

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2014

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INTRODUCTION

The following is the annual descriptive summary of DCFS Children’s Mental Health Services for Fiscal Year (FY) 2014, from July 1, 2013 through June 30, 2014. The FY 2014 Descriptive Summary provides an expanded analysis of DCFS programs. This 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 2798 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. DCFS Children’s Mental Health Mobile Crisis Response Team (SNCAS) information is also included in this report.

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

SNCAS	NNCAS
<i>Community-Based Services</i>	
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) (includes rural)
Mobile Crisis Response Team (MCRT)	MCRT (<i>Beginning in fiscal year 2015</i>)
<i>Treatment Homes</i>	
Oasis On-Campus Treatment Homes (OCTH)	Adolescent Treatment Center (ATC)
	Family Learning Homes (FLH)
<i>Residential Facility and Psychiatric Hospital</i>	
Desert Willow Treatment Center (DWTC)	



CHILDREN'S MENTAL HEALTH

Total Number of Children Served

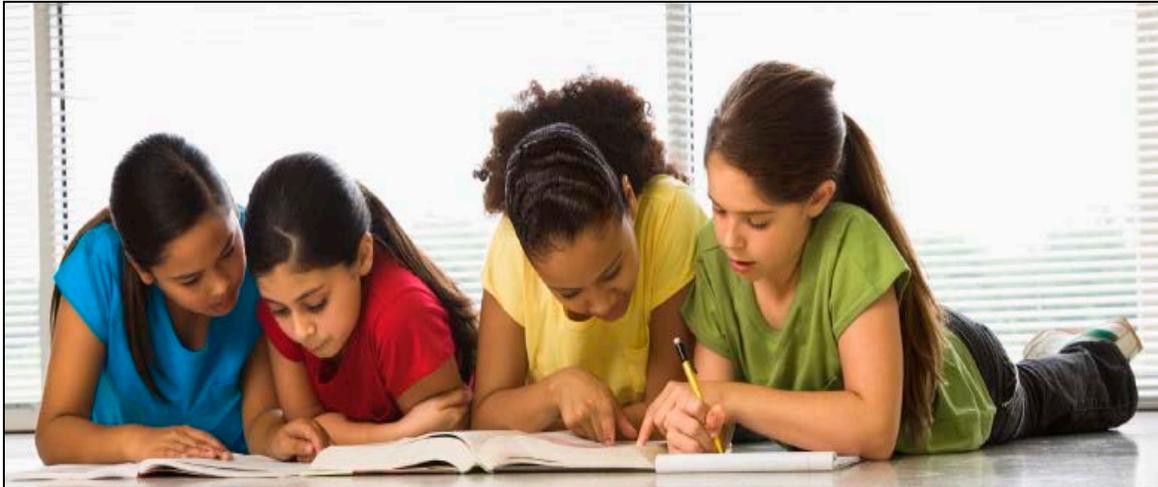
Statewide	NNCAS	SNCAS
2798	843	1955

Admissions

Statewide	NNCAS	SNCAS
1903	553	1350

Discharges

Statewide	NNCAS	SNCAS
2000	575	1425



CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

The average age of children served Statewide was 11.28 years, NNCAS was 11.62 years and SNCAS was 11.13 years.

Age Group	Statewide	NNCAS	SNCAS
0–5 years old	615	127	488
6–12 years old	896	341	555
13 + years old	1287	375	912

Gender

	Statewid	NNCAS	SNCAS
Male	1457	453	1004
Female	1329	387	942
Unknow	12	3	9

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	41	21	20
Asian	31	8	23
Black/African American	556	72	484
Native Hawaiian/Other Pacific Islander	29	8	21
White/Caucasian	2078	726	1352
Unknown	63	8	55
Ethnicity	Statewide	NNCAS	SNCAS
Hispanic Origin	839	193	646

Custody Status

	Statewide	NNCAS	SNCAS
Parent/Family	1406	450	956
Child Welfare Court Ordered	1127	375	752
ICPC	12	0	12
Voluntary Custody	2	0	2
Protective Custody	113	15	98
DCFS Youth Parole	9	0	9
Parental Custody On Probation	87	2	85

Severe Emotional Disturbance Status

Statewide	NNCAS	SNCAS
2295	726	1569

Demographics by Program

Community Based Programs:

The following tables include the demographic information for the clients served in Children’s Mental Health’s community based programs. These programs are available in both Northern and Southern Nevada. Our community based programs consist of Outpatient Services, Children’s Clinical Services, Early Childhood Mental Health Services, and Wraparound in Nevada. Information for our newest program, the Mobile Crisis Response Team, will be discussed in a later section of this summary.

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

Number of Children Served

Statewide	OPS	CCS
1267	408	859

Age

The average age of children served Statewide was 14.41, OPS was 14.20, and CCS was 14.50.

Age Group	Statewide	OPS	CCS
0–5 years old	3	0	3
6–12 years old	367	139	228
13 + years old	897	269	628

Gender

	Statewide	OPS	CCS
Male	616	217	399
Female	649	191	458
Unknown	2	0	2

Race and Ethnicity

Race	Statewide	OPS	CCS
American Indian/Alaskan Native	14	4	10
Asian	28	7	21
Black/African American	168	31	137
Native Hawaiian/Other Pacific	15	4	11
White/Caucasian	1024	362	662
Unknown	18	0	18
Ethnicity	Statewide	OPS	CCS
Hispanic Origin	488	115	373

Custody Status

	Statewide	OPS	CCS
Parent/Family	1032	299	733
Child Welfare	188	96	92
ICPC	10	0	10
Protective Custody	9	9	0
DCFS Youth Parole	2	2	0
Parental Custody / Probation	22	2	20
Unknown	4	0	4

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

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
858	236	622

Age

The average age of children served by ECMHS Statewide was 5.35, ECMHS (NNCAS) was 5.83, and ECMHS (SNCAS) was 5.17.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	547	124	423
6–12 years old	310	111	199
13 + years old	1	1*	-

*Hearing impaired child served by ECMHS therapist proficient in American Sign Language

Gender

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	482	128	354
Female	370	106	264
Unknown	6	2	4

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	7	4	3
Asian	2	1	1
Black/African American	224	28	196
Native Hawaiian/Other Pacific	9	2	7
White/Caucasian	599	200	399
Unknown	17	1	16
Ethnicity	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Hispanic Origin	209	52	157

Custody Status

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	197	66	111
Child Welfare	547	145	402
ICPC	1	0	1
Protective Custody	105	5	100
Unknown	8	0	8

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
654	203	94	357

Age

The average age of children served Statewide was 13.35, North was 13.85, Rural was 11.56, and South was 13.54.

Age Group	Statewide	North	Rural	South
0–5 years old	7	4	3	0
6–12 years old	276	70	59	147
13 + years old	371	129	32	210

Gender

	Statewide	North	Rural	South
Male	378	112	55	211
Female	274	91	38	145
Unknown	2	0	1	1

Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	24	5	9	10
Asian	6	0	0	6
Black/African American	144	22	4	118
Native Hawaiian/Other Pacific	7	3	0	4
White/Caucasian	453	171	76	206
Unknown	20	2	5	13
Ethnicity	Statewide	North	Rural	South
Hispanic Origin	133	46	7	80

Custody Status

	Statewide	North	Rural	South
Parent/Family	208	79	28	101
Child Welfare	422	121	62	239
ICPC	2	0	0	2
Protective Custody	6	2	3	1
Parental Custody / Probation	15	0	1	14
Unknown	1	1	0	0

Treatment Homes

DCFS Children's Mental Health also serves clients who need more intensive and specialized treatment than that which can be provided within their family home or community placement. The following information describes the children treated at the Adolescent Treatment Center and Family Learning Homes in Northern Nevada, as well as the On-Campus Treatment Homes located in Las Vegas.

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

Number of Children Served

Statewide	ATC	FLH	OCTH
137	53	55	29

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 14.52, ATC was 15.95, FLH was 13.12, and OCTH was 14.54.

Age Group	Statewide	ATC	FLH	OCTH
0–5 years old	-	-	-	-
6–12 years old	33	1	25	7
13 + years old	104	52	30	22

Gender

	Statewide	ATC	FLH	OCTH
Male	76	31	33	12
Female	61	22	22	17

Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	3	0	3	0
Asian	2	2	0	0
Black/African American	18	2	7	9
Native Hawaiian/Other Pacific Islander	0	0	0	0
White/Caucasian	112	49	45	18
Unknown	2	0	0	2
Ethnicity	Statewide	ATC	FLH	OCTH
Hispanic Origin	33	12	17	4

Custody Status

	Statewide	ATC	FLH	OCTH
Parent/Family	77	36	25	16
Child Welfare	56	16	30	10
ICPC	1	0	0	1
DCFS Youth Parole	1	1	0	0
Parental Custody / Probation	1	0	0	1
Unknown	1	0	0	1

Residential Facility and Psychiatric Hospital:

In Southern Nevada, DCFS Children’s Mental Health Services provides both residential and acute care for youth who are in need of this level of care. Below are the demographics for Desert Willow Treatment Center.

