DCFS 2014 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 2013 for DCFS CMHS. It also includes the Performance and Quality Improvement Plan for 2014-2015 (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 March 31, 2014.

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, and 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. Please refer to the appended DCFS Children's Mental Health Services Performance and Quality Improvement Plan: 2014-2015 (Attachment A).

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 2865 children served by the DCFS Children's Mental Health Services in Fiscal Year 2013 (July 1, 2012 through June 30, 2013). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 2865 children served by DCFS programs, 2000 (69.8%) received services in Clark County and 865 (30.1%) were served in Washoe County/Rural.

Of all children served, 57.7% were 12 years of age or younger and 55.1% were male. Caucasian children accounted for 73.7% of all those served and African-American children 20.2%. Children of Hispanic origin came to 30.1%.

In FY13, 55.5% of the children admitted to mental health services statewide were in the custody of their parent or family, 42.5% were in Child Welfare custody, 1.1% were in the custody of their parent or family and on probation, 0.2% were in Youth Parole custody, and .7% were unknown.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY13. (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 from March 25 through May 3 (Spring) of 2013. 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 421 parents/caregivers and 225 youth receiving services. Spring survey results indicated a statewide average of 89.5% parent/caregiver positive rating and an 82.7% 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 2013 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 2013 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: SNCAS WIN, Oasis, and FLH. Program Managers submitted quality improvement plans to the PEU.

SNCAS WIN and FLH programs had a 60% or less positive response by parents to a participation in treatment item. These programs have a quality improvement plan to increase parent involvement in the treatment planning process including advocating and supporting the parent's right to be heard in Child and Family Team (CFT) meetings and be an active participant in treatment planning. FLH also had a 60% or less positive response by parents concerning their child's functioning in school. The plan to improve this includes addressing grades that are below average with school staff and parents and obtain tutoring. School personnel will also be invited to the CFT and behavior plans or changes to the IEP will be initiated if deemed beneficial and approved by the parent.

Oasis had a 60% or less positive responses by youths in the areas of Cultural Sensitivity, Positive Outcomes, and General Satisfaction. Oasis will address this by increasing training and focus on cultural sensitivity and hiring bilingual staff when possible. Oasis will continue efforts to engage youth prior to admission to build relationships and define expectations. When not prohibited by a court ordered admission, Oasis will try to screen out children who have clearly stated they do not wish to be there or who are clearly inappropriate for the program.

All Treatment Home programs developed improvement plans to increase completion of parent/caregiver and youth surveys. The current survey shows a statewide increase (14%) in parent/caregiver participation and a corresponding increase (9%) in youth participation when compared to the same survey conducted last year. Statewide there were a combined total of 546 agency parent/caregiver and youth survey participants. There was an overall statewide participation increase of (11.6%) from the 2012 survey. The efforts to increase participation in the survey at discharge continue.

DWTC, ATC, CCS, Outpatient, ECMHS, and NNCAS WIN 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. An employee survey is being considered for 2014.

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 whether treatment was 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. The checklists are integrated in Avatar; once being fully implemented by supervisors, the DCFS/PEU will collect Supervisor Checklists on a regular basis and produce a report for clinical staff as directed by policy.

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 2013, DWTC served 187 children in its acute care programs and 110 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 mandates. 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 part of 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 December 2, 3, and 4 2013, which recognized the accomplishments of DWTC leadership and staff. Renewal of DWTC's accreditation status retroactive to December 5, 2013 was received on February 4, 2014. The next Joint Commission survey will take place before 2017. DWTC is licensed and monitored regularly by Health Care Quality and Compliance (HCQC) under the Division of Public and Behavioral Health. The hospital is likewise monitored regularly by the Legislative Counsel Bureau (LCB).

Medication Administration and Management

In May 2012, 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 reviews Medication Administration Records on a monthly basis. DCFS/PEU conducts reviews at least annually. At Oasis the PEU conducts medication administration and management reviews monthly and provides consultation and training regarding this policy.

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 suggest report improvements/modifications and additional methods to ensure that data is entered as required.

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 ten principles of the Wraparound model. Out of the ten elements of the model, the only area needing improvement is the incorporation of natural and community supports as part of the team and wraparound plan. In 2013, 69 team meetings were observed in SNCAS WIN. The PEU is going to continue to partner with WIN management in order to increase the numbers of TOMS completed and to encourage increased use of this tool statewide. PEU staff are attending Child and Family Teams to provide increased opportunities for observation and to obtain additional data.

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 evaluates this program.

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 Behavioral Health 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. DCFS residential programs have been implementing measures to reduce seclusion and restraint such as informing staff concerning the impact of trauma and secondary trauma, reinforcing adherence to treatment models, adding a consultant at Oasis, and adding cameras to further increase accountability and safety for residents and staff. DCFS/PEU is also piloting an additional debriefing procedure following a seclusion and restraint.

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 as required.

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 including how to use it when evaluating their clientele and how to use it to help treatment planning. 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). Training is being developed to alert staff to changes in the diagnostic classifications with the advent of DSM-V. The Comprehensive Uniform Mental Health Assessment (CUMHA) was also updated in 2013 to more thoroughly screen for suicidal behavior, trauma, and substance use. Trainings will be provided on using this assessment.

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. DCFS/PEU is assisting managers and supervisors in reviewing these reports and facilitating closure of those cases that are inactive.

Mobile Crisis Response Team

In 2013, DCFS/PEU, program managers, community stakeholders and partners participated in planning and began to implement a DCFS Mobile Crisis Response Team in Southern Nevada. This service is provided by teams of qualified mental health

professionals to a child or youth and their family who are experiencing a psychiatric crisis. Crisis intervention services include follow-up and debriefing sessions to ensure stabilization and continuity of care coordination. Staff are highly trained in assessment and interventions related to children's mental health and have skills in de-escalation of a crisis situation. The team will work to reduce the impact of a crisis, mitigate the likelihood of future crisis incidents, and stabilize the family situation. Program goals are to eliminate unneeded hospitalizations, placement disruptions, risk of harm to self or others and provide a solution-focused, sensitive resolution to the crisis. DCFS/PEU will look at outcomes and evaluate the effectiveness of this program.

Trauma Informed Care

Beginning in 2012 and throughout 2013, DCFS/PEU has been coordinating efforts to educate foster parents and residential caregivers as well as other parts of the system of care concerning the effects of trauma on children and their families. A collaborative of individuals trained to present a curriculum obtained from the National Child Traumatic Stress Network has been educating individuals statewide. Trainings have been provided to nearly 700 persons across Nevada including members of the judiciary. Additional trainings are planned to create system awareness of the impact of secondary trauma on the workforce at all levels.

Family Management Program

DCFS/PEU along with clinical staff are beginning the implementation of a family management program, specifically Family Check Up/Everyday Parenting. This program's efficacy is supported by evidence and utilizes motivational interviewing techniques and a comprehensive assessment in order to guide the family through services and techniques that can improve their family's functioning. The initial focus will be on serving children ages 6 and above who are in their parents' custody and have exhibited primarily externalized behavioral challenges. DCFS/PEU will look at outcomes and evaluate the effectiveness of this program as well as methods to support sustainability.

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 and community stakeholders 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 2014 DCFS Performance and Quality Improvement 2013 Summary and are pleased to submit it on behalf of all of our dedicated DCFS Children's Mental Health Services program managers and staff.

MEDICAID REPORT 2014
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2013 SUMMARY

Approved by:

_____	_____
Katherine Mayhew, Clinical Program Planner 2 Planning and Evaluation Unit, DCFS	Date
_____	_____
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
_____	_____
Darryl McClintock, M.D. Medical Director, Northern Nevada Child and Adolescent Services, DCFS	Date
_____	_____
Amber Howell, Administrator Division of Child and Family Services	Date

MEDICAID REPORT 2014
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2013 SUMMARY

ATTACHMENT INDEX

ATTACHMENT A

DCFS Children's Mental Health Services
Performance and Quality Improvement Plan
2014-2015

DIVISION OF CHILD AND FAMILY SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
PERFORMANCE AND QUALITY IMPROVEMENT PLAN: 2014-15

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	This domain features systematic child, family and stakeholder feedback regarding the quality of services provided with

QUALITY

specific focus on such service attributes as accessibility, general satisfaction, treatment participation, treatment information, environmental safety, cultural sensitivity, adequacy of education, social connectedness, and positive treatment outcomes.
Employee feedback is another component of service quality that focuses on employee satisfaction, and systemic issues such as communication in the work place, adequate resources, staff support, and training.

PLAN FUNCTIONAL DETAILS

SERVICE COMPLIANCE

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

		SC 1.2.3 Work together with identified program area personnel in designing PQI processes for addressing selected areas found in need of remediation. **SC 1.2.4** Work with identified program area personnel in developing agreed upon plan for re-assessment of remediated areas. **SC 1.2.5** Be available to the Deputy Administrator to respond to Legislative requests for data **SC 1.2.6** Develop annual quality assurance plans to report to Medicaid.
SC 2. CMHS programs will be in compliance with applicable federal, state and Division policy, regulation and standards of care.	**SC 2.1** Review and update/revise program policies on service delivery for compliance with standards of care	**SC 2.1.1** Program policy review and update occurs as a standard component of the CMHS Program Managers administrative group. A list of needed policies and policies requiring revision will be developed and prioritized.
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SC 3. Ensure that clients are informed of their rights and responsibilities at the onset of service contact including the right to file grievance or complaint and the right to receive a timely response toward resolution of the complaints.	**SC 3.1** Complaint/Grievance reports are reviewed and the nature of grievances summarized.	**SC 3.1.1** Programs will follow established procedures in forwarding Complaint/Grievance report information to PEU for data capture **SC 3.1.2** In accordance with Consumer Complaint Policy and Procedures, PEU develops and maintains a database for Complaint/Grievance report data **SC 3.1.3** A report summarizing Complaint/Grievance particulars will be compiled, composed and disseminated annually by PEU
SC 4. Ensure that the services to children and their families are provided in healthy and safe environments.	**SC 4.1** DCFS services are provided in locations where health and safety of the occupants is monitored by the members of the Safety and Security Committee.	**SC 4.1.1** Safety and Security Committee in each site is responsible for informing/alerting staff and clients of any safety concerns and emergency situation by telephone/e-mails so that the

		safety and security of the occupants are ensured. **SC 4.1.2** Physical and environmental safety concerns are reported and tracked by facility Supervisors who provide ongoing inspection of the physical plants and conduct all the necessary drills and provide competency based training for health and safety practices. **SC 4.1.3** PEU developed and currently utilizes a monthly Physical Plant Checklist for Oasis On-Campus Treatment Home. Expand to other DCFS residential programs when feasible.
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SC 5 DCFS CMHS meet or exceed accepted standards of practice documentation	**SC 5.1** CMHS program supervisors will stress standards of practice case documentation by using the Supervisor Checklist when supervising direct service staff	**SC 5.1.1** The Supervisor Checklist Workgroup revised the direct services and targeted case management Supervisor Checklists and developed a business process for using the checklists. **SC 5.1.2** Checklist items are integrated into the Avatar IMS for ease of use. Qualitative items will be reviewed by supervisors. PEU will compile report. Assist in training.
SC 6. Targeted case management services will adhere to wraparound process principles	**SC 6.1** Evaluate wraparound service delivery model fidelity using the Wraparound Fidelity Index (WFI) evaluation instrument	**SC 6.1.1 1.** The PEU will partner with program managers and supervisors to plan for WFI implementation. **SC 6.1.1.2** Interview service youth, parent/caregivers and Wraparound facilitators by utilizing the WFI. **SC 6.1.1.3** Analysis of data for feedback on strengths and areas

	SC 6.2 Evaluate the wraparound Child and Family Team process using the Team Observation Measure. PEU to also observe teams and complete TOMS.	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 for both administrative and clinical supervision if supervisee provides clinical services to clients.	**SC 7.1** Supervisors will meet with each staff member at least monthly for supervision. Probationary employees and clinical interns at least weekly.	**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 using Physical Plant Checklist. **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. PEU will assist in closing inactive cases. **SEF 2.1.2** Establish a data clean-up committee and related data clean-up process. PEU will collaborate with program managers to improve data accuracy and timeliness.
SEF 3. Support on-going CMHS staff professional competency and development	**SEF 3.1** DCFS practitioners will be proficient when using CMHS standardized assessment tools	**SEF 3.1.1** CMHS direct service staff are trained in all standardized assessment tools used by CMHS
PLAN GOAL	**PLAN OBJECTIVE**	**PLAN ACTIVITIES**
SEF 4. Monitor adequacy of major or systemic factors affecting DCFS capacity to deliver quality CMHS services	**SEF 4.1** Desert Willow Treatment Center (DWTC) will maintain its Joint Commission certification	**SEF 4.1.1** DWTC will abide by all Joint Commission regulations and requirements in the conduct of its day to day operations **SEF 4.1.2** DWTC will prepare for and successfully pass its annual Joint Commission recertification assessment
SEF 5 Recommend actions that serve to improve standards of care, enhance service delivery and improve service outcomes	**SEF 5.1** Conduct quality assurance activities in collaboration with CMHS Program Supervisors **SEF 5.2** CMHS supervisors will work with direct service staff to	**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

	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

DIVISION OF CHILD AND FAMILY SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
PERFORMANCE AND QUALITY IMPROVEMENT PLAN: 2014-15

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 staff satisfaction survey to obtain feedback regarding workplace strengths and challenges as requested.

