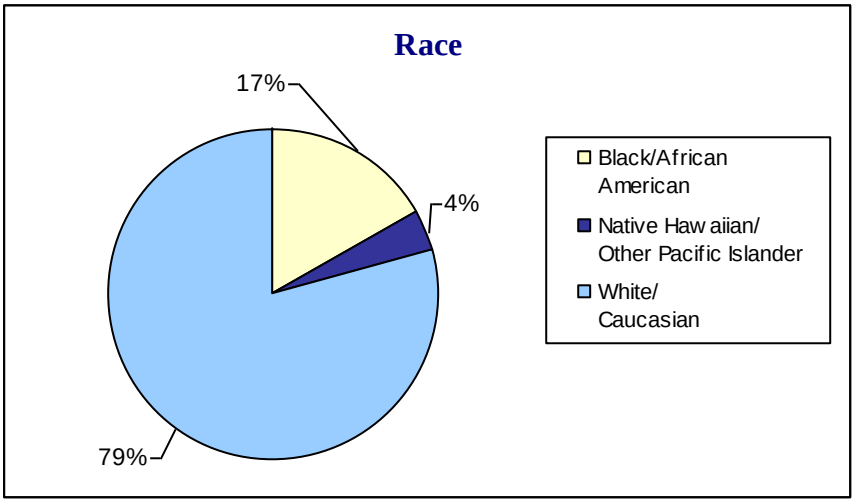
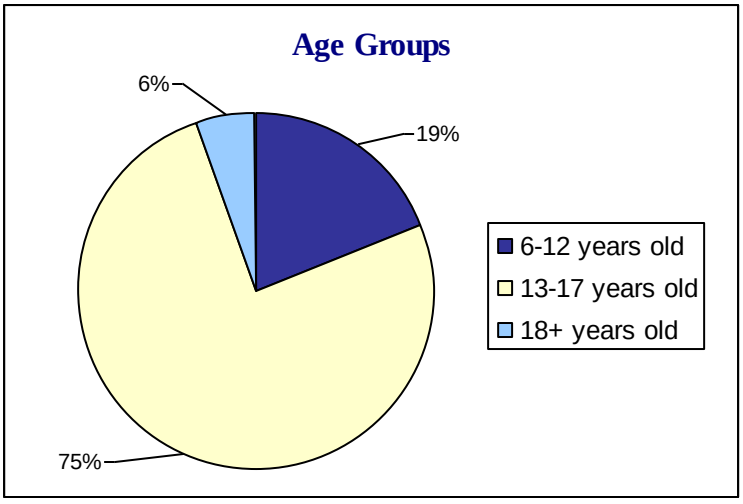
Race	
Black/African American	9 (17%)
Native Hawaiian/Other Pacific Islander	2 (3.8%)
White/Caucasian	42 (79.2%)
Ethnicity	
Hispanic Origin	9 (17%)



Custody Status	
Parent/Family	49 (92.5%)
Washoe County Court Ordered Custody	4 (7.5%)

The average age at admission is 14.26.

Age Group	
6–12 years old	10 (18.9%)
13–17 years old	40 (75.5%)
18+	3 (5.7%)