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

Number of Children Served

Acute	RTC
240	74

Age

The average age of children served by Desert Willow Acute was 15.74, and it was 16.16 for the Desert Willow Residential Treatment Center.

Age Group	Acute	RTC
6–12 years old	17	2
13 + years old	223	72

Gender

	Acute	RTC
Male	82	42
Female	157	32
Unknow	1	0

Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	2	0
Asian	6	0
Black/African American	38	21
Native Hawaiian/Other Pacific Islander	4	0
White/Caucasian	186	53
Unknown	4	0
Ethnicity	Acute	RTC
Hispanic Origin	103	10

Custody Status

	Acute	RTC
Parent/Family	220	38
Child Welfare	3	7
Voluntary Custody	0	2
Protective Custody	0	1
DCFS Youth Parole	2	7
Parental Custody / Probation	9	17
Unknown	6	2



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 6 identified below (and listed in order of prevalence) accounted for 44.70% of all primary presenting problems reported for admissions in FY2014.

- Suicide Attempt-Threat (10.26%)
- Depression (9.55%)
- Child Neglect Victim (8.98%)
- Parent-Child Problems (5.82%)
- Physical Aggression (5.38%)
- Oppositional (4.71%)

Suicide Attempt-Threat replaced Child Neglect Victim as the most prevalent presenting problem for this year.

Diagnosis

In FY 2014, 35.4 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- Both Male and Female
Neglect of Child
Disruptive Behavior Disorder NOS
Anxiety Disorder NOS
Anxiety Disorder NOS

Age Group 6-12.99

Female	Male
Neglect of Child	Disruptive Behavior Disorder NOS
Disruptive Behavior Disorder NOS	Attention-Deficit/Hyperactivity Disorder/Combined Type
Attention-Deficit/Hyperactivity Disorder/Combined Type	Neglect of Child
Anxiety Disorder NOS	Adjustment Disorder Mixed Disturbance of Emotions and Conduct

Age Group 13-17.99

Female	Male
Posttraumatic Stress Disorder	Mood Disorder NOS
Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features	Oppositional Defiant Disorder
Mood Disorder NOS	Posttraumatic Stress Disorder
Oppositional Defiant Disorder	Attention-Deficit/Hyperactivity Disorder/Combined Type
Depressive Disorder NOS	Attention-Deficit/Hyperactivity 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. There are eight subscales reflecting the client's functioning in that area. Subscale scores can range from Minimal or No Impairment (0) to Severe Impairment (30). Total CAFAS scores can range from 0 to 240, with higher total 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. Total PECFAS scores range from 0 to 210, with a higher total score indicating greater impairment.

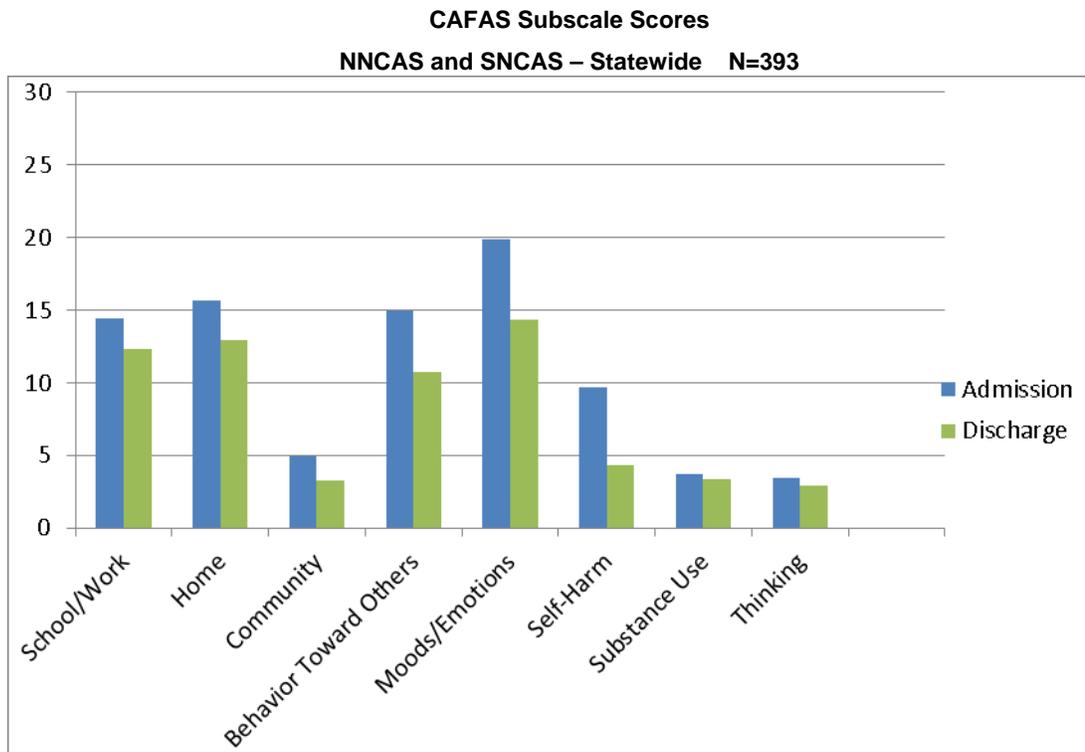
The CAFAS and the PECFAS are standardized instruments commonly used across child-serving agencies to guide treatment planning and as clinical outcome measures for individual clients and program evaluation (Hodges, 2005). The CAFAS and the PECFAS are used as outcome measures for DCFS Children's Mental Health. Only FY 2014 CAFAS and PECFAS scores were used in this Descriptive Summary.

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.

Outpatient and Children’s Clinical Services

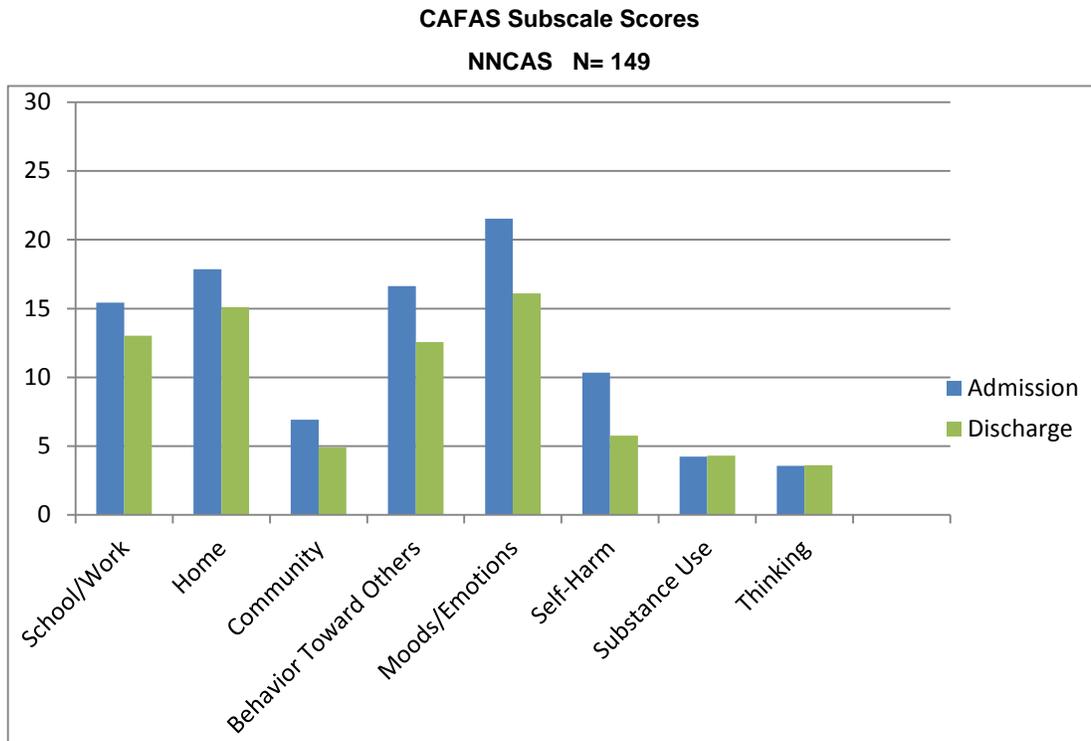
The graph below shows the admission and discharge CAFAS subscale scores for Outpatient (NNCAS) and Children’s Clinical Services (SNCAS) statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 223 (56.7%) of 393 qualified DCFS outpatient clients statewide. The mean total score for all clients at admission was 86.69 and the mean total score at discharge was 64.02. Clients were qualified if they had been discharged and if the CAFAS was rated at both admission and discharge.