ATTACHMENT B

Descriptive Summary of
Children's Mental Health Services
SFY13

DESCRIPTIVE SUMMARY OF CHILDREN'S MENTAL HEALTH SERVICES Fiscal Year 2013

CONTENTS

INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2013, from July 1, 2012 through June 30, 2013. The FY 2013 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 2865 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
2865	865	2000

Admissions

Statewide	NNCAS	SNCAS
1630	478	1152

Discharges

Statewide	NNCAS	SNCAS
1591	460	1131

SURVEY COMMENT FROM A SATISFIED PARENT

Learning coping skills on a weekly basis.
Open communication is an everyday learning experience.

CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

The average age of children served Statewide was 10.94, NNCAS was 11.60 and SNCAS was 10.65.

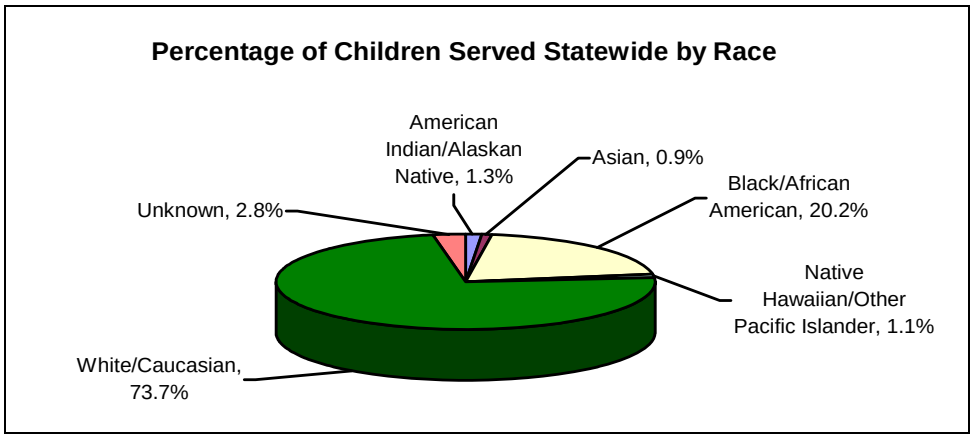
Age Group	Statewide	NNCAS	SNCAS
0–5 years old	679 (23.7%)	131 (15.1%)	548 (27.4%)
6–12 years old	974 (34.0%)	344 (39.8%)	630 (31.5%)
13–17 years old	1050 (36.6%)	336 (38.8%)	714 (35.7%)
18+ years old	162 (5.7%)	54 (6.2%)	108 (5.4%)

Gender

	Statewide	NNCAS	SNCAS
Male	1578 (55.1%)	468 (54.1%)	1110 (55.5%)
Female	1287 (44.9%)	397 (45.9%)	890 (44.5%)

Race and Ethnicity

Race	Statewide	NNCAS	SNCAS
American Indian/Alaskan Native	38 (1.3%)	23 (2.7%)	15 (0.8%)
Asian	25 (0.9%)	1 (0.1%)	24 (1.2%)
Black/African American	579 (20.2%)	73 (8.4%)	506 (25.3%)
Native Hawaiian/Other Pacific Islander	31 (1.1%)	12 (1.4%)	19 (1.0%)
White/Caucasian	2111 (73.7%)	746 (86.2%)	1365 (68.3%)
Unknown	81 (2.8%)	10 (1.2%)	71 (3.6%)
Ethnicity	**Statewide**	**NNCAS**	**SNCAS**
Hispanic Origin	861 (30.1%)	209 (24.2%)	652 (32.6%)



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	209 (24.2%)	32.6%	652 (32.6%)	37.1%

Custody Status

	Statewide	NNCAS	SNCAS
Parent/Family	1590 (55.5%)	496 (57.3%)	1094 (54.7%)
Child Welfare	1217 (42.5%)	366 (42.3%)	851 (42.6%)
DCFS Youth Parole	7 (0.2%)	1 (0.1%)	6 (0.3%)
Parental Custody on Probation	31 (1.1%)	2 (0.2%)	29 (1.5%)
Unknown	20 (0.7%)	0 (0.0%)	20 (1.0%)

Severe Emotional Disturbance Status

Statewide	NNCAS	SNCAS
2408 (84.0%)	792 (91.6%)	1616 (80.8%)

[1] 2012 Nevada KIDS COUNT County Profiles • http://kidscount.unlv.edu/countyprofiles/2012/direct.html, 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
1211	400 (33.0%)	811 (67.0%)

Age

The average age of children served Statewide was 14.2, OPS was 13.9, and CCS was 14.4.

Age Group	Statewide	OPS	CCS
0–5 years old	4 (0.3%)	0 (0.0%)	4 (0.5%)
6–12 years old	393 (32.5%)	145 (36.3%)	248 (30.6%)
13–17 years old	708 (58.5%)	224 (56.0%)	484 (59.7%)
18+ years old	106 (8.8%)	31 (7.8%)	75 (9.2%)

Gender

	Statewide	OPS	CCS
Male	624 (51.5%)	204 (51.0%)	420 (51.8%)
Female	587 (48.5%)	196 (49.0%)	391 (48.2%)

Race and Ethnicity

Race	Statewide	OPS	CCS
American Indian/Alaskan Native	9 (0.7%)	4 (1.0%)	5 (0.6%)
Asian	17 (1.4%)	1 (0.3%)	16 (2.0%)
Black/African American	163 (13.5%)	29 (7.3%)	134 (16.5%)
Native Hawaiian/Other Pacific Islander	16 (1.3%)	7 (1.8%)	9 (1.1%)
White/Caucasian	979 (80.8%)	358 (89.5%)	621 (76.6%)
Unknown	27 (2.2%)	1 (0.3%)	26 (3.2%)
Ethnicity	**Statewide**	**OPS**	**CCS**
Hispanic Origin	462 (38.2%)	119 (29.8%)	343 (42.3%)

Custody Status

	Statewide	OPS	CCS
Parent/Family	993 (82.0%)	321 (80.3%)	672 (82.9%)
Child Welfare	204 (16.8%)	78 (19.5%)	126 (15.5%)
DCFS Youth Parole	2 (0.2%)	1 (0.3%)	1 (0.1%)
Parental Custody on Probation	10 (0.8%)	0 (0.0%)	10 (1.2%)
Unknown	2 (0.2%)	0 (0.0%)	2 (0.2%)

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

Number of Children Served

Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
930	239 (25.7%)	691 (74.3%)

Age

The average age of children served by ECMHS Statewide was 5.4, ECMHS (NNCAS) was 6.1, and ECMHS (SNCAS) was 5.2.

Age Group	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
0–5 years old	579 (62.3%)	120 (50.2%)	459 (66.4%)
6–12 years old	350 (37.6%)	118 (49.4%)	232 (33.6%)
13–17 years old	1 (0.1%)	1 (0.4%)	0 (0.0%)

Gender

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Male	539 (58.0%)	133 (55.6%)	406 (58.8%)
Female	391 (42.0%)	106 (44.4%)	285 (41.2%)

Race and Ethnicity

Race	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
American Indian/Alaskan Native	7 (0.8%)	5 (2.1%)	2 (0.3%)
Asian	2 (0.2%)	0 (0.0%)	2 (0.3%)
Black/African American	223 (24.0%)	26 (10.9%)	197 (28.5%)
Native Hawaiian/Other Pacific Islander	11 (1.2%)	4 (1.7%)	7 (1.0%)
White/Caucasian	660 (71.0%)	204 (85.4%)	456 (66.0%)
Unknown	27 (2.9%)	0 (0.0%)	27 (3.6%)
Ethnicity	**Statewide**	**ECMHS (NNCAS)**	**ECMHS (SNCAS)**
Hispanic Origin	256 (27.5%)	56 (23.4%)	200 (28.9%)

Custody Status

	Statewide	ECMHS (NNCAS)	ECMHS (SNCAS)
Parent/Family	373 (40.1%)	105 (43.9%)	268 (38.8%)
Child Welfare	552 (59.4%)	134 (56.1%)	418 (60.5%)
Unknown	5 (0.5%)	0 (0.0%)	5 (0.7%)

SURVEY COMMENT FROM A SATISFIED YOUTH

I'm able to talk to mom better—better handle situations.
I receive help to handle things when I'm struggling.

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
652	195 (29.9%)	117 (17.9%)	340 (52.2%)

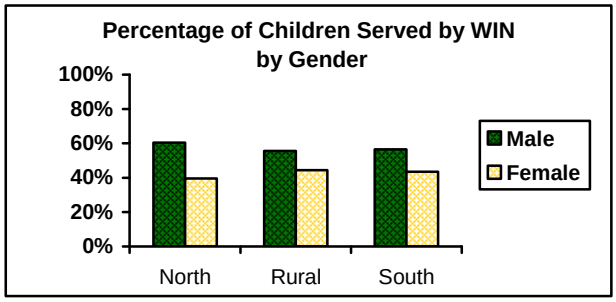
Age

The average age of children served Statewide was 13.2, North was 14.3, Rural was 11.7, and South was 13.1.

Age Group	Statewide	North	Rural	South
0–5 years old	18 (2.8%)	3 (1.5%)	14 (12.0%)	1 (0.3%)
6–12 years old	280 (42.9%)	56 (28.7%)	55 (47.0%)	169 (49.7%)
13–17 years old	317 (48.6%)	118 (60.5%)	39 (33.3%)	160 (47.1%)
18+ years old	37 (5.7%)	18 (9.2%)	9 (7.7%)	10 (2.9%)

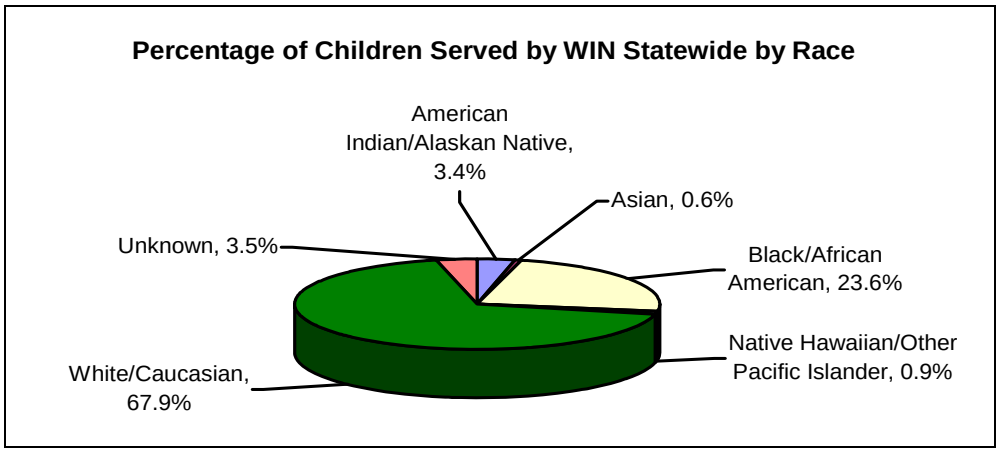
Gender

	Statewide	North	Rural	South
Male	375 (57.5%)	118 (60.5%)	65 (55.6%)	192 (56.5%)
Female	277 (42.5%)	77 (39.5%)	52 (44.4%)	148 (43.5%)



Race and Ethnicity

Race	Statewide	North	Rural	South
American Indian/Alaskan Native	22 (3.4%)	6 (3.1%)	8 (6.8%)	8 (2.4%)
Asian	4 (0.6%)	0 (0.0%)	0 (0.0%)	4 (1.2%)
Black/African American	154 (23.6%)	24 (12.3%)	5 (4.3%)	125 (36.8%)
Native Hawaiian/Other Pacific Islander	6 (0.9%)	2 (1.0%)	0 (0.0%)	4 (1.2%)
White/Caucasian	443 (67.9%)	158 (81.0%)	100 (85.5%)	185 (54.4%)
Unknown	23 (3.5%)	5 (2.6%)	4 (3.4%)	14 (4.1%)
Ethnicity	**Statewide**	**North**	**Rural**	**South**
Hispanic Origin	132 (20.2%)	47 (24.1%)	11 (9.4%)	74 (21.8%)



Custody Status

	Statewide	North	Rural	South
Parent/Family	155 (23.8%)	74 (37.9%)	43 (36.8%)	38 (11.2%)
Child Welfare	494 (75.8%)	119 (61.0%)	74 (63.2%)	301 (88.5%)
Parental Custody on Probation	3 (0.5%)	2 (1.0%)	0 (0.0%)	1 (0.3%)

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
144	54 (37.5%)	58 (40.3%)	32 (22.2%)

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

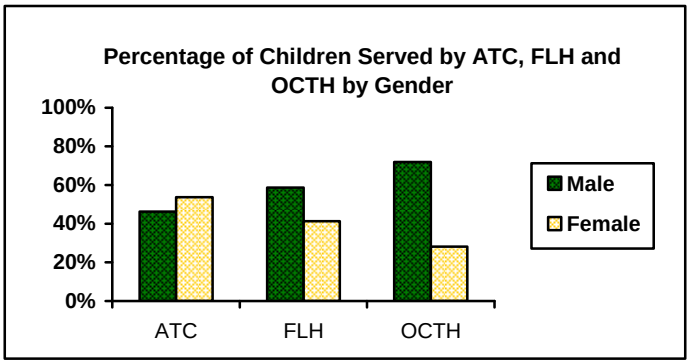
Age

The average age of children served Statewide was 14.3, ATC was 16.1, FLH was 13.1, and OCTH was 13.7.