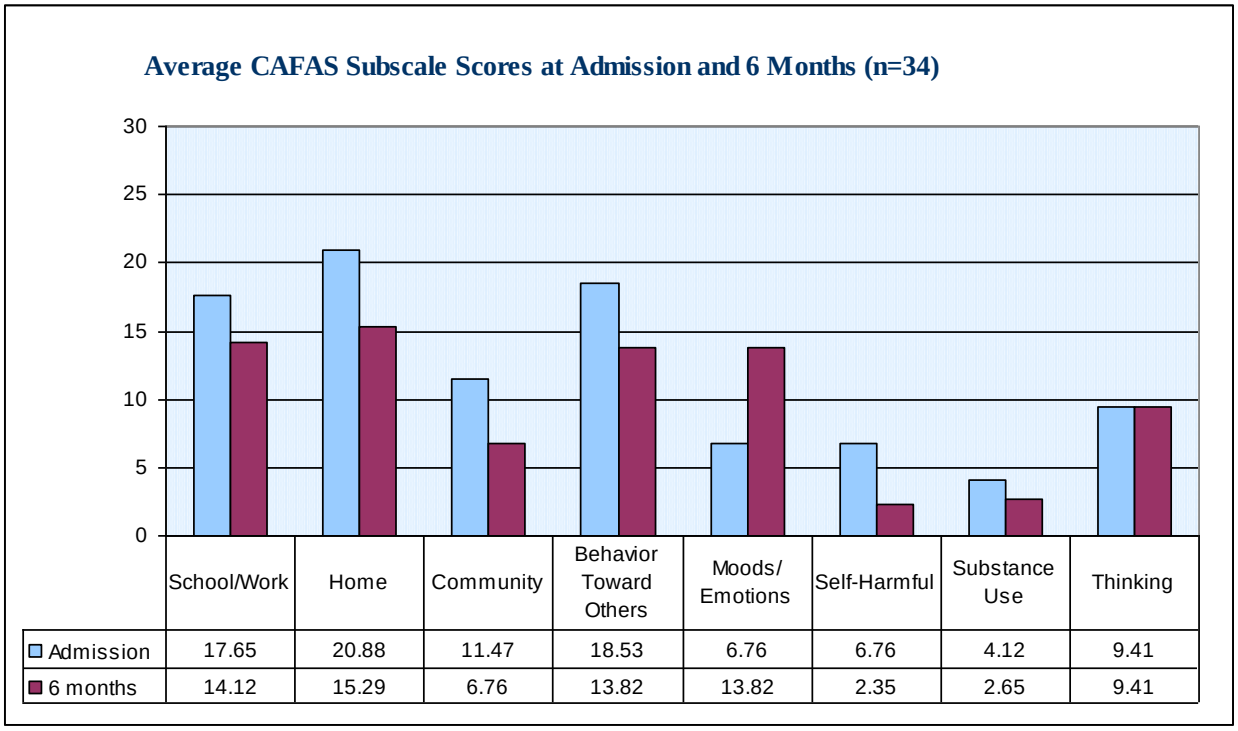


Child and Adolescent Functional Assessment

The Child and Adolescent Functional Assessment Scale[8] (CAFAS) 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 CAFAS has 8 subscales reflecting different domains of functioning. Subscale scores can range from 0 (minimal to no impairment) to 30 (severe impairment). The subscales are: school, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance use, and thinking. The CAFAS is used for treatment planning and to track the child's functioning over time.

A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for children and adolescents enrolled in the WWE. The mean CAFAS score was 105.6 (SD=42.3) at admission. At 6 months, the mean CAFAS score decreased to 78.2 (SD=37.3); t (33) = 3.83, p = .001. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 6 months. A clinically significant change is minimally a 20 point difference in the total score from admission to 6 months.

The graph below shows the average CAFAS score on each subscale at admission and 6 months.



	School/Work	Home	Community	Behavior Toward Others	Moods/ Emotions	Self-Harmful	Substance Use	Thinking
Admission	17.65	20.88	11.47	18.53	6.76	6.76	4.12	9.41
6 months	14.12	15.29	6.76	13.82	13.82	2.35	2.65	9.41

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

Caregiver Strain Questionnaire

The Caregiver Strain Questionnaire[9] (CGSQ) measures the caregiver strain experienced by families of children and adolescents with mental, emotional, or behavioral problems. The CGSQ is a 21-item self report instrument that is scored on a 5-point scale ranging from "not at all" to "very much" a problem. There are three subscales and a global measure of strain:

- Objective Strain – assesses the extent to which observable negative events or consequences related to the child's disorder have been a problem for the family
- Subjective-externalized Strain relates to negative feelings about the child such as anger, resentment, or embarrassment
- Subjective-internalized Strain refers to the negative feelings that the caregiver experiences such as worry, guilt, and fatigue
- Global Strain provides an indication of the total impact on the family

Parents and caregivers were asked to complete the CGSQ at admission to the WWE program and after 6 months in services.

A paired-samples t-test was conducted to compare the Objective Strain subscale score at admission and after 6 months of services. The mean Objective Strain score was 3.30 (SD=1.02) at admission. At 6 months, the mean Objective Strain score decreased to 2.79 (SD=1.12); t (23) = 3.10, p = .005. These results indicate a decrease in Objective Strain for caregivers.