Outpatient (NNCAS)

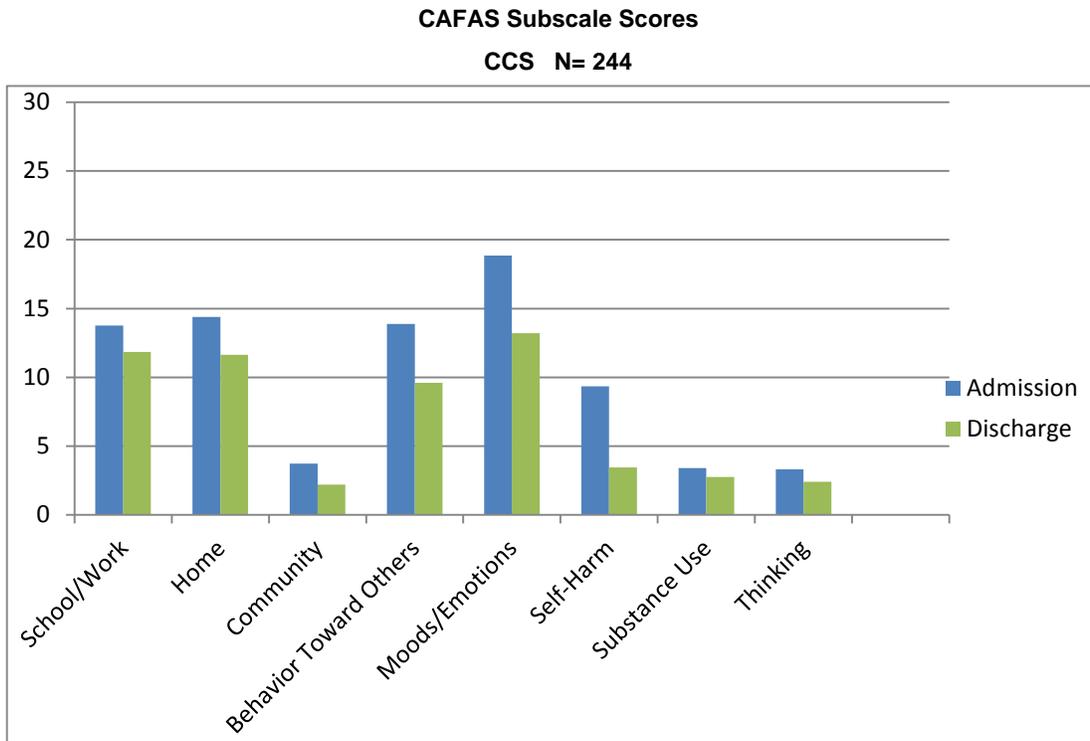
Admission and discharge CAFAS subscale scores for NNCAS Outpatient Services are depicted in the following graph.



Of those served, 84 (56.4%) of 149 qualified DCFS North Region Outpatient Services clients showed clinically significant improvement. The mean total score for all clients at admission was 96.51 and the mean total score at discharge was 75.37. Clients were qualified if they had been discharged and if they received CAFAS testing at admission and discharge.

Children's Clinical Services (SNCAS)

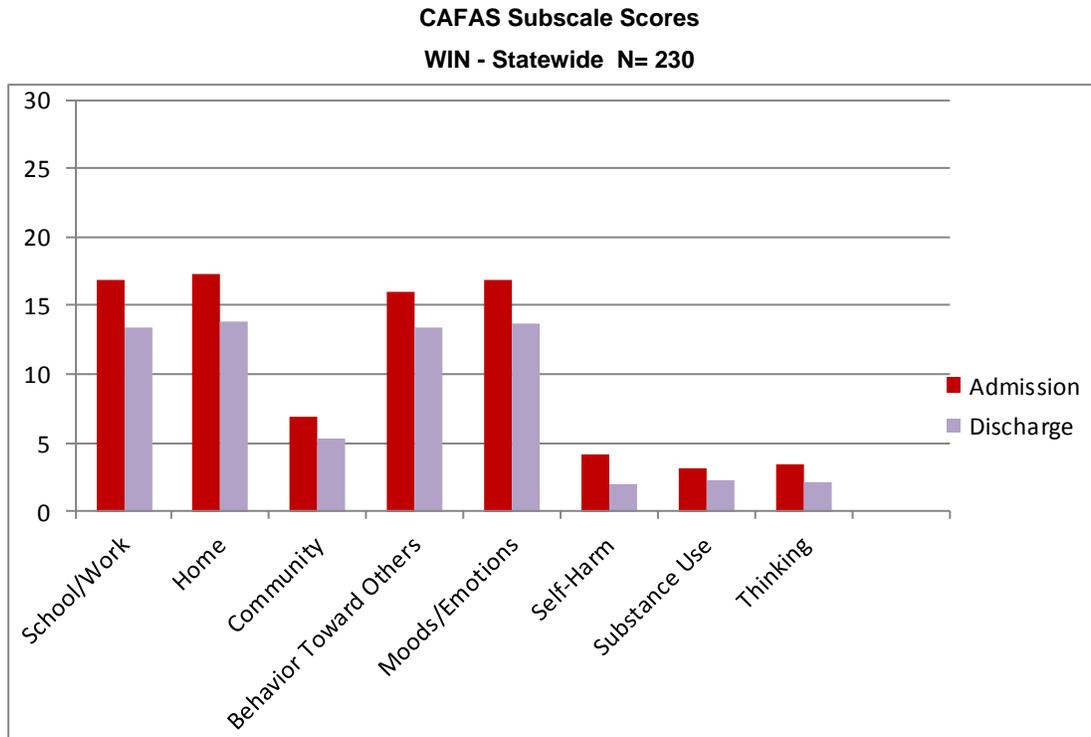
The following illustrates the admission and discharge CAFAS subscale scores for Children's Clinical Services (CCS).



Clinically significant improvement was observed for 139 (57.0%) of 244 qualified DCFS South Region Children's Clinical Services clients. The mean total score for all clients at admission was 80.70 and the mean total score at discharge was 57.09. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

WIN

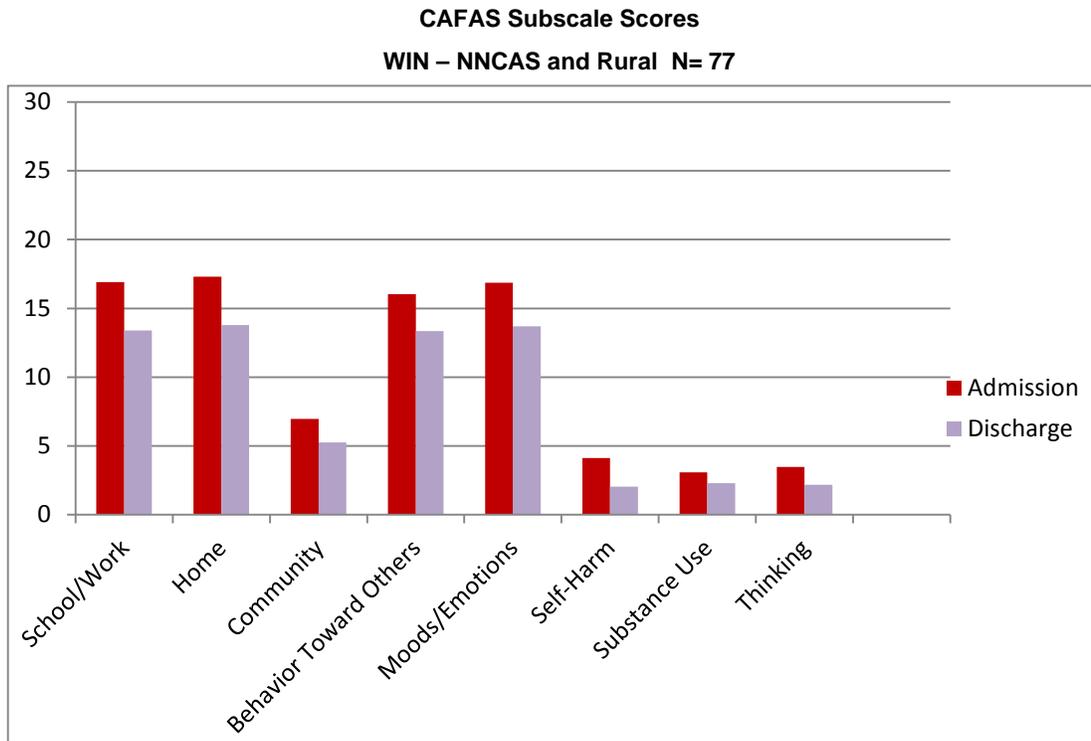
The graph below shows the admission and discharge CAFAS subscale scores for WIN statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 118 (51.3%) of 230 qualified DCFS Wraparound In Nevada (WIN) clients statewide. The mean total score for all clients at admission was 84.78 and the mean total score at discharge was 66.00. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