Age Group	Statewide	ATC	FLH	OCTH
0–5 years old	1 (0.7%)	0 (0.0%)	1 (1.7%)	0 (0.0%)
6–12 years old	40 (27.8%)	0 (0.0%)	26 (44.8%)	14 (43.8%)
13–17 years old	94 (65.3%)	48 (88.9%)	30 (51.7%)	16 (50.0%)
18+ years old	9 (6.3%)	6 (11.1%)	1 (1.7%)	2 (6.3%)

Gender

	Statewide	ATC	FLH	OCTH
Male	82 (56.9%)	25 (46.3%)	34 (58.6%)	23 (71.9%)
Female	62 (43.1%)	29 (53.7%)	24 (41.4%)	9 (28.1%)



Race and Ethnicity

Race	Statewide	ATC	FLH	OCTH
American Indian/Alaskan Native	2 (1.4%)	0 (0.0%)	1 (1.7%)	1 (3.1%)
Asian	1 (0.7%)	0 (0.0%)	0 (0.0%)	1 (3.1%)
Black/African American	18 (12.5%)	3 (5.6%)	7 (12.1%)	8 (25.0%)
Native Hawaiian/Other Pacific Islander	1 (0.7%)	0 (0.0%)	1 (1.7%)	0 (0.0%)
White/Caucasian	121 (84.0%)	51 (94.4%)	49 (84.5%)	21 (65.6%)
Unknown	1 (0.7%)	0 (0.0%)	0 (0.0%)	1 (3.1%)
Ethnicity	**Statewide**	**ATC**	**FLH**	**OCTH**
Hispanic Origin	40 (27.8%)	16 (29.6%)	20 (34.5%)	4 (12.5%)

Custody Status

	Statewide	ATC	FLH	OCTH
Parent/Family	78 (54.2%)	36 (66.7%)	29 (50.0%)	13 (40.6%)
Child Welfare	63 (43.8%)	17 (31.5%)	29 (50.0%)	17 (53.1%)
DCFS Youth Parole	1 (0.7%)	1 (1.9%)	0 (0.0%)	0 (0.0%)
Unknown	2 (1.4%)	0 (0.0%)	0 (0.0%)	2 (6.3%)

SURVEY COMMENT FROM A SATISFIED PARENT

My WIN worker is the glue that keeps us together and is good at getting our needs done.

Residential Facility and Psychiatric Hospital

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

Number of Children Served

Acute	RTC
187	110

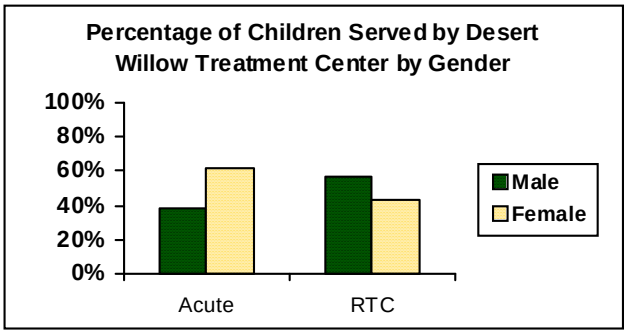
Age

The average age of children served by Desert Willow Acute was 15.8, and it was 16.2 for the Desert Willow Residential Treatment Center.

Age Group	Acute	RTC
6–12 years old	11 (5.9%)	4 (3.6%)
13–17 years old	162 (86.6%)	92 (83.6%)
18+ years old	14 (7.5%)	14 (12.7%)

Gender

	Acute	RTC
Male	72 (38.5%)	62 (56.4%)
Female	115 (61.5%)	48 (43.6%)



Race and Ethnicity

Race	Acute	RTC
American Indian/Alaskan Native	1 (0.5%)	0 (0.0%)
Asian	2 (1.1%)	2 (1.8%)
Black/African American	35 (18.7%)	28 (25.5%)
Native Hawaiian/Other Pacific Islander	1 (0.5%)	1 (0.9%)
White/Caucasian	146 (78.1%)	78 (70.9%)
Unknown	2 (1.1%)	1 (0.9%)
Ethnicity	**Acute**	**RTC**
Hispanic Origin	72 (38.5%)	23 (20.9%)

Custody Status

	Acute	RTC
Parent/Family	177 (94.7%)	84 (76.4%)
Child Welfare	6 (3.2%)	5 (4.5%)
DCFS Youth Parole	2 (1.1%)	3 (2.7%)
Parental Custody on Probation	2 (1.1%)	18 (16.4%)

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 41% of all primary presenting problems reported for admissions in FY2013.

- Child Neglect Victim (16.1%)
- Suicide Attempt-Threat (11.9%)
- Depression (4.2%)
- Attention Deficit Problems (3.3%)
- Adjustment Problems (2.8%)
- Anxiety (2.7%)

Child neglect was the most prevalent presenting problem for the third consecutive year. The top six presenting problems are the same as in FY 2012.

Diagnosis

In FY 2013, 37.6 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	Adjustment Disorder	Disruptive Behavior Disorder NOS
Adjustment Disorder	Disruptive Behavior Disorder NOS	Anxiety Disorder NOS
Anxiety Disorder NOS	Anxiety Disorder NOS	Adjustment Disorder

Age Group 6-12.99

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

Age Group 18+

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

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

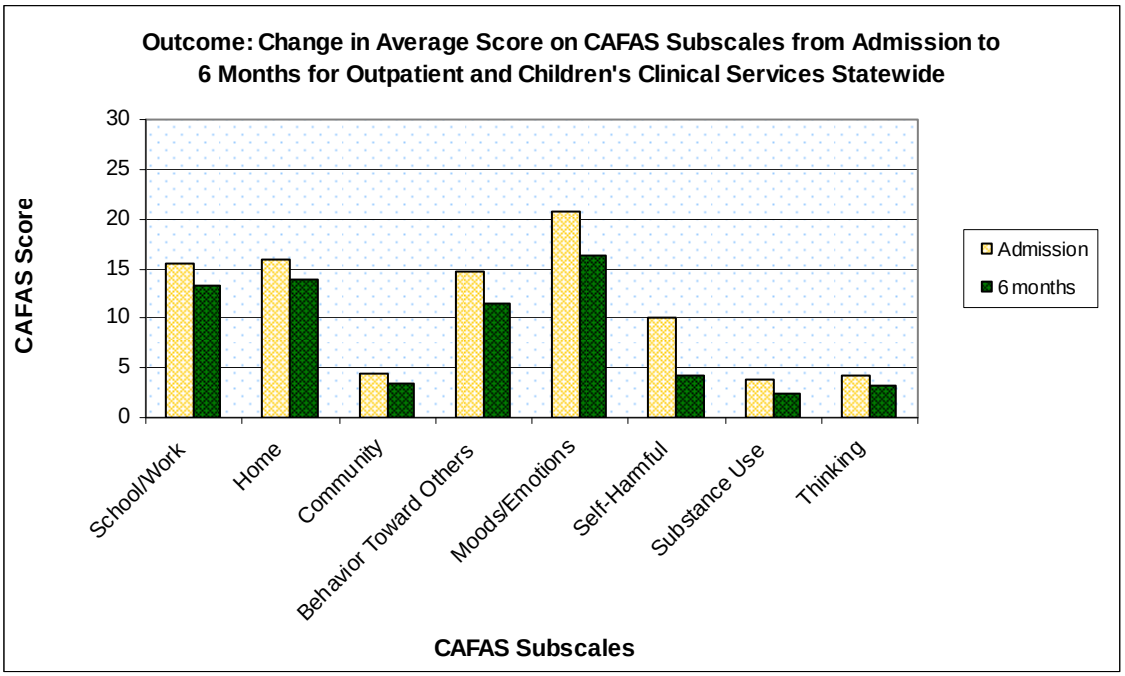
The Child and Adolescent Functional Assessment Scale (CAFAS)[1] is designed to assess in children ages 6 to 18 years the degree of functional impairment regarding emotional, behavioral, psychiatric, psychological and substance-use problems. CAFAS scores can range from 0 to 240, with higher scores reflecting 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 2013 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.

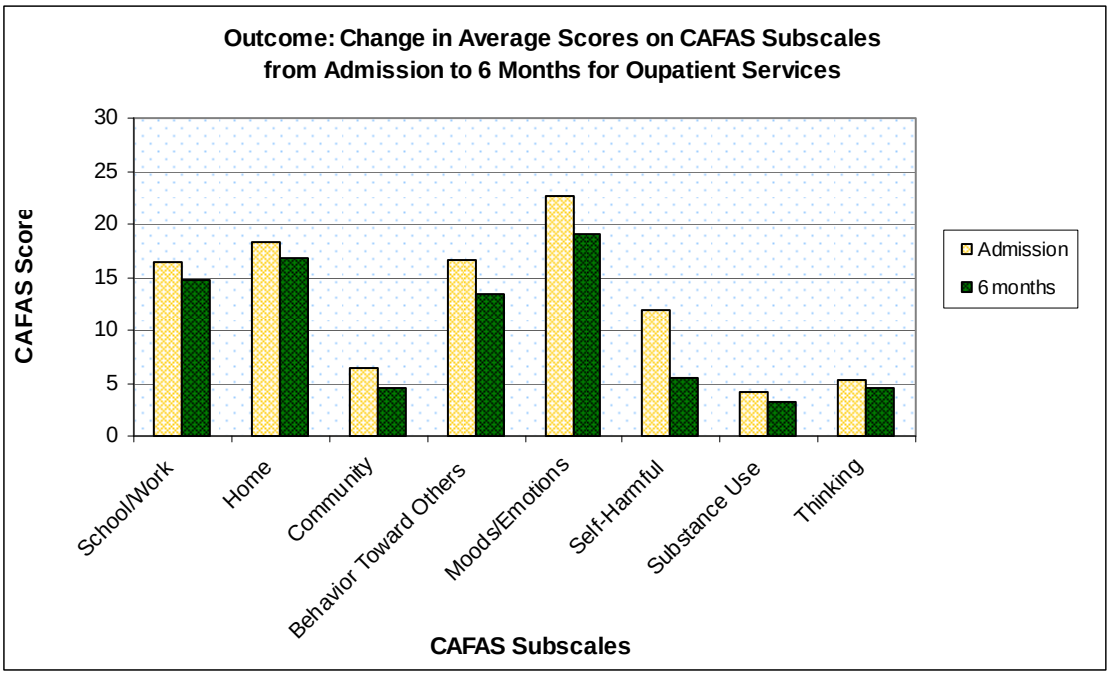


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Outpatient and Children's Clinical Services statewide. The mean CAFAS score was 89.09 (SD= 38.74) at admission. At 6 months into services, the mean CAFAS score decreased to 68.17 (SD= 40.89); *t* (251)

[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.