A paired-samples t-test was conducted to compare the Subjective-externalized Strain subscale score at admission and after 6 months of services. The mean Subjective-externalized Strain score was 2.57 (SD=.98) at admission. At 6 months, the mean Subjective-externalized score decreased to 2.0 (SD=.90); t (23) = 3.41, p = .002. These results indicate a decrease in Subjective-externalized Strain for caregivers.

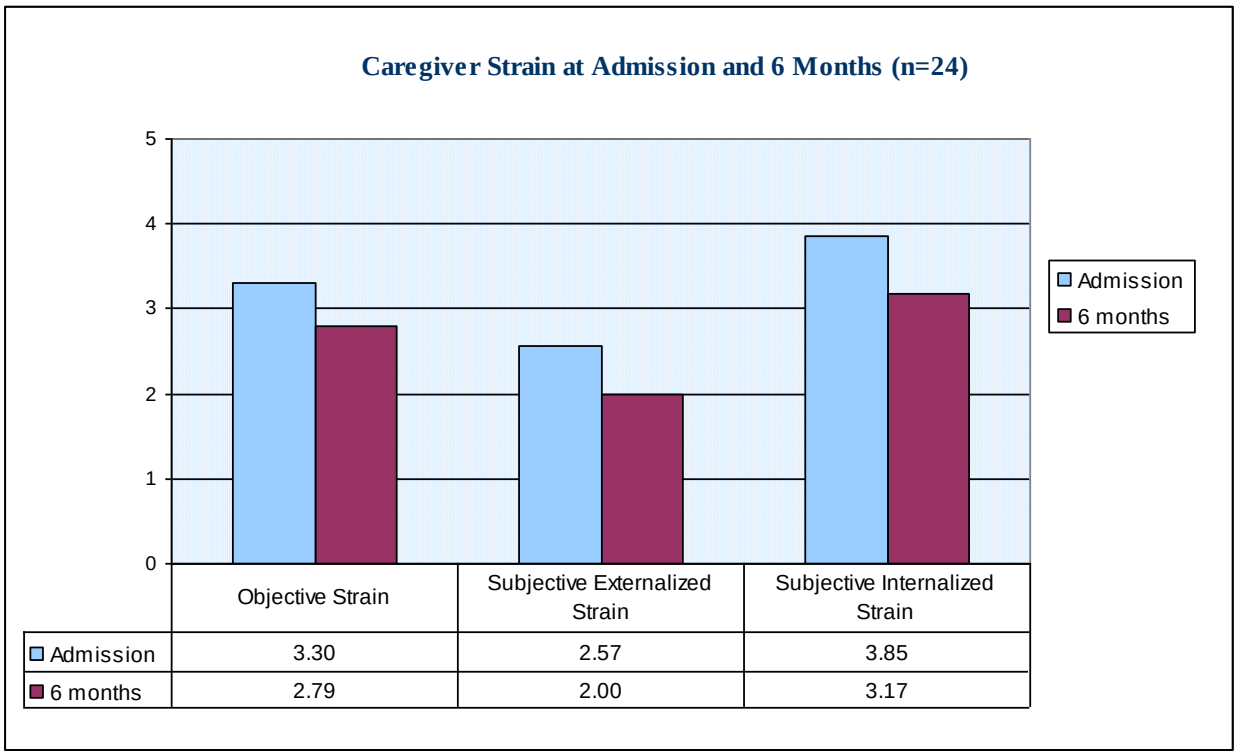
A paired-samples t-test was conducted to compare the Subjective-internalized Strain subscale score at admission and after 6 months of services. The mean Subjective-internalized Strain score was 3.85 (SD=.88) at admission. At 6 months, the mean Subjective-internalized Strain score decreased to 3.17 (SD=1.0); t (23) = 4.05, p = .000. These results indicate a decrease in Subjective-internalized Strain for caregivers.

A paired-samples t-test was conducted to compare the Global Strain score at admission and after 6 months of services. The mean Global Strain score was 9.73 (SD=2.26) at admission. At 6 months, the mean Global Strain score decreased to 7.97 (SD=2.40); t (23) = 4.56, p = .000. These results indicate a decrease in Global Strain for caregivers.

Results from the global rating of strain and the three subscale measures on the CGSQ indicate that parents and caregivers experienced a reduction in strain after receiving WWE services.