WIN-NNCAS and Rural

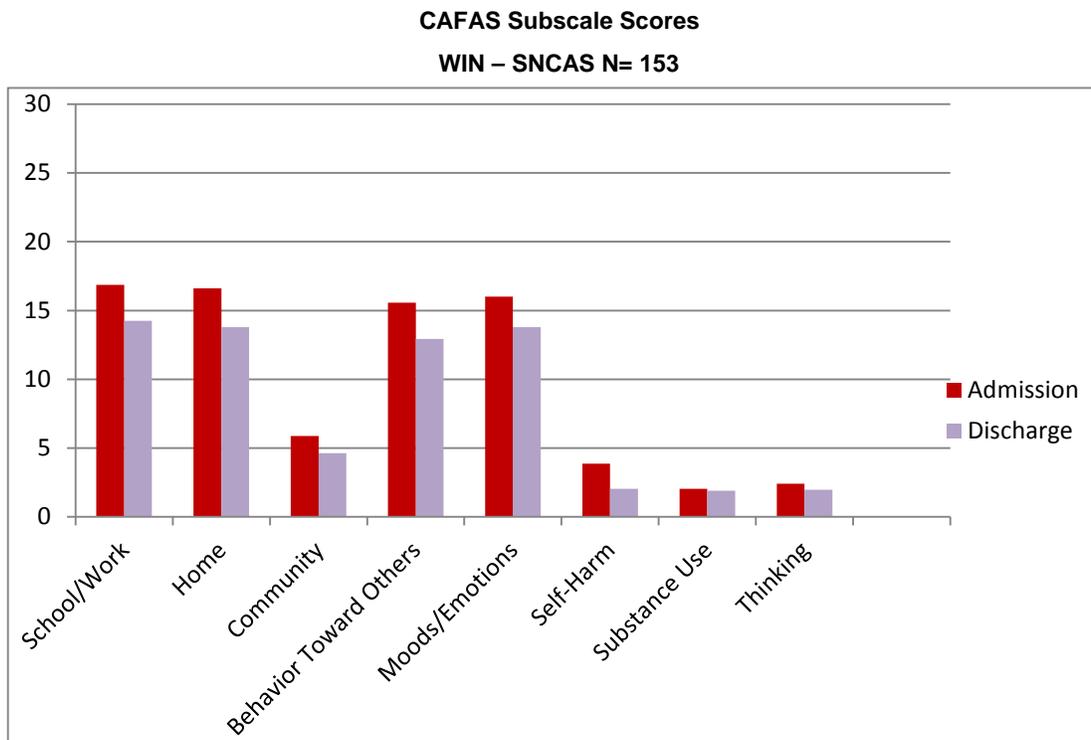
The following graph shows the admission and discharge CAFAS subscale scores for WIN at NNCAS and Rural.



As previously stated, clinically significant improvement on the CAFAS is indicated if the total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 49 (63.6%) of 77 qualified DCFS Northern and Rural Region WIN clients. The mean total score for all clients at admission was 95.84 and the mean total score at discharge was 67.40. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

WIN-SNCAS

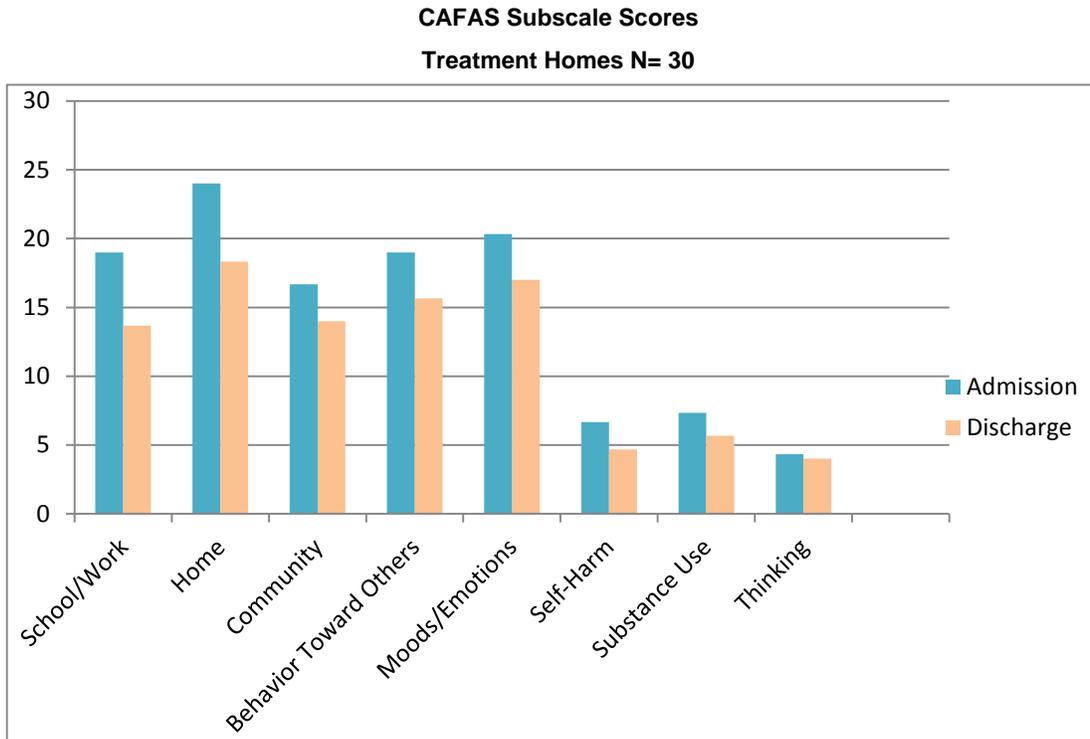
The admission and discharge CAFAS subscale scores for WIN at SNCAS are depicted below.



A child has improved by a clinically significant difference on the CAFAS if his/her score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 69 (45.1%) of 153 qualified DCFS Southern Region WIN clients. The mean score for all clients at admission was 79.22 and the mean score at discharge was 65.29. Clients were qualified if they had been discharged and if they were rated on the CAFAS at admission and discharge.

Treatment Homes

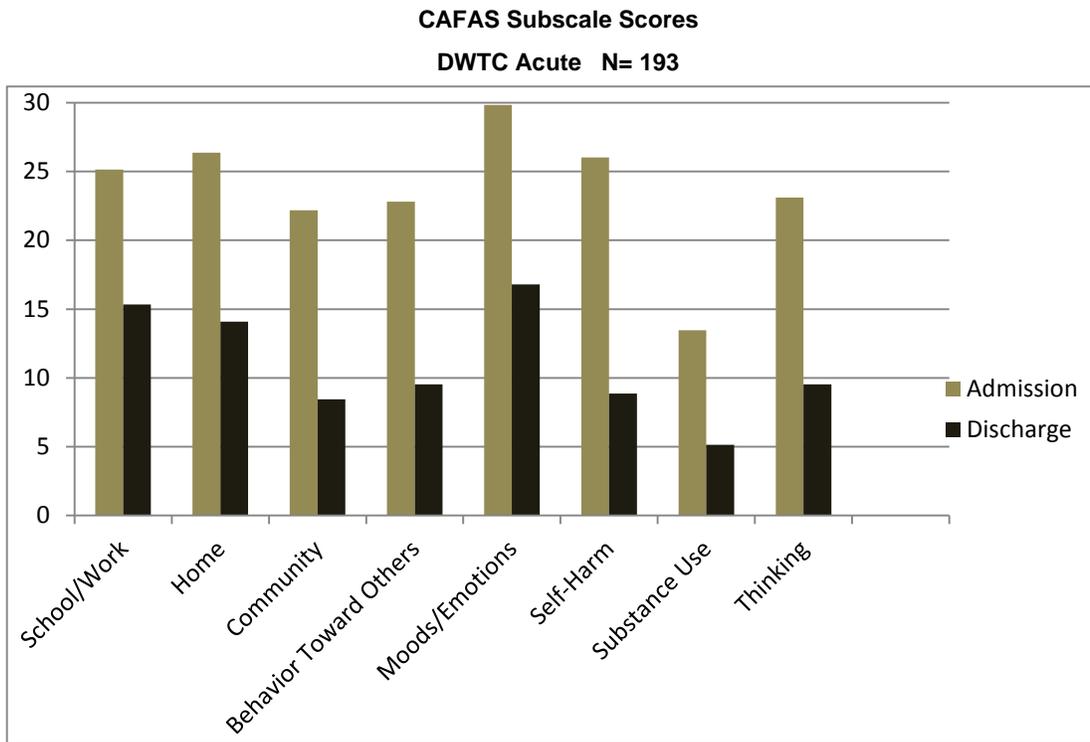
The graph below shows the admission and discharge CAFAS subscale scores for Treatment Homes Statewide.