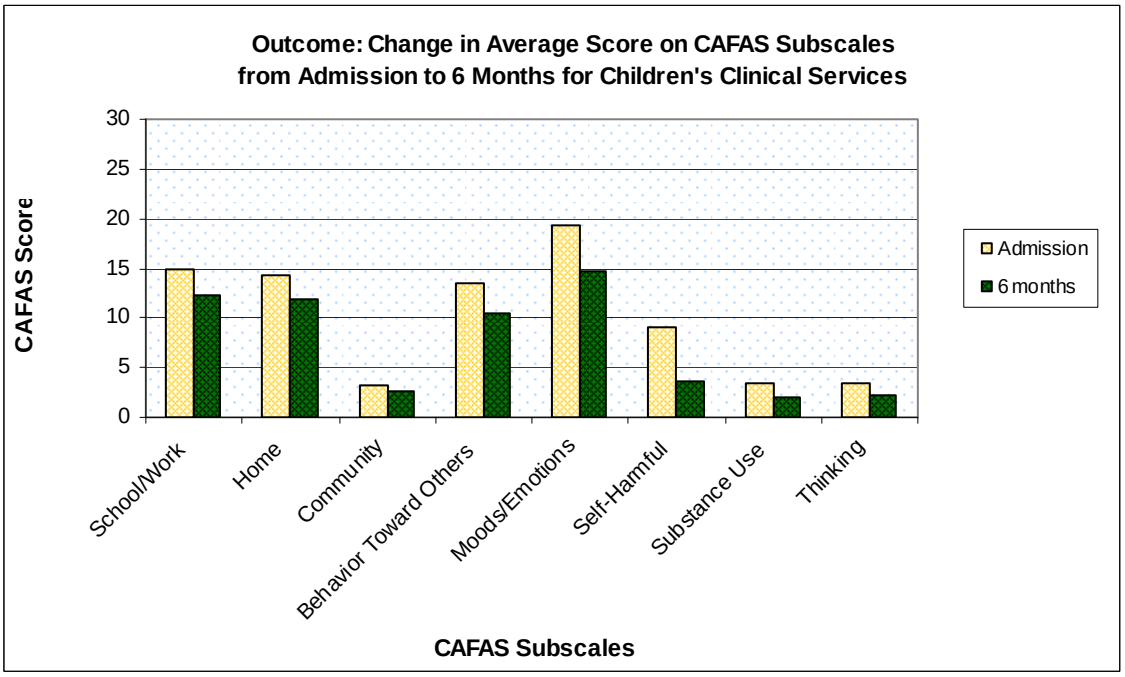
= 9.63, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 6 months.

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



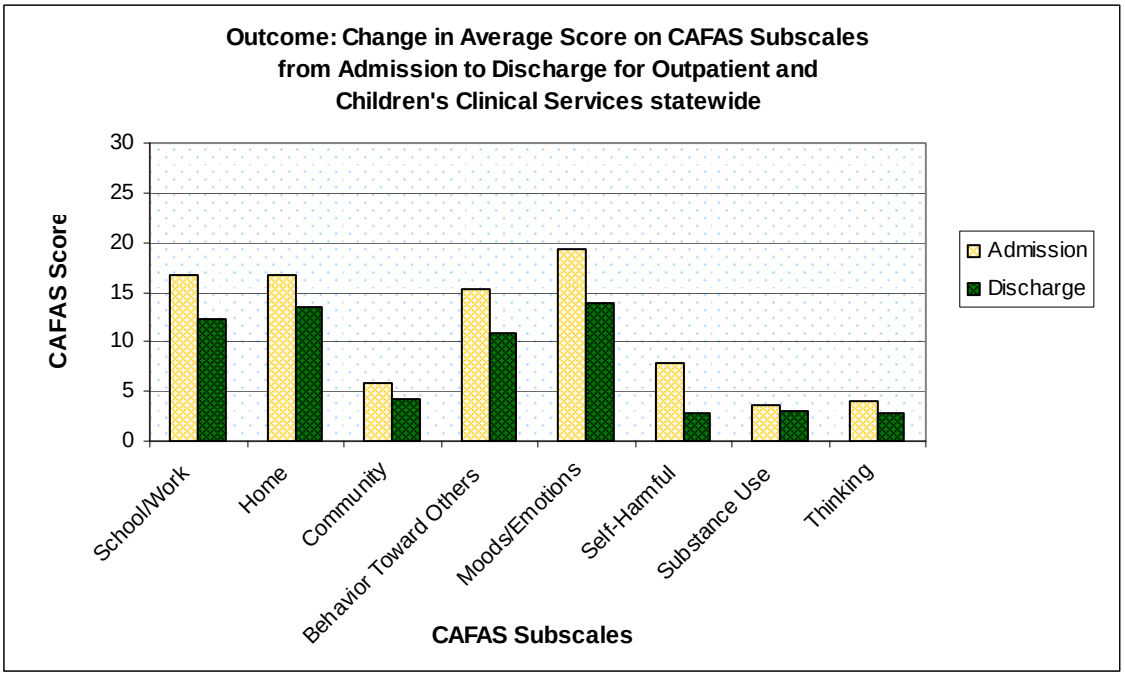
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Outpatient Services. The mean CAFAS score was 101.82 (SD= 46.28) at admission. At 6 months into services, the mean CAFAS score decreased to 81.21 (SD= 44.73); t (98) = 5.82, p = .000. These results indicate 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 Children's Clinical Services.



A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for Children's Clinical Services. The mean CAFAS score was 80.85 (SD= 30.39) at admission. At 6 months into services, the mean CAFAS score decreased to 59.74 (SD= 35.89); t (152) = 7.66, 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 discharge CAFAS subscale scores for Outpatient and Children's Clinical Services statewide.

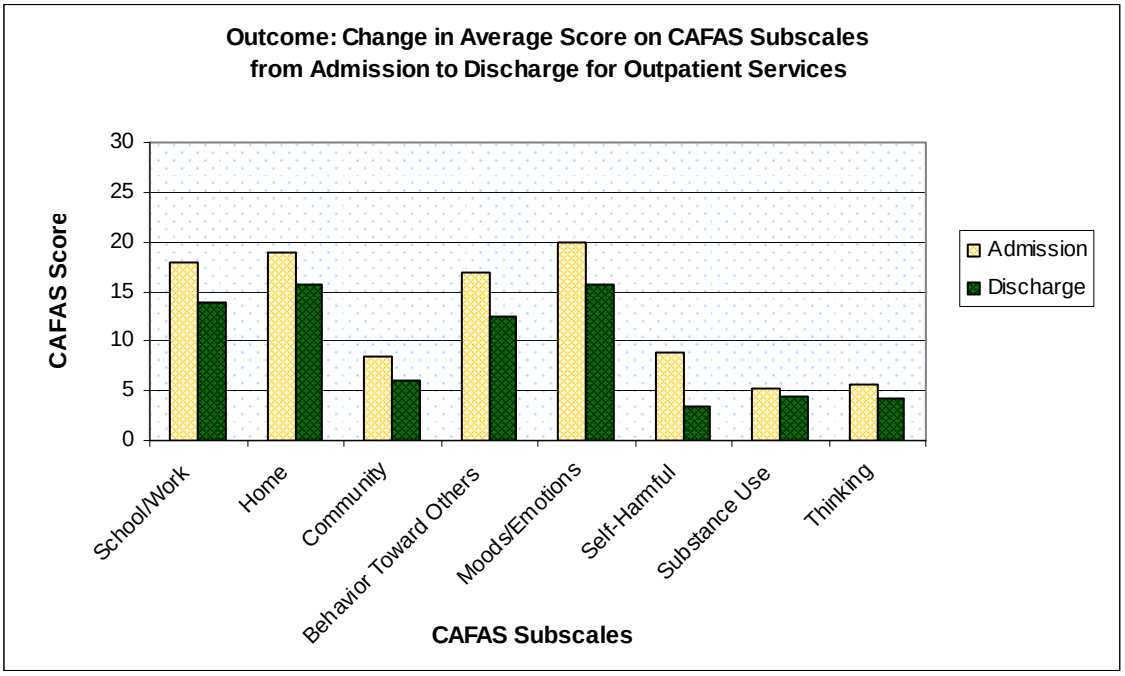


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Outpatient and Children's Clinical Services statewide. The mean CAFAS score was 89.52 (SD= 39.15) at admission. At discharge, the mean CAFAS score decreased to 63.27 (SD= 43.82); t (394) = 13.335, p = .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

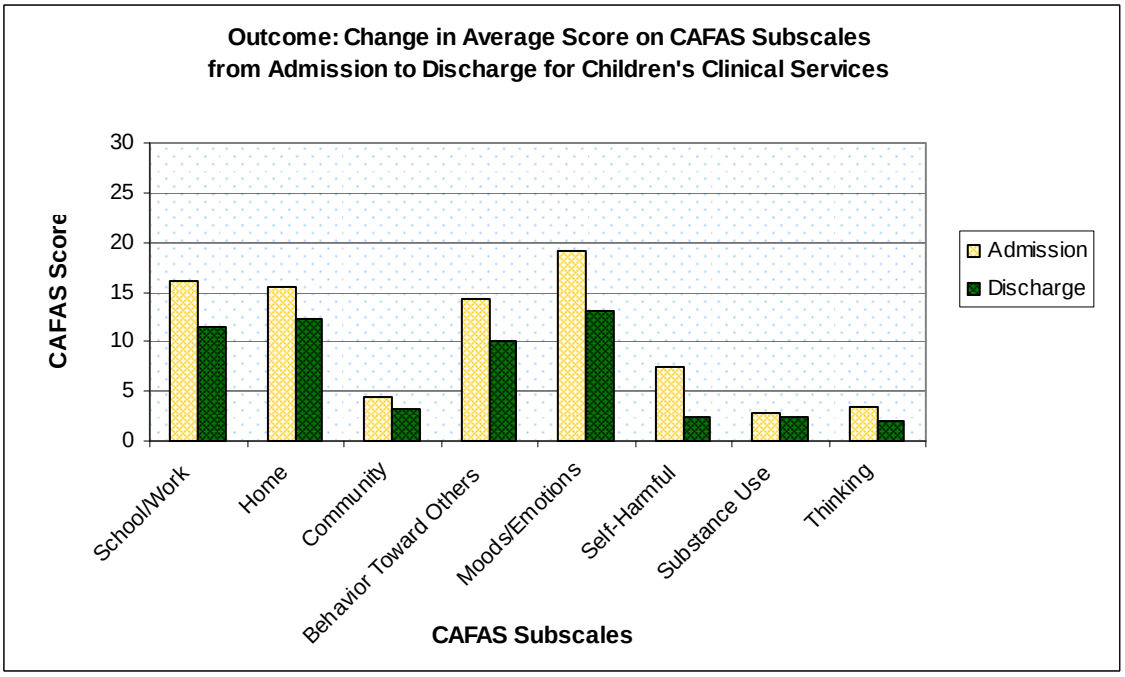
I have someone to talk to, meds that are helping, and my mom and I have a good relationship now.

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 102.79 (SD= 43.57) at admission. At discharge, the mean CAFAS score decreased to 76.12 (SD= 44.73); t (128) = 7.473, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

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

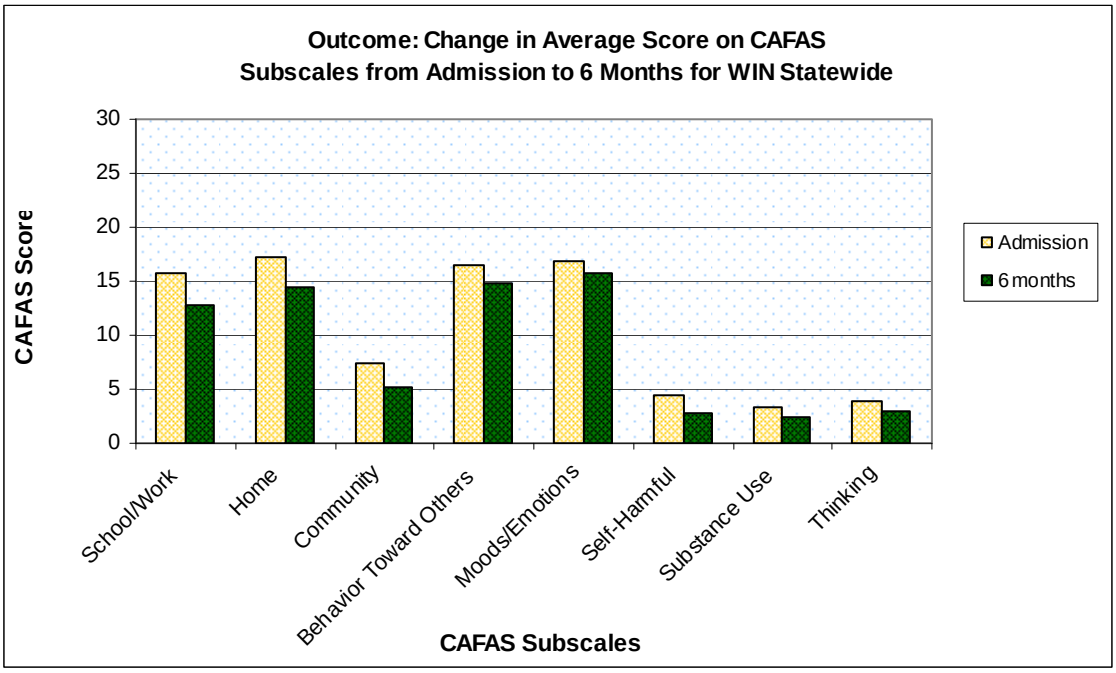


A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for Children's Clinical Services. The mean CAFAS score was 83.08 (SD= 35.13) at admission. At

discharge, the mean CAFAS score decreased to 57.03 (SD= 42.07); *t* (265) = 11.034, *p* = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