[9] Brannan, A.M., Heflinger, C.A., & Bickman, L. (1999). *Caregiver strain questionnaire.*

The graph below shows the average CGSQ score on each subscale at admission and at 6 months.



	Objective Strain	Subjective Externalized Strain	Subjective Internalized Strain
Admission	3.30	2.57	3.85
6 months	2.79	2.00	3.17

Restrictiveness of Living Environment Scale

The Restrictiveness of Living Environment Scale[10] (ROLES) is a scale developed to quantify the restrictiveness typically seen in settings for children and adolescents with a severe emotional disturbance. Restrictiveness is defined by 1) the physical facility, appearance, and layout; 2) the rules and requirements that affect movement and activity; and 3) the voluntariness with which children and adolescents enter or leave the setting permanently. The ROLES is a list of settings that are ranked from low restrictiveness to high restrictiveness. Researchers[11] more recently revised the ROLES by creating a measure that more accurately reflected the level of restrictiveness. Four clusters of general environment types were found:

- Low-restriction environments are characterized by few limitations on what youth can do, where they can go in the community and environment, and who they can be with and for how long
- Moderate-restrictiveness environments are ones in which there are moderate limitations. Personal choices are more restricted in terms of where youth can go in the community, and there are time and duration limitations on peer associations
- Elevated-restrictiveness environments are characterized by even greater restriction in access and time limits for communication and Internet access. Interaction with friends, choices in recreation, and movement in the community also become more limited and typically monitored. Seclusion and restraint are sometimes used, and treatment is part of the living environment

[10] Hawkins, R.P., Almeida, M.C., Fabry, B. & Reitz, A.L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Journal of Hospital and Community Psychiatry*, 43(1), 54-58.
[11] Rauktis, M.E., Huefner, J.C., O'Brien, K., Pecora, P.J., Doucette, A. & Thompson, R.W. (2009). Measuring the restrictiveness of living environments for children and youth. *Journal of Emotional and Behavioral Disorders,* 17(3), 147-163.

- High-restrictiveness environments are characterized by the greatest limitations on what children and adolescents can do, where they can go, in the community and environment, and whom they can be with and for how long. Activities are very limited or prohibited. Additionally, active measures may be taken to prevent contact with friends, or it may be closely supervised

WWE facilitators completed the ROLES at admission and after 6 months of services.

A paired-samples t-test was conducted to compare the ROLES score at admission and after 6 months of services. The mean ROLES score was 2.53 (SD=.61) at admission. At 6 months, the mean ROLES score decreased to 2.32 (SD=.43); t (29) = 2.09, p = .045. These results indicate that the restrictiveness of the environment in which the child or adolescent is living decreased from admission to 6 months. However, both mean scores fell within the moderate-restrictiveness environment, indicating no substantive change in restrictiveness.

Functional Outcomes

Education

Education information was collected to determine if there were changes in key indicators for children and adolescents attending school. Data was collected on the number of disciplinary actions, special education eligibility, school placement and services, absences, and grade point average. The table below compares education data from the first to the second semester while in the WWE program. More than one school placement type could be selected.

Education Outcome	N	First semester	Second semester
Number of Children with Disciplinary Actions	30	3	3
Special Education Eligible	30	19 (63.3%)	20 (66.7%)
School Placement: Regular Classroom	30	8 (26.7%)	11 (36.7%)
School Placement: Resource Services	30	4 (13.3%)	4 (13.3%)
School Placement: Self-Contained Services	30	8 (26.7%)	9 (30.0%)
School Placement: Special School	30	6 (20.0%)	6 (20.0%)
School Placement: Home Bound	30	0	0
School Placement: Out-of-District Residential Services	30	6 (20.0%)	0

The number of children and adolescents who were eligible for special education services and school placement types varied only slightly from the first semester to the second semester. However, in the first semester 6 children and adolescents were in out-of-district residential services and none in the second semester. This may indicate that through the WWE children and adolescents were able to be returned to schools in their district.

A Wilcoxon Signed Ranks test was conducted to evaluate whether the number of absences decreased from the first semester to the second semester with WWE intervention. The results indicated that the number of absences increased at the second semester, although the increase was not significant, z = -1.02, p = .306. The mean ranks at the first semester were 12.45, while the mean ranks at the second semester were 13.37.