Higher subscale scores indicate a greater level of impairment in functioning in that area. A child has improved by a clinically significant difference on the CAFAS if his/her total score at discharge is at least twenty (20) points lower than the initial testing at admission. Clinically significant improvement was observed for 18 (60.0%) of 30 qualified DCFS Residential Treatment Center clients. Facilities included in the analysis were Northern Region ATC, Northern Region Family Learning Homes, and Southern Region On-Campus Treatment Homes (OASIS). The mean total score for all clients at admission was 117.33 and the mean total score at discharge was 93. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

Desert Willow Treatment Center Acute Hospital

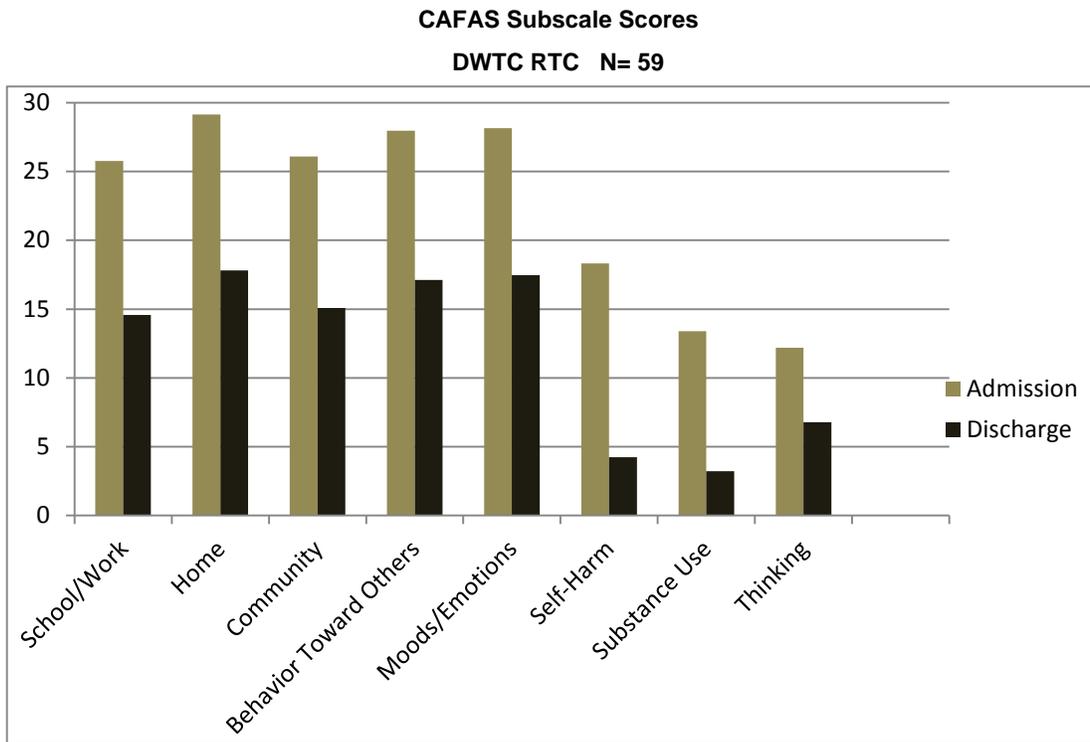
The admissions to discharge CAFAS subscale scores for Desert Willow Treatment Center Acute Hospital are depicted below.



184 (95.3%) of 193 qualified DCFS Desert Willow Treatment Center Acute clients showed clinically significant improvement in their overall functioning as measured by the CAFAS. The mean total score for all clients at admission was 188.91 and the mean total score at discharge was 87.72. Clients were qualified if they had been discharged and if they were rated on the CAFAS at admission and discharge

Desert Willow Treatment Center RTC

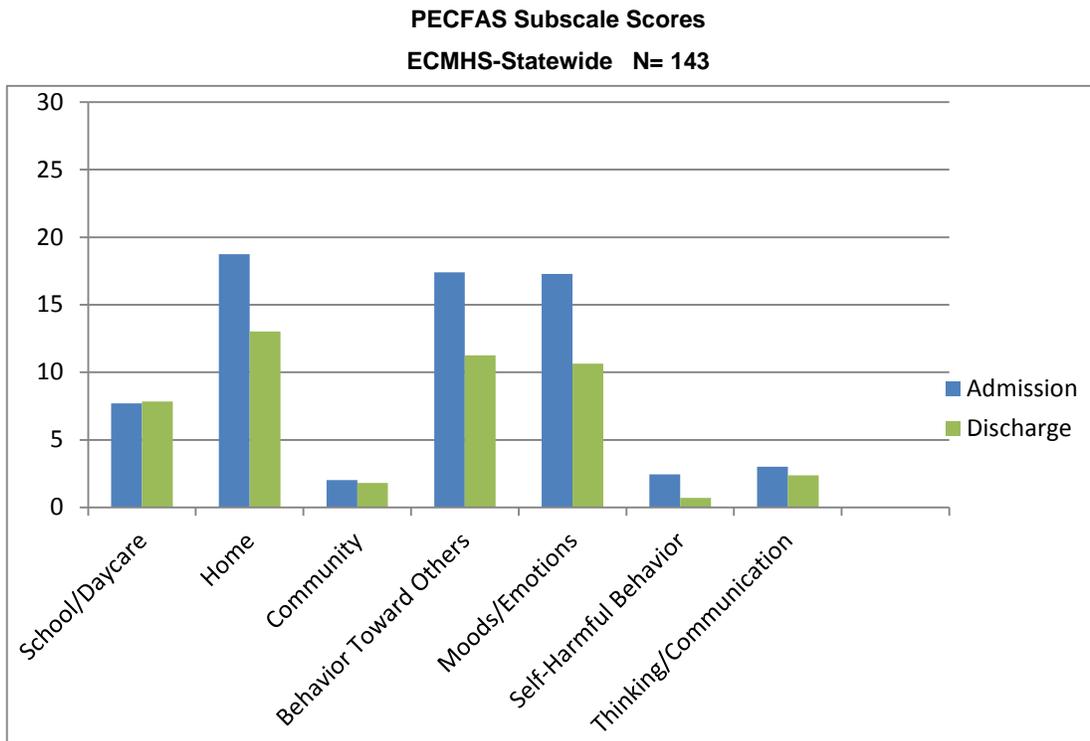
The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Residential Treatment Center.



Clinically significant improvement was observed for 56 (94.9%) of 59 qualified DCFS Desert Willow Residential Treatment Center (RTC) clients. The mean total score for all clients at admission was 181.02 and the mean total score at discharge was 96.27. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

Early Childhood Mental Health Services

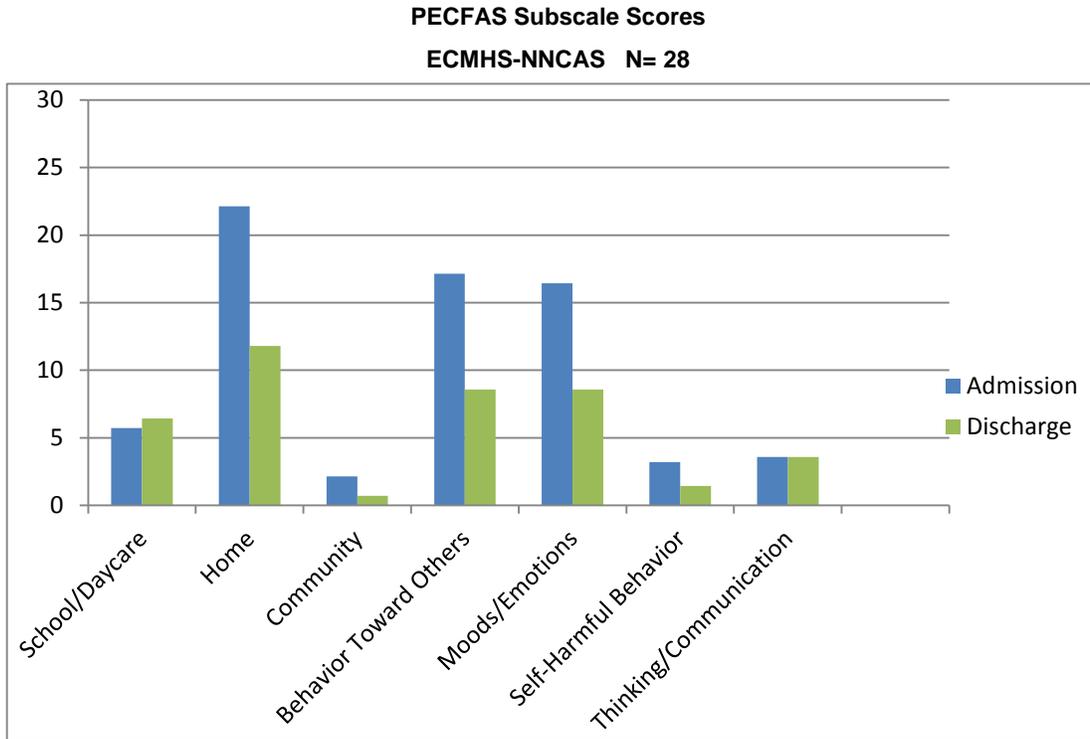
The graph below shows the admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services statewide.