WIN

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

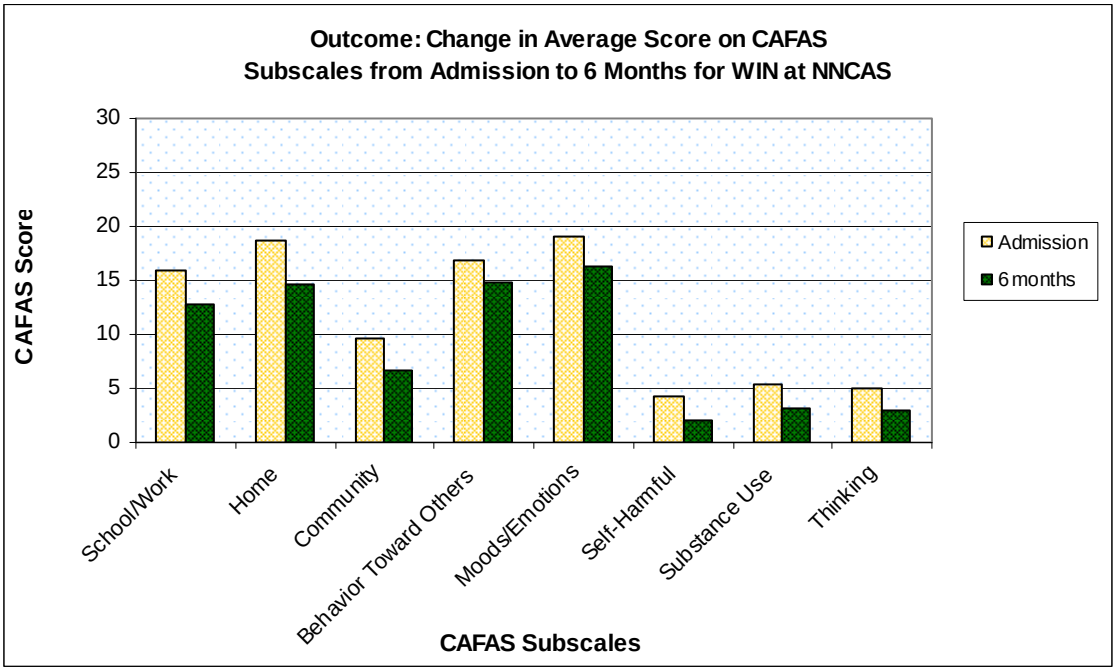


A paired-samples t-test was conducted to compare CAFAS total scores from admission to 6 months for WIN statewide. The mean CAFAS score was 85.45 (SD= 37.42) at admission. At 6 months into services, the mean CAFAS score decreased to 71.03 (SD= 36.56); *t* (241) = 6.831, *p* = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

SURVEY COMMENT FROM A SATISFIED YOUTH

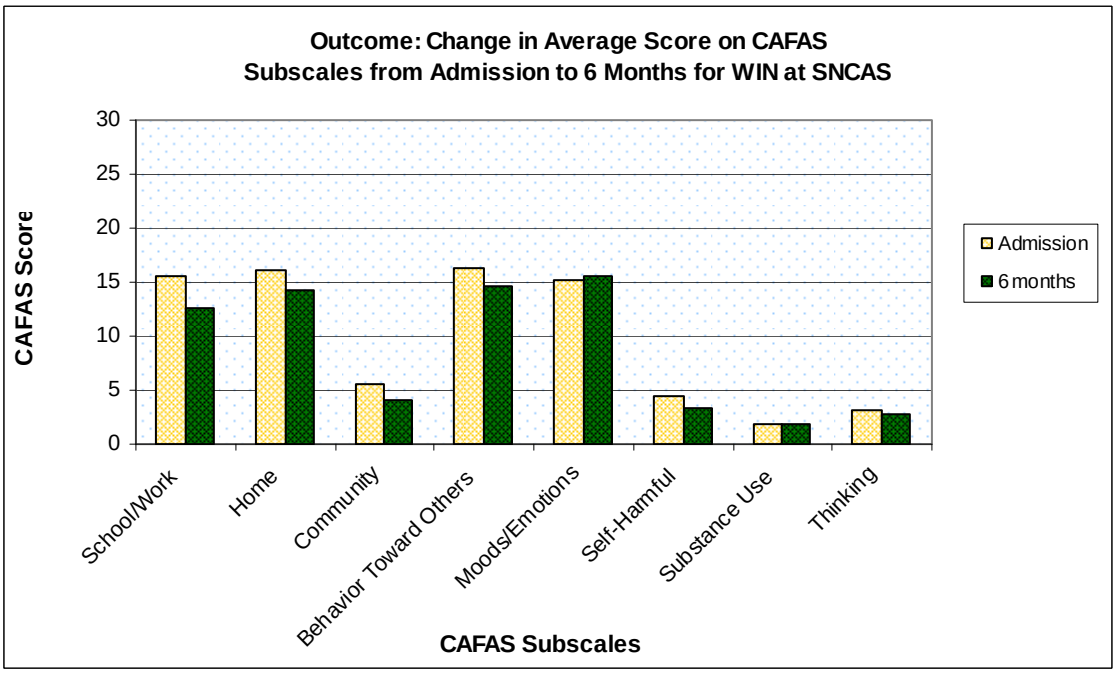
The most helpful thing is the respect they give me
and how they show they want to help me in my life—the way I act!

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 94.72 (SD= 40.24) at admission. At 6 months into services, the mean CAFAS score decreased to 73.49 (SD= 36.67); t (105) = 5.944 p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 6 months.

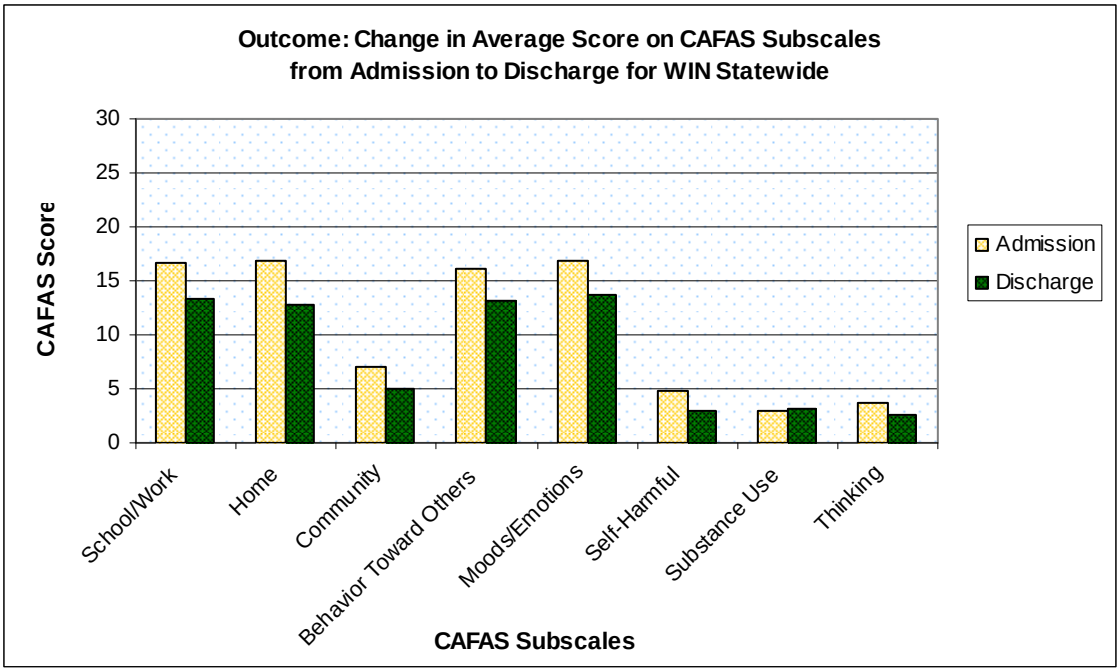
The graph below shows the admission and 6 months CAFAS subscale scores for WIN at SNCAS.



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 78.24 (SD= 33.46) at admission. At 6 months into services, the mean CAFAS score decreased to 69.12 (SD= 36.48); t (135) = 000, p = .xxx. Although

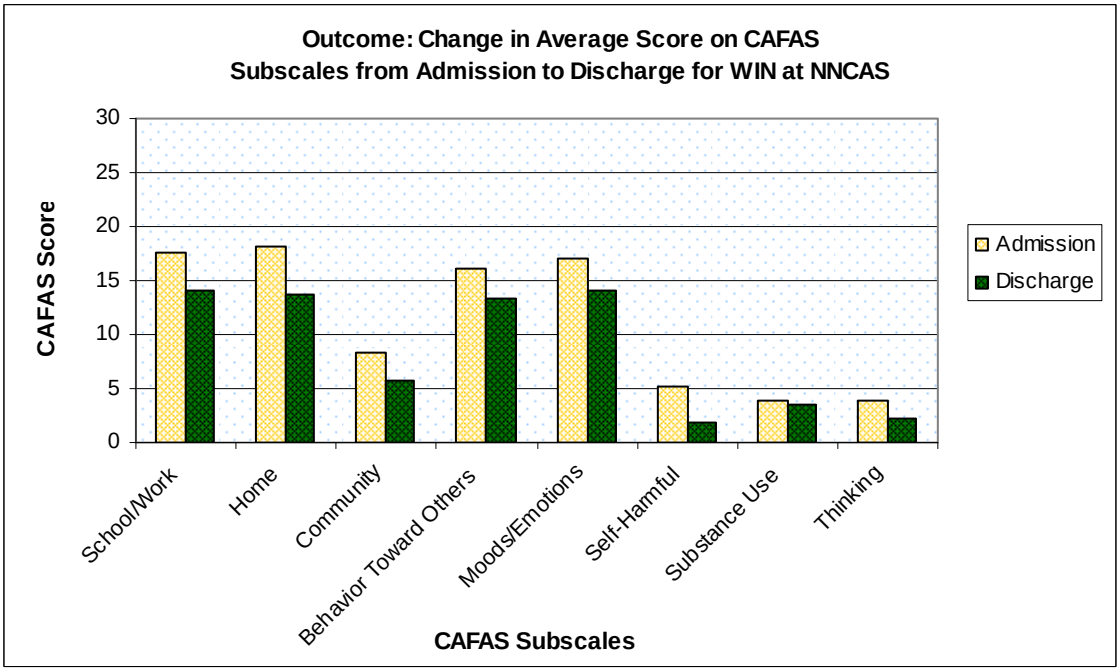
these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

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



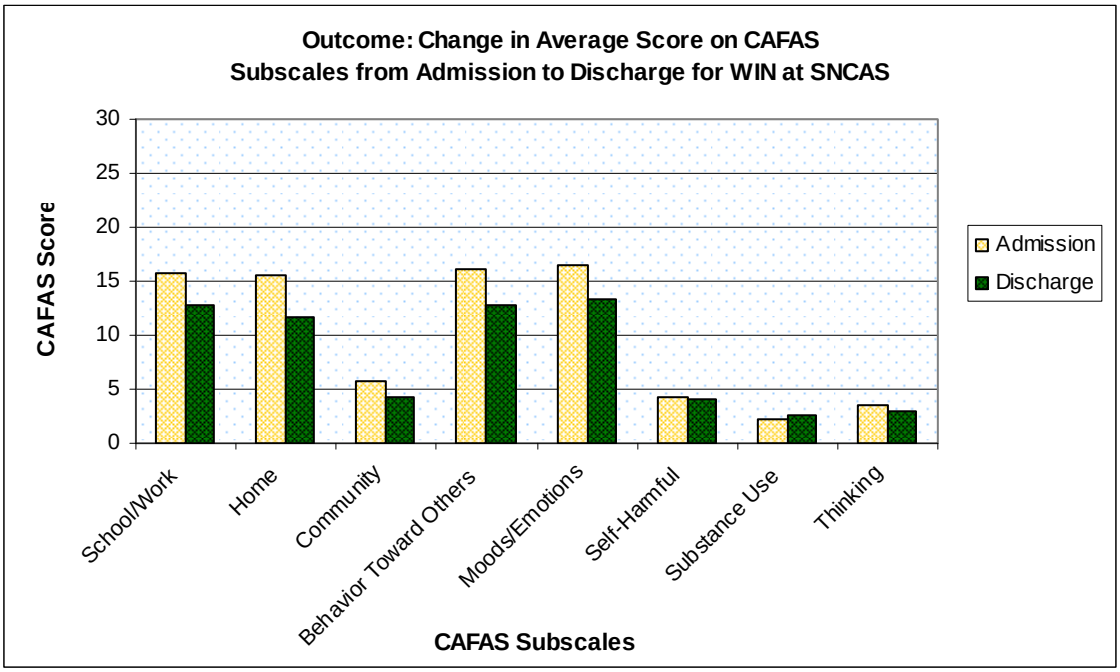
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN statewide. The mean CAFAS score was 84.96 (SD= 37.06) at admission. At discharge, the mean CAFAS score decreased to 66.55 (SD= 45.72); t (225) = 6.576, p = .000. Although these results show a statistically 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 90.45 (SD= 37.21) at admission. At discharge, the mean CAFAS score decreased to 68.65 (SD= 42.84); t (110) = 4.995, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