A Wilcoxon Signed Ranks test was conducted to evaluate whether grades improved from the first semester to the second semester with WWE intervention. The results indicated that grades were lower at

the second semester, although the increase was not significant, $\underline{z} = -.98$, $p = .327$. The mean ranks at the First semester were 10.80, while the mean ranks at the second semester were 7.88.

Juvenile Justice

Juvenile justice information was collected at admission and at 6 months in services. Data was collected on time spent in detention and the number of arrests. Due to the low frequency of these events, there was not sufficient data to conduct statistical tests.

The graph below shows the number of youth who spent time in detention and the number arrested at admission and at 6 months in services.

Juvenile Justice Outcomes	N	Admission	6 months
Number of Youth Who Spent Time in Detention	31	8	5
Number of Youth Arrested	29	12	5

Child Welfare

Information was collected on the number of substantiated reports of abuse or neglect on children and adolescents in the WWE program. The graph below shows the number of substantiated reports of abuse or neglect at admission and at 6 months in services.

Child Welfare Outcomes	N	Admission	6 months
Number of Substantiated Reports of Abuse or Neglect	31	4	1

Status at Discharge

What happens to children and adolescents at discharge is a primary concern. Information was collected on the child or adolescent's status at discharge to determine if permanency was achieved.

Discharge Status	N
Number of Youth Who Discharged	35
Number of Youth Who Achieved Permanency at Discharge	12 (34.3%)
Number of Youth Who Returned to Parents/Family	9 (25.7%)
Number of Youth Who are Living with a Legal Guardian	3 (8.6%)

Of the 35 children and adolescents who discharged from the WWE program more than one third achieved permanency. Of the 12 children and adolescents who achieved permanency, 9 returned to live with a parent or family member, and 3 returned to live with a legal guardian.

Some data collection records provided a narrative description of the child's status at discharge. Of the 12 children and adolescents who achieved permanency, 10 indicated that they successfully completed services. Of the non-completers, 5 indicated that the child or adolescent went AWOL and 2 indicated that the child or adolescent went to an out-of-state facility.

Youth Services Surveys

Each spring DCFS Children's Mental Health conducts a survey of children's community-based mental health service programs. The WWE was included in the community-based surveys in 2011 and 2012. Parent/caregivers with children in treatment and the children themselves (if age 11 or older) are solicited to voluntarily participate in completing the survey instrument. 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 (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); respondents' ability to direct the course of their treatment (Participation in Treatment); whether staff were respectful of respondents' 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

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.

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.

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.

The following table shows the number of parent/caregiver and number of youth surveys received for 2011 and 2012.

	Parent/Caregiver	Youth
Wraparound Washoe Expansion 2011	14	9
Wraparound Washoe Expansion 2012	8	5
2011 - 2012 Total	22	14

The table below shows the combined results for 2011 and 2012 on the Youth Services Survey for WWE.

Parent/Caregiver N=22; Youth N=14	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	72	93
Services were scheduled at times that were right for us.	84	79
GENERAL SATISFACTION		

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Parent/Caregiver N=22; Youth N=14	Parent/Caregiver Positive Response %	Youth Positive Response %
Overall, I am pleased with the services my child and/or family received.	84	57
The people helping my child and family stuck with us no matter what.	72	64
I felt my child and family had someone to talk to when he/she was troubled.	80	86
The services my child and family received were right for us.	76	64
I received the help I wanted for my child.	76	71
My family got as much help as we needed for my child.	64	92
POSITIVE OUTCOMES		
My child is better at handling daily life.	58	64
My child gets along better with family members.	54	92
My child gets along better with friends and other people.	67	86
My child is doing better in school and/or work.	63	79
My child is better able to cope when things go wrong	63	57
I am satisfied with our family life right now.	58	92
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	80	71
I helped to choose my child and/or family's treatment goals.	80	79
I participated in my child's and family's treatment.	84	77
CULTURAL SENSITIVITY		
Staff treated our family with respect.	80	93
Staff respected our family's religious/spiritual beliefs.	80	79
Staff spoke with me in a way that I understood.	84	71
Staff was sensitive to my family's cultural and ethnic background.	84	93
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	80	N/A
I have people that I am comfortable talking with about my child's problems.	80	N/A
In a crisis, I would have the support I need from family or friends.	68	79
I have people with whom I can do enjoyable things.	68	86
I am happy with the friendships I have.	N/A	79
I feel I belong in my community.	N/A	29
FUNCTIONING		
My child is better at handling daily life.	58	64
My child gets along better with family members.	54	92
My child gets along better with friends and other people.	67	86
My child is able to do the things he/she wants to do.	58	93
My child is doing better in school and/or work.	63	79
My child is better able to cope when things go wrong.	63	57