Similar to the CAFAS, although with fewer subscales, a child has improved by a clinically significant difference on the PECFAS if his/her score at discharge is at least 17.5 points lower than the initial testing at admission. Clinically significant improvement was observed for 86 (60.1%) of 143 qualified DCFS Early Childhood clients statewide. The mean total score for all clients at admission was 68.6 and the mean total score at discharge was 47.62. Clients were qualified if they had been discharged and if they were rated on the PECFAS at admission and discharge.

Early Childhood Mental Health Services- NNCAS

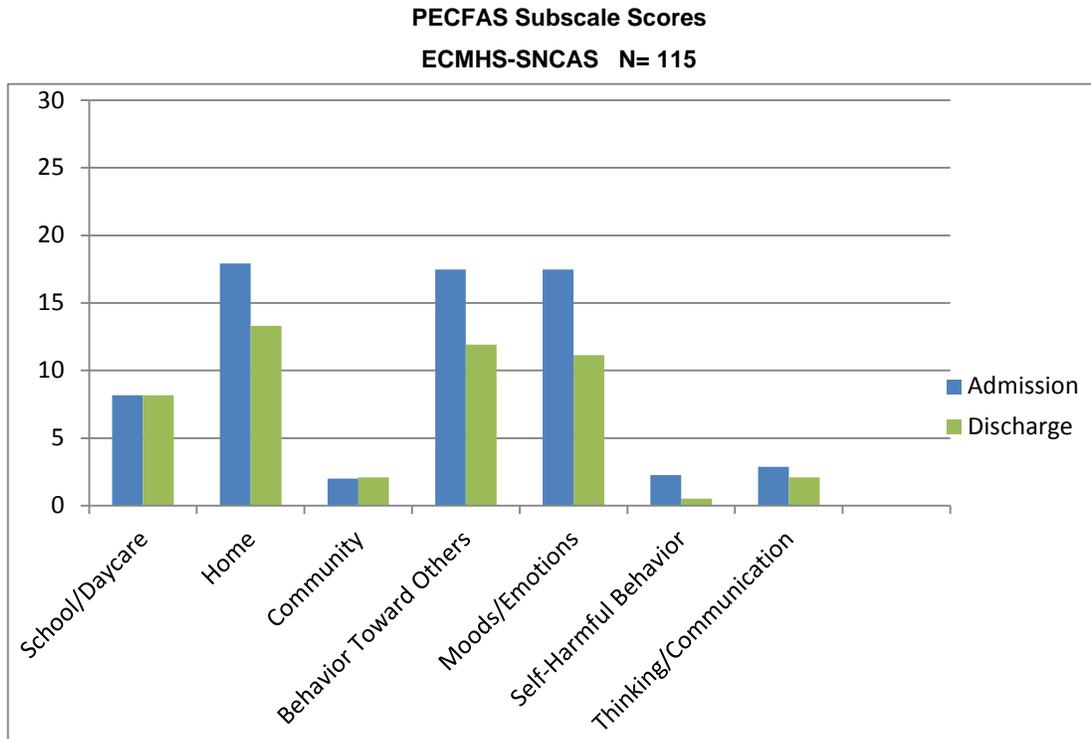
The graph below shows the admission to discharge for PECFAS subscale scores for Early Childhood Mental Health Services at NNCAS.



20 (71.4%) of 28 qualified DCFS Early Childhood clients in NNCAS had clinically significant improvement in total scores. The mean total score for all clients at admission was 70.36 and the mean total score at discharge was 41.07. Clients were qualified if they had been discharged and if they were rated on the PECFAS at both admission and discharge.

Early Childhood Mental Health Services- SNCAS

The Admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services at SNCAS are depicted below.



As previously noted, a child has improved by a clinically significant difference on the PECFAS if his/her score at discharge is at least 17.5 points lower than the initial testing at admission. For SNCAS ECMHS clients, clinically significant improvement was observed for 66 (57.4%) of 115 qualified discharged clients who had ratings at both admission and discharge. The mean total score at admission was 68.17 and the mean total score at discharge was 49.22.



Education and Juvenile Justice Outcomes

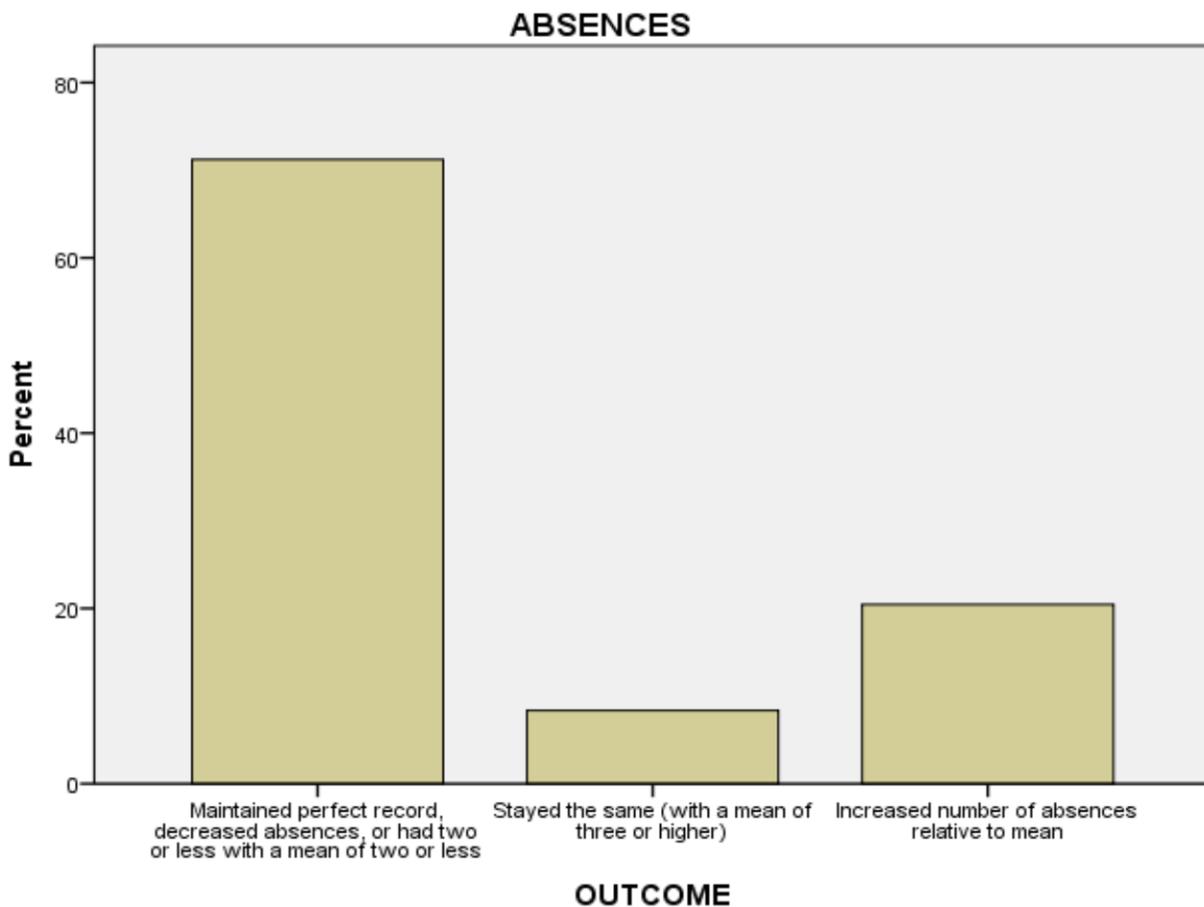
An analysis was conducted on client's absences, suspensions/expulsions, and arrests. Each client's absences, suspensions/expulsions, and arrests in the most recent period were compared to his or her average over at least two periods to see if these measures increased, decreased, or stayed the same. If 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).