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



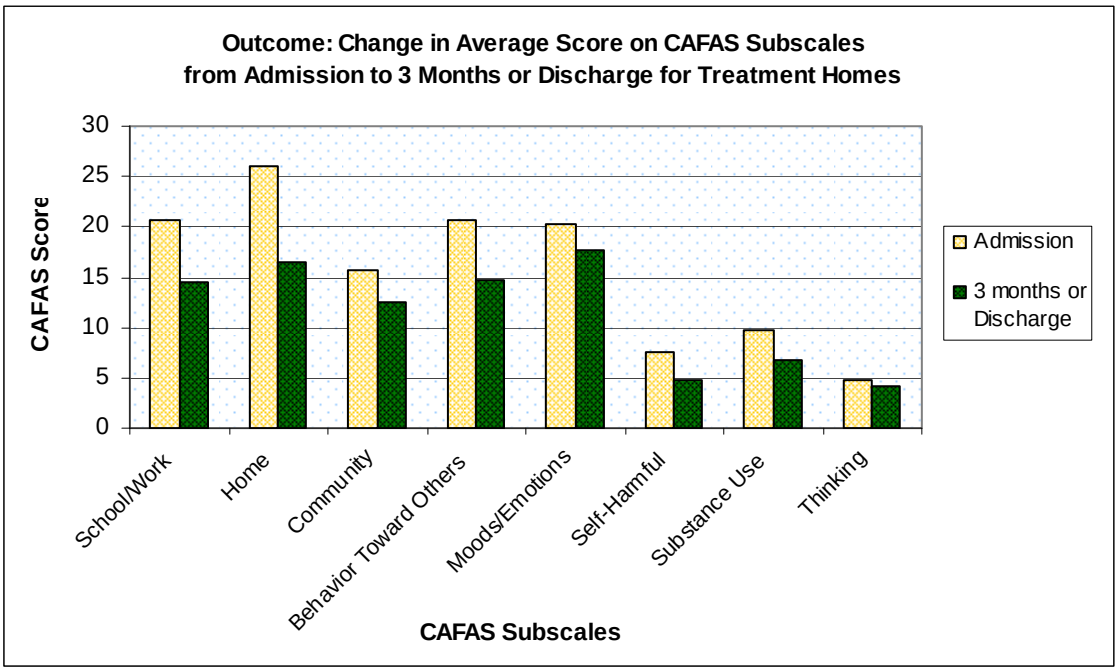
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for WIN at SNCAS. The mean CAFAS score was 79.65 (SD= 36.30) at admission. At discharge, the mean CAFAS score decreased to 64.52 (SD= 48.47); t (114) = 4.287, p = .000. Although these results show a statistically significant reduction in overall impairment, a clinically significant change must be a total CAFAS score decrease of 20 points or more.

SURVEY COMMENT FROM A SATISFIED PARENT

These services have prevented my child from escalating and assisted him in "shaping" a more productive/positive foundation.

Treatment Homes

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



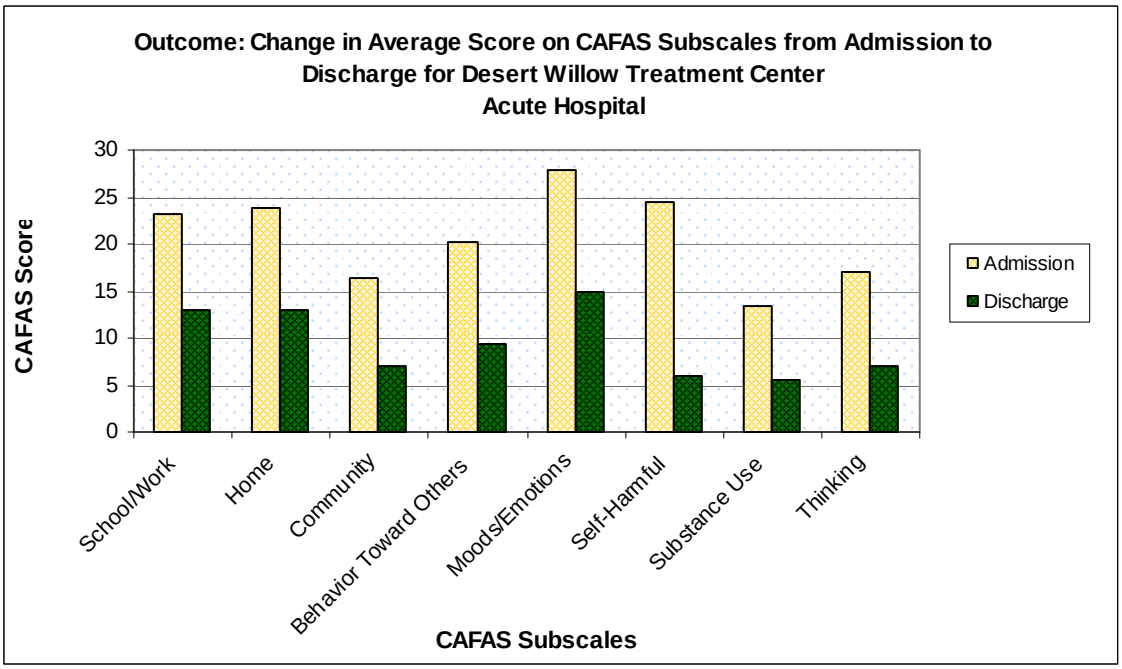
A paired-samples t-test was conducted to compare CAFAS total scores from admission to 3 months or at discharge for Treatment Homes. The mean CAFAS score was 125.21 (SD= 22.88) at admission. At 3 months into services or discharge, the mean CAFAS score decreased to 91.67 (SD= 33.48); t (47) = 8.78, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to 3 months or discharge.

SURVEY COMMENT FROM A SATISFIED YOUTH

Being able to learn coping skills for my anger.

Desert Willow Treatment Center Acute Hospital

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



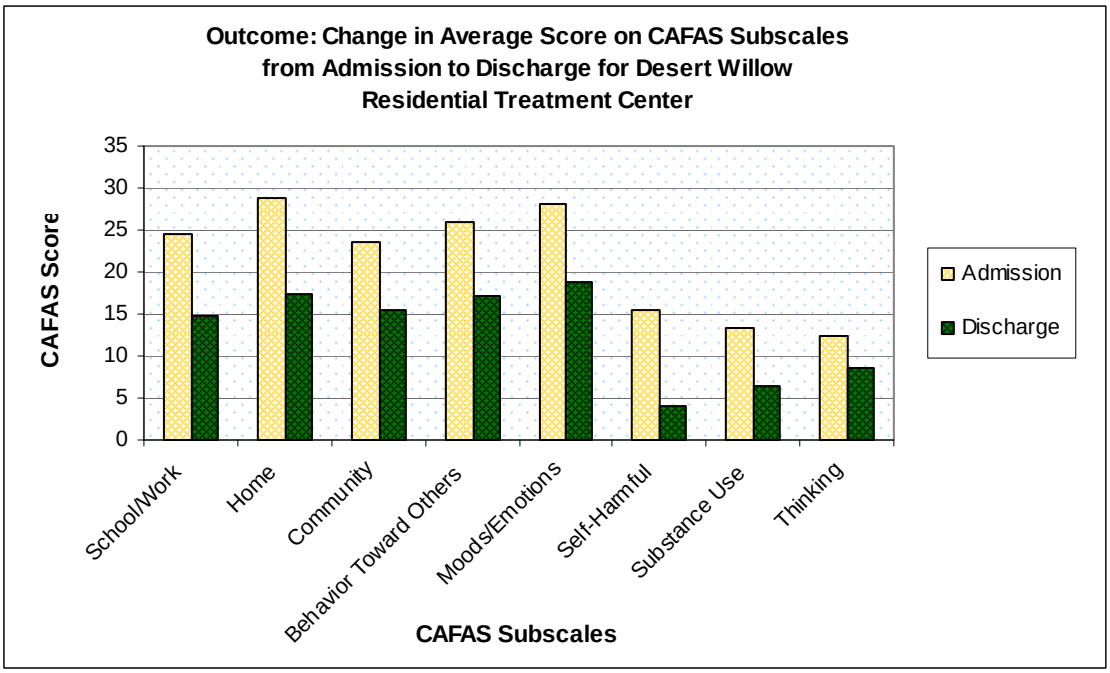
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Acute Hospital. The mean CAFAS score was 166.23 (SD= 37.55) at admission. At discharge from services, the mean CAFAS score decreased to 75.77 (SD= 32.30); t (129) = 25.06, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED YOUTH

Being able to understand and be comfortable with my emotions.

Desert Willow Treatment Center RTC

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



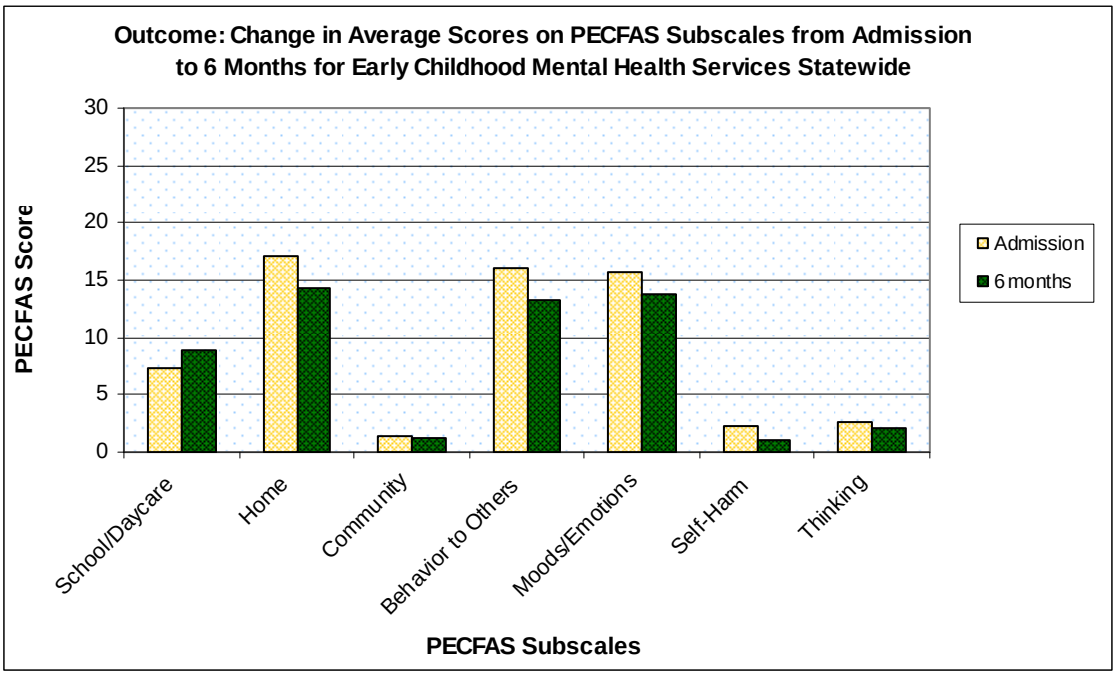
A paired-samples t-test was conducted to compare CAFAS total scores from admission to discharge for DWTC Residential Treatment Center. The mean CAFAS score was 172.15 (SD= 19.65) at admission. At discharge, the mean CAFAS score decreased to 102.77 (SD= 27.53); t (64) = 17.45, p = .000. These results indicate a statistically significant reduction in overall impairment and a clinically significant change from admission to discharge.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

Learning about resources I didn't know about and the ongoing support system.