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	80	79
Staff explained my child and my family's rights and confidentiality issues.	84	79
I receive support and advocacy from my Nevada PEP Family Specialist.	73	93
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	76	86
Our family is aware of people/ services in the community that support us.	83	79
I am better able to handle our family issues.	67	86

I am learning helpful parenting skills while in services.	79	86
I have information about my child's developmental expectations and needs.	83	29

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ Support. ♦ Learning different ways in handling situations with my children. ♦ Helping me to deal with problems my daughter has and giving me hope that we'll make it through and complete goals that we have. ♦ To have better communication. ♦ I don't know. ♦ Consistency. ♦ People are helping. ♦ When we need help, people are there. ♦ I hope he's been given some tools to learn to deal with anger and choices. ♦ Sincerity of the staff. ♦ Staff has been great. I really feel I can talk with her and trust her with the things we talk about. ♦ Our wrap around services. ♦ WIN facilitator being a voice advocate in school and community settings. Providing community resources for family.	1. What has been the most helpful thing about the services you received? ♦ The structure. ♦ 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. ♦ By people giving me praise.
2. What would improve services your child and the family received? ♦ More important information in writing. ♦ Everything and everyone was helpful. ♦ I don't know. ♦ New to program so not sure yet. ♦ Transition to home with sessions at home instead of facility - know it's difficult but might make going from facility back home more stable. ♦ Not really - the system is doing the best they can. ♦ I wish we could keep my child on probation. ♦ Continue on with path it's going.	2. What would improve services you received? ♦ People being easier to reach. ♦ None I believe. ♦ Probably more interactions with the family. ♦ To not be [?] studied. ♦ More appointments. ♦ Do as I told.
3. Additional Comments ♦ It was an asset to have this service provided - don't know how I would have done it myself without the help. ♦ Thank you Staff - you're a very special, honest, caring person.	3. Any additional comments? ♦ Drew a happy face. ♦ Thanks

Summary

Missing data was a major limitation in evaluating the results of this study. Although this was an issue with all of the indicators, it was especially a problem with education, juvenile justice, child welfare, and discharge status. Statistical analyses could not be conducted due to the low amounts of data collected or data was collected at only one point in time. Missing data leads to uncertainty about how it might have affected outcomes. Results should be viewed cautiously when indicators have low numbers as a result of missing data.

Outcomes measures were collected by the WWE facilitators. A built-in bias is seen when data are collected by the same person providing the service. Independent data collectors increase the validity of findings and may improve data collection.

The wraparound model was used in the WWE program. The WWE facilitators were trained in the wraparound model but no fidelity measure was used to determine whether facilitators were applying the model as intended. It is uncertain if the model was implemented with fidelity.

The two standardized measures, the CAFAS and the CGSQ, showed promising results. The WWE facilitator completes the CAFAS and the parent or caregiver completes the CGSQ; and the other outcome measures were objective reports or counts such as grades, number and type of placements, number of arrests, and so on. The data was triangulated, having used more than two methods, thus adding credibility to positive findings.

Members of the Collaborative may consider the following recommendations in moving forward with the evaluation of the WWE:

1. Address missing data through better monitoring of WWE facilitators as data collectors or by enlisting independent data collectors.
2. Conduct a fidelity study using a standardized fidelity measure of the wraparound model.
3. Review and reconsider indicators that may not be meaningful to the population served by the WWE while emphasizing those that can guide practice. Numbers of substantiated reports of abuse and neglect were very low even considering missing data. Numbers of arrests and days spent in detention were too low to conduct statistical analyses. However, the simple counts for each indicator decreased from admission to discharge therefore indicating they were in the positive direction of showing improvement.
4. Determine how the data may be used for decision-making, policy development, or system change to better focus and guide the WWE program.