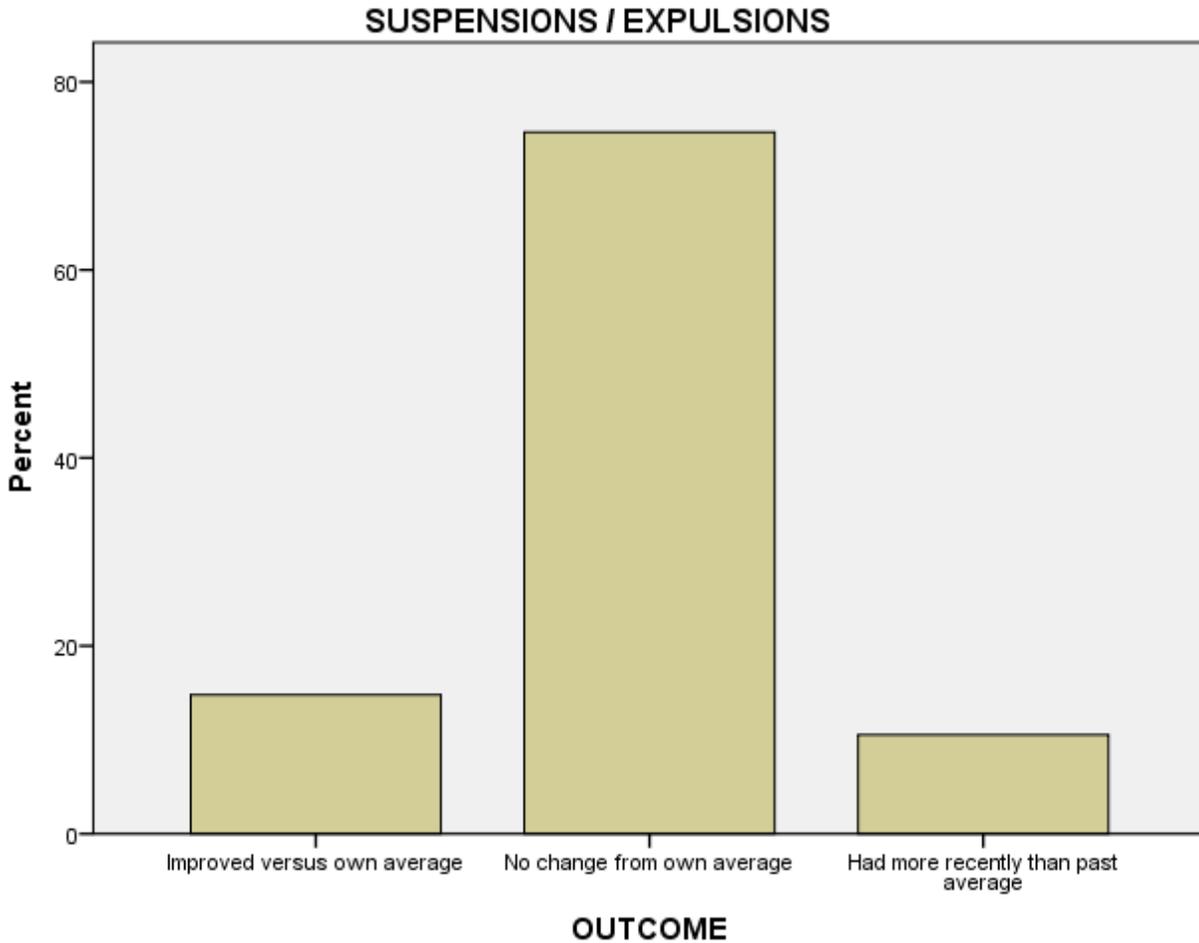
Absences: Statewide/All Programs



In FY2014, 827 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 589 (71.2%) of the clients.

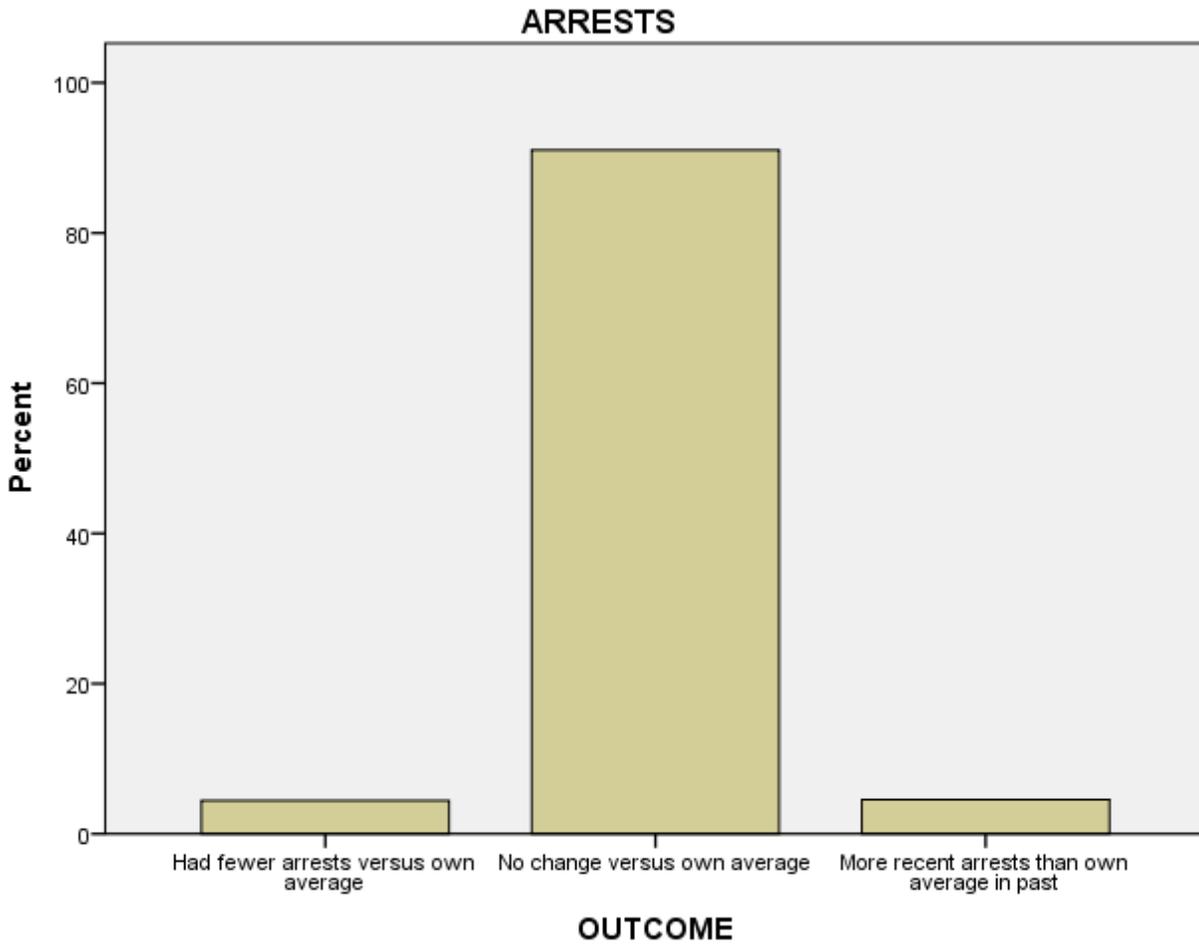
Absences remained the same at three or more compared with a mean of three or more for 69 (8.3%) clients. Absences increased to three or more and the client average was greater than two days for 169 (20.4%) of the clients.

Suspensions and Expulsions: Statewide/All Programs



In FY2014, 825 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 122 (14.8%) of the clients. For 616 (74.7%) of the clients, there was no change in suspensions and expulsions versus his or her own average. Suspensions and expulsions increased versus the client’s own average for 87 (10.5%) of the clients.

Arrests: Statewide/All Programs



In FY2014, 769 clients had arrest data entered for at least two periods from which an average could be constructed. Of the 769 clients with arrest data, 681 (77.1%) had no arrests current or prior. Arrests decreased or remained zero versus the client's own average for 700 (91.0%) of the clients and 34 (4.4%) of the clients had fewer arrests than the client's historical average. Arrests increased versus the client's own average for 35 (4.6%) for the clients.



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.

Children's residential programs offered through NNCAS and SNCAS also collect surveys at discharge from services. Like the community-based programs, parent/caregivers with children in residential and the children themselves (age 12 or older) are solicited to voluntarily participate in completing a survey.

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

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

Community Based Services Survey – Spring 2014	Youth % positive	Parent % positive	National Benchmark for Parent Response¹
Services are seen as accessible and convenient regarding location and scheduling	88	92.89	85.7%
Services are seen as satisfactory and helpful	81	93.84	86.1%
Clients get along better with family and friends and are functioning better in their daily life	78	76.92	66.3%
Clients feel they have a role in directing the course of their treatment	77	95.56	87.6%
Staff are respectful of client religion, culture and ethnicity	94	99.39	92.8%
Clients feel supported in their program and in their community	82	95.48	86.9%
Clients are better able to cope and are doing better in work or school	80	77.71	66.3%

Residential Discharge Services Survey	Youth % positive	Parent % positive
Services are seen as accessible and convenient regarding location and scheduling	92	100
Services are seen as satisfactory and helpful	80	95
Clients get along better with family and friends and are functioning better in their daily life	83	84
Clients feel they have a role in directing the course of their treatment	85	92
Staff are respectful of client religion, culture and ethnicity	84	100
Clients are better able to cope and are doing better in work or school	79	84

¹ 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/data/outcomes/urs/2012/nevada.pdf

MOBILE CRISIS RESPONSE TEAM ACTIVITIES

The Mobile Crisis Response Team (MCRT) is a new program serving youth in the greater Las Vegas area who are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization. Information gathered from mobile crisis response units in other US states indicates that in many cases when children and adolescents are in crisis, they can be safely de-escalated and stabilized in their home and community. This is a favorable outcome for families, preventing the unnecessary use of costly forms of mental health care such as hospitalization and allowing the family to remain united with their child while working through the current mental health crisis with the support of a crisis stabilization team.