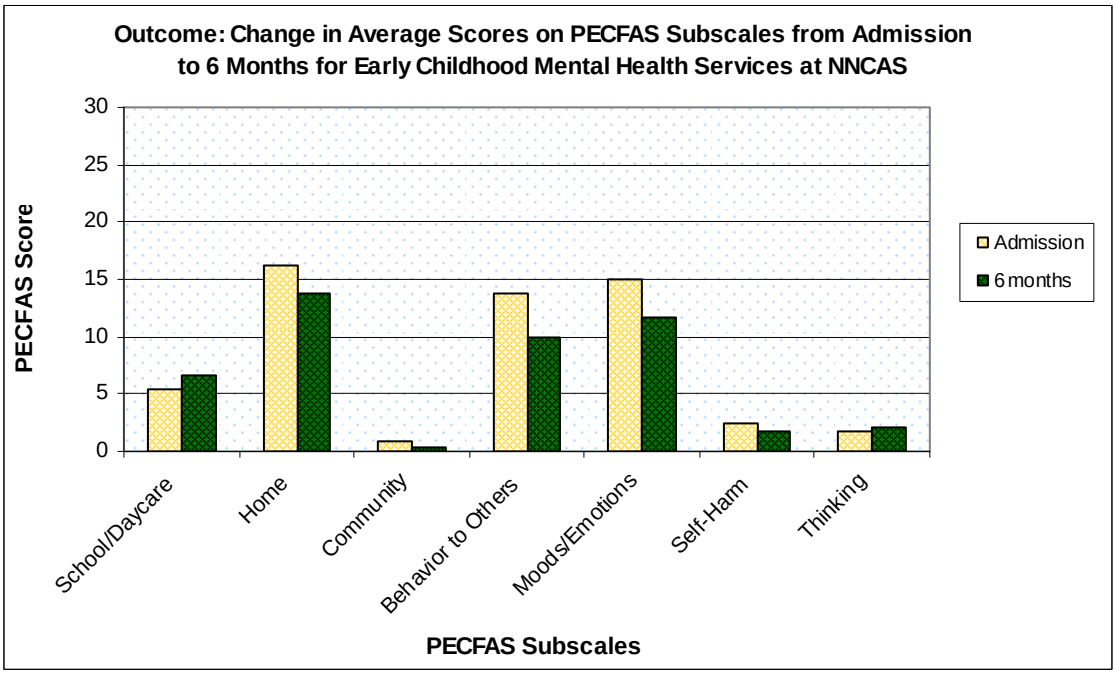
Early Childhood Mental Health Services

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



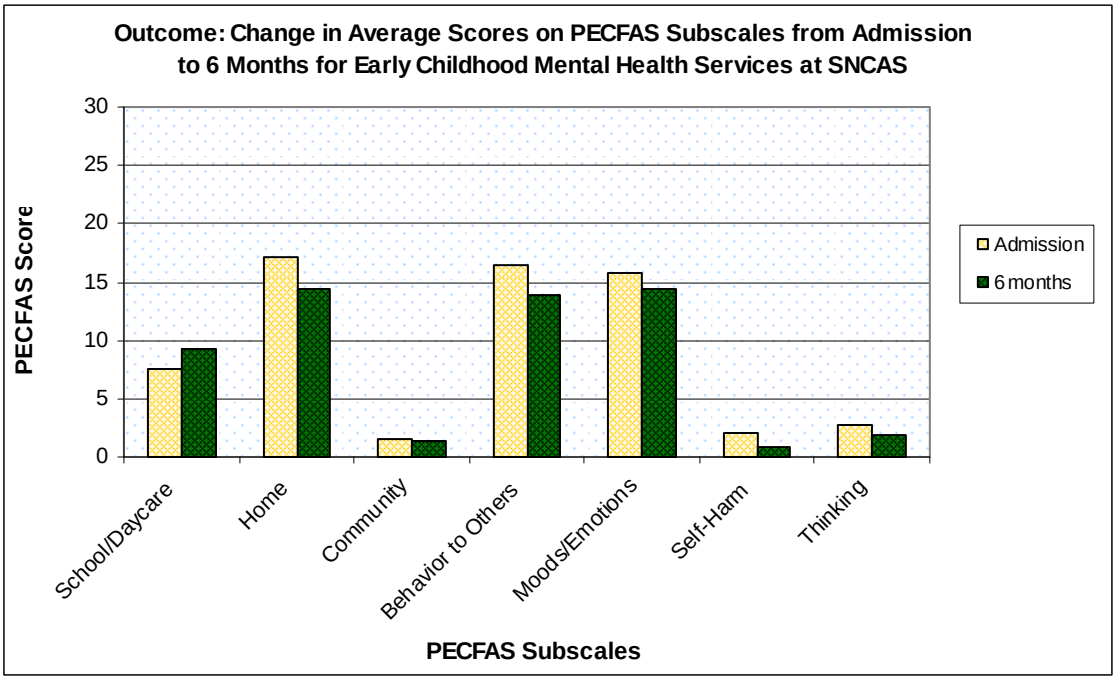
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services statewide. The mean PECFAS score was 62.39 (SD= 28.27) at admission. At 6 months into services, the mean PECFAS score decreased to 54.40 (SD= 32.87); t (158) = 3.044, p = .003. 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.



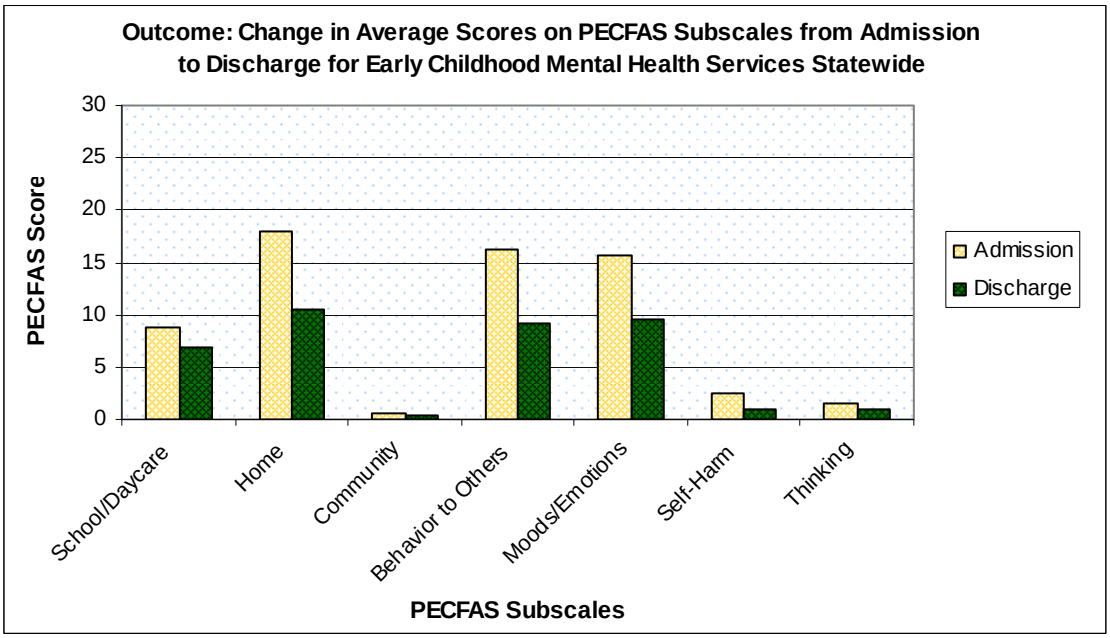
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services at NNCAS. The mean PECFAS score was 55.42 (SD= 25.53) at admission. At 6 months into services, the mean PECFAS score decreased to 46.25 (SD= 30.48); *t* (23) = 2.074, *p* = .049. 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.



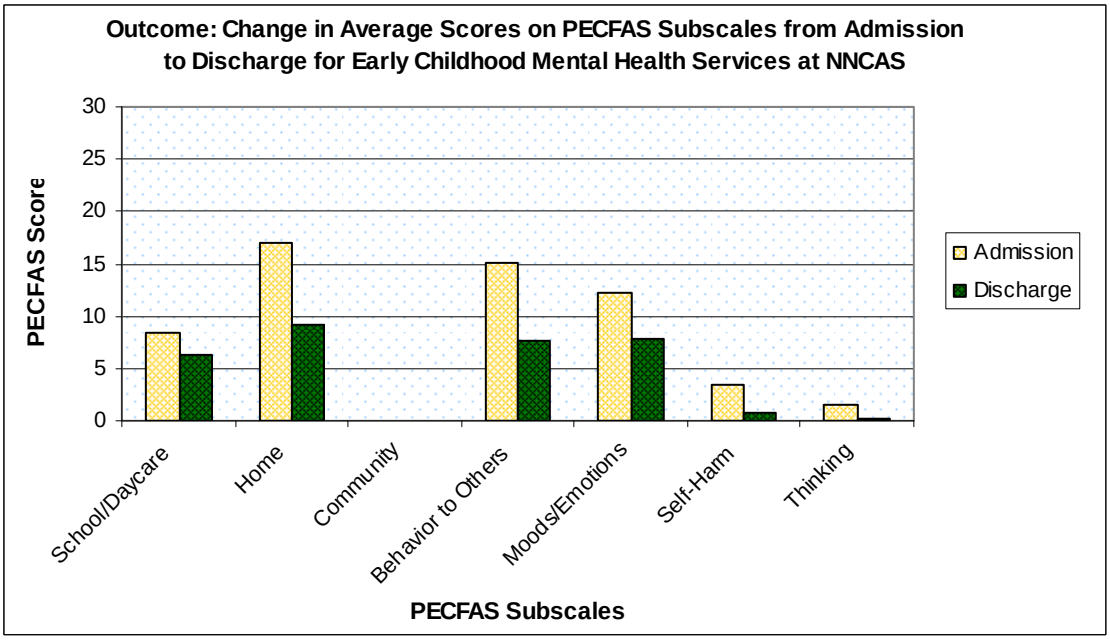
A paired-samples t-test was conducted to compare PECFAS total scores from admission to 6 months for Early Childhood Mental Health Services at SNCAS. The mean PECFAS score was 63.33 (SD= 28.78) at admission. At 6 months into services, the mean PECFAS score decreased to 55.98 (SD= 33.47); *t* (131) = 2.427, *p* = .017. 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 for PECFAS subscale scores for Early Childhood Mental Health Services statewide.



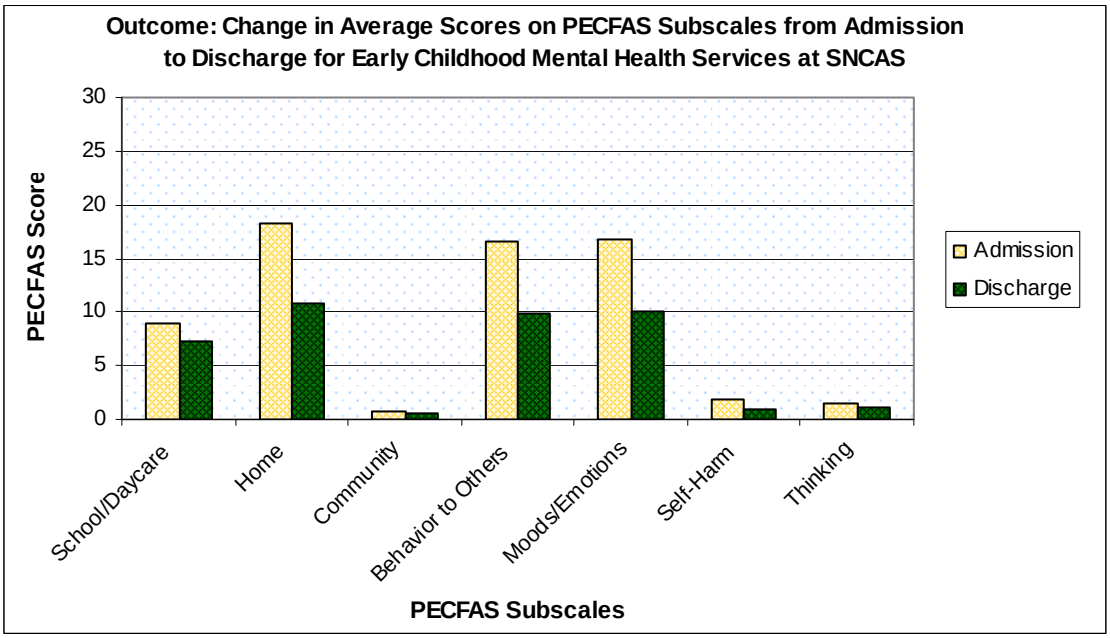
A paired-samples t-test was conducted to compare PECFAS total scores from admission to discharge for Early Childhood Mental Health Services statewide. The mean PECFAS score was 63.16 (SD= 27.04) at admission. At discharge, the mean PECFAS score decreased to 38.23 (SD= 28.14); t (157) = 10.660, p = .000. These results show a clinically and statistically significant reduction in overall impairment.

The graph below shows the admission to discharge 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 for Early Childhood Mental Health Services at NNCAS. The mean PECFAS score was 57.84 (SD= 32.84) at admission. At discharge, the mean PECFAS score decreased to 31.89 (SD= 24.48); t (36) = 6.026, p = .000. These results show a clinically and statistically significant reduction in overall impairment.