Comments from satisfied parents and guardians of MCRT clients:

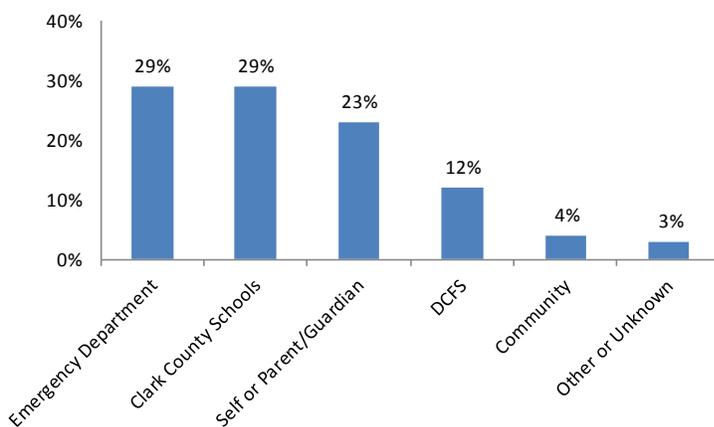
“The team was very professional. I appreciate all the help and support that has been given to my son.”

“I am very happy. They gave me phone numbers to call if I need help. My daughter is doing better and we are talking more.”

“This is the first time that my daughter was given the help that was needed.”

“My son is engaged and smiling. We are looking forward to continuing.”

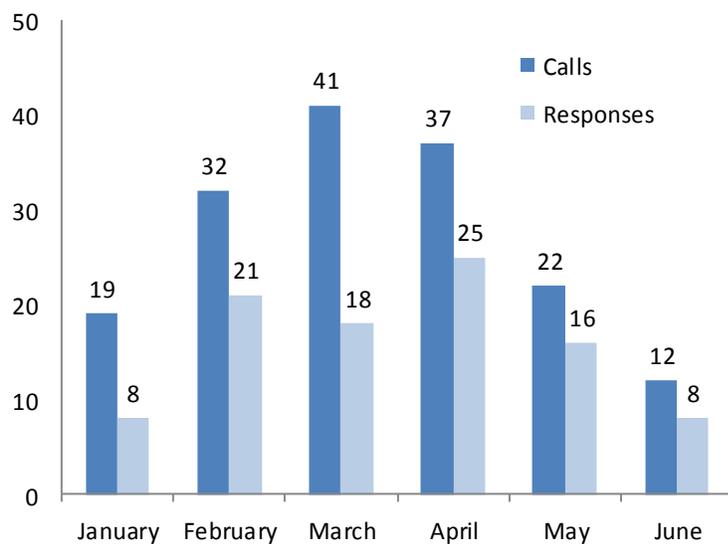
Referral Sources: UMC & Schools Refer Most



During early FY14, MCRT focused on creating partnerships in the community in order to build a referral stream for the crisis hotline. The main sources of referrals for MCRT have been University Medical Center (29% of calls) and Clark County School District (29% of calls; see left). Additionally during early FY14, MCRT focused on hiring staff,

including a clinical program manager, five mental health clinicians, and five psychiatric caseworkers. Later in FY14, four additional staff were hired to replace outgoing staff. MCRT offers Spanish-speaking support staff and several Spanish-speaking response team members; additionally, other MCRT staff can communicate with Spanish-speaking youth and families with the use of a translation service. Eight percent of youth served during FY14 were Spanish-speaking as their primary language and 11% were bilingual, and an even greater number of parents/caregivers were Spanish-speaking requiring the use of our Spanish-speaking staff and/or a translation service. Fifty-five percent of clients served during FY14 were female.

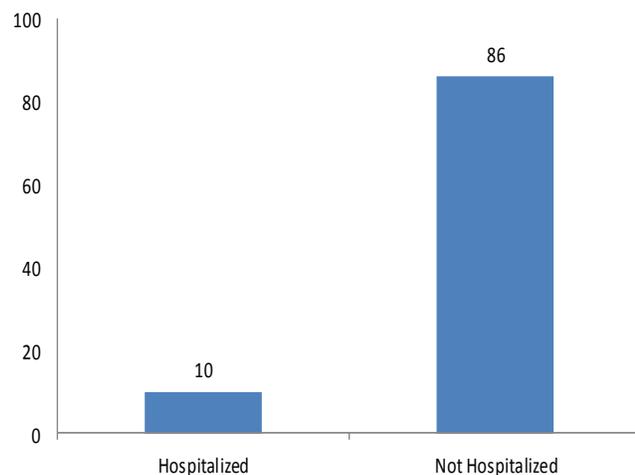
April Was Busiest Month



Beginning in January 2014, the MCRT operated a crisis hotline from 8am-7pm on weekdays. Staff offered information/support over the phone ($n = 20$ calls for information/support; 12% of calls) and triaged calls regarding potential crises occurring in the community. The greatest number of calls were received in March ($n = 41$), but the busiest month for the staff was in April with teams sent out into the community on 25 occasions to respond to youth in crisis.

When appropriate, MCRT staff responded to community locations where youth were in crisis ($n = 96$ calls; 59% of all calls during FY14). MCRT teams consisting of a mental health clinician and psychiatric caseworker met with the youth and his/her parent or guardian to assess the nature of the crisis, contract for safety and de-escalate the crisis when possible, and facilitate hospitalization if necessary (10 hospitalizations total during FY14; 90% hospital diversion rate; see right).

Hospital Diversion Rate = 90%



If appropriate, the MCRT team offered 30-45 days of intensive crisis stabilization services, where an MCRT team provides services 2-3 times per week while simultaneously initiating referrals to additional mental health and community resources. If stabilization services were not recommended or not desired by the family, MCRT referred the family back to their current provider or provided referrals to a new provider in order to ensure that the child and family's mental health service needs were met. During FY14, after the initial response and crisis de-escalation, 64% of families were referred for crisis stabilization with MCRT, 11% were referred to their current provider, 5% were referred to a new community provider and 4% were referred to a DCFS provider.

Parents and Guardians Provided High Consumer Satisfaction Ratings

MCRT policy during FY14 was that all families were offered an opportunity to complete a satisfaction survey after they were seen for the initial response visit. There was an overall response rate for the satisfaction survey of close to 45%, which is very good for a survey of this nature. Results of the survey indicate that overall, parents and guardians were very satisfied with the services they received from the MCRT teams. Notably, 100% of parents/guardians responded that "the response team was courteous and respectful" and "the response team was thorough and explained the program," while 92.9% of families stated that they were satisfied with the services overall. It appears that the MCRT staff are doing an excellent job at interfacing with families in a professional, compassionate manner that puts families at ease during a difficult time. One item was rated noticeably lower than the others: "I received the services I wanted from the response team" (65.4%). Comments from parents/guardians suggest that in most cases, parents who were dissatisfied with the type of services provided by MCRT were those who had wanted their child put into an out-of-home placement but were recommended stabilization services, or conversely, those for whom the outcome of crisis services had been hospitalization. However, although some families felt they did not receive the services they desired, respondents who disagreed with this statement were not more likely to say they were dissatisfied overall with MCRT. That is, it appears that even if families did not receive the services they thought they wanted, they still felt that MCRT's services were beneficial. See table (next page) for full survey results.

Parent/Caregiver Satisfaction Survey Question	% agreeing
The response team arrived in a timely manner.	96.5%
The response team was courteous and respectful.	100%
The response team was thorough and explained the program.	100%
The response team provided me with community resources.	96.3%
The response team was able to de-escalate the crisis.	80.8%*
If a friend were in need of similar help, I would recommend the team.	96.2%
I received the services I wanted from the response team.	65.4%
Overall, I am satisfied with the Mobile Crisis Response Team services.	92.9%

*Rate of agreement with this item may have been artificially lowered due to some families not considering themselves to be “in crisis” when the response team arrived, and therefore disagreeing with the question when asked.

MCRT in FY2015

Changes to the MCRT program for FY2015 include additional staff joining the Las Vegas team, expansion into the North with the opening of a Reno MCRT team, and extended hotline hours including weekend hours (Las Vegas: 8am-11pm weekdays, 12pm-11pm weekends; Reno: 7am-8pm weekdays, 9am-8pm weekends).