The graph below shows the admission to discharge 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 for Early Childhood Mental Health Services at SNCAS. The mean PECFAS score was 64.70 (SD= 25.04) at admission. At discharge, the mean PECFAS score decreased to 40.43 (SD= 29.17); t (116) = 8.683, 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:

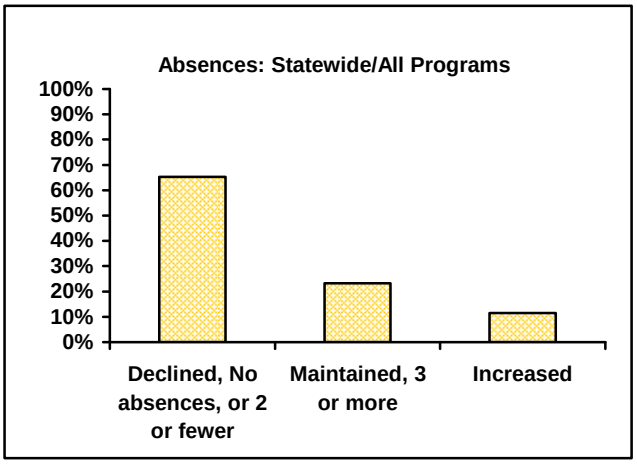
1. A client was considered to be maintaining an excellent performance or showing improvement if he or she met any one of three criteria:
   - The client had a perfect record historically and in the most recent period;
   - The client had a history of averaging no more than two absences per grade period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

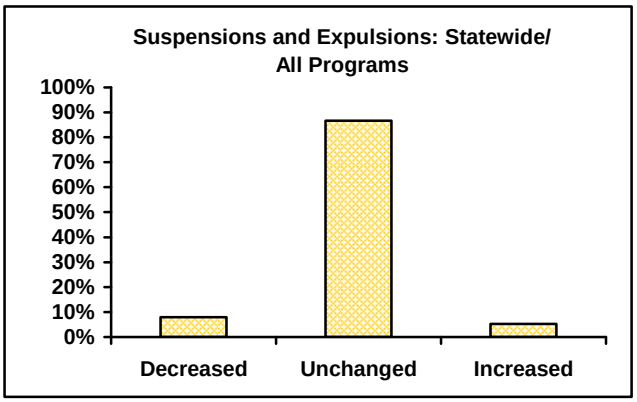
3. A client was considered to have decreased in performance if he or she had:
   - A historical average of three or more per period and more than his or her historical average in the most recent period, or an average from zero to two and absences in the most recent period of three or more (absences only), 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



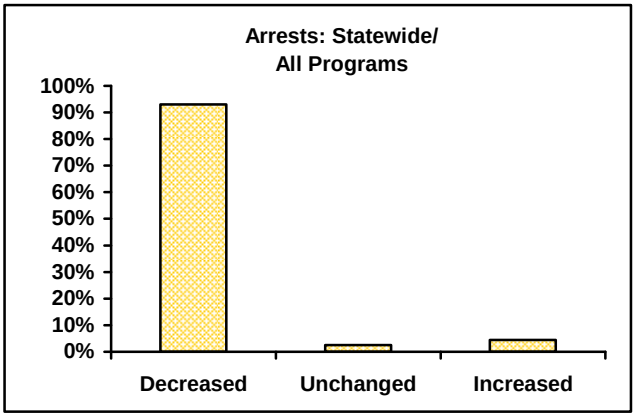
In FY2013, 1297 clients had absences data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 847 (65.3%) of the clients. There were 443 (34.2%) 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 301 (23.2%) clients. Absences increased to three or more and the client average was greater than two days for 149 (11.5%) of the clients.

Suspensions and Expulsions: Statewide/All Programs



In FY2013, 1290 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 102 (7.9%) of the clients. For 1119 (86.7%) of the clients, there was no change in suspensions and expulsions versus his or her own average, and 1012 (90.4%) of them had a zero average and zero suspensions or expulsions. Suspensions and expulsions increased versus the client's own average for 69 (5.3%) of the clients.

Arrests: Statewide/All Programs



In FY2013, 647 clients had arrest data entered for at least two periods from which an average could be constructed. Of the 647 clients with arrest data, 499 (77.1%) had no arrests. Arrests decreased or remained zero versus the client's own average for 602 (93.0%) of the clients and 33 (5.1%) of the clients had fewer arrests than the client's historical average. For 16 (2.5%) 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 29 (4.5%) for the clients.

SURVEY COMMENT FROM A SATISFIED CAREGIVER

My child is able to use his active listening skills
and can control his emotions through expressing his thoughts, feelings and needs.

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.

Percent of Positive Response for Each Survey Domain

Community Based Services Survey – Spring 2013	Youth % positive	Parent % positive	National Benchmark for Parent Response[1]
Services are seen as accessible and convenient regarding location and scheduling	85%	94%	85.7%
Services are seen as satisfactory and helpful	85%	96%	86.1%
Clients get along better with family and friends and are functioning better in their daily life	79%	78%	66.3%
Clients feel they have a role in directing the course of their treatment	83%	95%	87.6%
Staff are respectful of client religion, culture and ethnicity	92%	98%	92.8%
Clients feel supported in their program and in their community	81%	94%	86.9%
Clients are better able to cope and are doing better in work or school	90%	81%	66.3%

Residential Discharge Services Survey	Youth % positive	Parent % positive
Services are seen as accessible and convenient regarding location and scheduling	NA	NA
Services are seen as satisfactory and helpful	91.2%	88.9%
Clients get along better with family and friends and are functioning better in their daily life	96.9%	84.6%
Clients feel they have a role in directing the course of their treatment	85.3%	88.0%
Staff are respectful of client religion, culture and ethnicity	84.8%	100.0%
Clients feel supported in their program and in their community	No Data	84.6%
Clients are better able to cope and are doing better in work or school	96.9%	84.6%

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

ATTACHMENT C

DCFS Community Based Services Parent/Caregiver –
Youth Survey Results Statewide
Spring 2013 report

DCFS Community-Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2013

From March 25 to May 3, 2013, 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 and a ninth domain surveyed satisfaction with the agency's medical doctors.

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. The ninth domain (Psychiatrist/MD) includes statements that relate to the overall satisfaction with the medical doctor at the specific site care was received.

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 should 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 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 421 parent/caregivers and 225 youth in program services. Of the 421 parent/caregiver surveys, 37 respondents chose to complete the Spanish language survey. 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	90	426	21%	72
WIN	61	215	28%	55
Early Childhood Mental Health Services	60	415	14%	N/A
SNCAS Total	211	1,056	20%	127
NNCAS				
Outpatient Services	76	223	34%	35
WIN–Reno/Rural/Expansion	84	187	45%	63
Early Childhood Mental Health Services	50	153	33%	N/A
NNCAS Total	210	563	37%	98
Statewide Total	421	1,619	26%	225

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 2013

SNCAS
Children's Clinical Services Results

Parent/Caregiver N=90; Youth N=72 Total Served = 426 Sample = 21%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	95	85
Services were scheduled at times that were right for us.	98	86
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	92
The people helping my child and family stuck with us no matter what.	94	93
I felt my child and family had someone to talk to when he/she was troubled.	96	85
The services my child and family received were right for us.	92	83
I received the help I wanted for my child.	91	88
My family got as much help as we needed for my child.	88	90
POSITIVE OUTCOMES		
My child is better at handling daily life.	76	86
My child gets along better with family members.	79	81
My child gets along better with friends and other people.	77	83
My child is doing better in school and/or work.	75	82
My child is better able to cope when things go wrong	71	76
I am satisfied with our family life right now.	66	75
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	70
I helped to choose my child and/or family's treatment goals.	91	86
I participated in my child's and family's treatment.	98	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	94
Staff respected our family's religious/spiritual beliefs.	96	94
Staff spoke with me in a way that I understood.	98	92
Staff was sensitive to my family's cultural and ethnic background.	99	88
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.	85	N/A
In a crisis, I would have the support I need from family or friends.	83	88
I have people with whom I can do enjoyable things.	81	93
I am happy with the friendships I have.	N/A	88
I feel I belong in my community.	N/A	79
FUNCTIONING		
My child is better at handling daily life.	76	86
My child gets along better with family members.	79	81
My child gets along better with friends and other people.	77	83
My child is able to do the things he/she wants to do.	77	78
My child is doing better in school and/or work.	75	82
My child is better able to cope when things go wrong.	71	76

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	93	93
Staff explained my child and my family's rights and confidentiality issues.	96	90
I receive support and advocacy from my Nevada PEP Family Specialist.	93	86
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	89	85
Our family is aware of people and services in the community that support us.	82	82
I am better able to handle our family issues.	84	72
I am learning helpful parenting skills while in services.	87	90
I have information about my child's developmental expectations and needs.	87	82
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	93	97
My child's Psychiatrist/MD answered my questions.	89	94
My child's Psychiatrist/MD spends enough time with him/her.	89	94
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	90	94
My child's Psychiatrist/MD understood his/her problems and feelings.	89	90
My child's meetings with his/her Psychiatrist/MD were helpful.	85	91
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	83	85
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	85	93

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ The therapy. ♦ Meeting with the psychologist/therapist to discuss his feelings seems to be beneficial. ♦ The ability to cope and telling the truth. ♦ Learning coping skills on a weekly basis. Open communication is an everyday learning experience. ♦ Teaching him new ways to deal with things. ♦ Keeping him in school. ♦ Good talks. ♦ So far the medication. ♦ The building of trust that has been established for both our family and son enabling him with the most potential for his emotional and behavioral healing and growth. ♦ The consistency of all the service providers. ♦ Letting us know that we're not alone and that everyone has problems. ♦ Rapid response to issues that have occurred. ♦ Consistency and reliability. ♦ Aware the support my family receives assist my child to maintain a stable emotional well being these services cannot cure a lifelong condition. These services have prevented him from escalating and assisted my child in "shaping" a more productive/positive foundation. ♦ His PSR worker. ♦ Caring, awesome people! ♦ My daughter now has someone to talk to besides me about things I might get hurt over or that she does not feel comfortable talking to me about. ♦ Learning different ways to handle different situations. ♦ Understanding emotions - learning to deal with past abuse issues. ♦ Psychiatrist / MD. ♦ Overcome his tantrums. ♦ The medicine. ♦ That we could talk about something so delicate. ♦ Child has more understanding of how to behave and do more	1. What has been the most helpful thing about the services you received? ♦ More than one person to talk to. ♦ Treatment for my depression. ♦ I'm able to talk to mom better - better handle situations. I receive help to handle things when I'm struggling. ♦ The most helpful thing is the respect they give me and how they show they want to help me in my life - the way I act! ♦ It helps me understand everything I need to. ♦ Coping skills learned and better family life. ♦ Dr. is a very kind and nice person. Very, very, very friendly. ♦ The therapists are really helpful for my family. ♦ I learned to control my anger. ♦ Actually I don't feel pleased about my service because my psychiatrist is always mocking me about his religion and I feel uncomfortable that he is always trying to "challenge" me and I feel that he doesn't understand my emotions. ♦ We have someone to talk to and let out emotions and feelings. ♦ Talking to my psychiatrist. ♦ They help me with my anger. ♦ The advice. ♦ Talking about school and other important things. ♦ I am able to control myself most of the time. ♦ Informational, educational, helpful in long run, learned coping skills, beneficial and overall benefit. ♦ The money. ♦ Now I could talk to my mother on the way that I could feel good. I understand everything. I'm happy and I know how to control myself. How to be a really good person, she helps me a lot. ♦ I have someone to vent to. ♦ My therapist helps me with coping and letting my feeling be heard. ♦ My psychiatrist and therapist understand me, my problems. ♦ Being able to have coping skills that can help me with any situation. And things I have learned about life in general. ♦ My therapy sessions, my in home BST and my PSR worker. ♦ Coping with anxiety. ♦ That they help me with all my problems and thank the Clark county Department of Family Services that my Counselor help me

Parent/Caregiver comments	Youth comments
things for themselves. ♦ To have someone to talk to. ♦ We get to work together on bettering each other. ♦ We have some one to talk to and let out our emotions and feelings. ♦ Lots of resources. ♦ The real life examples of how to implement proper scheduling and routines to help my child improve his overall behavior in school and at home. I was surprised to find out how much sleep he actually needed! ♦ Counselor mitigates arguments between my son and I. ♦ Overall how everything was explained and with respect and understanding my child and family needs with child's mental illness. ♦ An adult to listen to her. ♦ Connection to resources - being understood without being judged. ♦ Goals are done as a team and suggestions are given to help the child improve. ♦ Learning to think through things rather than acting impulsively. Improved communication between the two of us. Connection to outside sources. ♦ My son has better coping skills, and learned how to talk more about his feelings with us. ♦ Our therapist is helping my child to learn coping skills and behavior modification. ♦ Being able to control emotions and behavior. ♦ Our therapist is helping my child to learn coping skills and behavior modification Basic - Attitude, manners - getting along with family. ♦ Services for School, Clothes, other resources. ♦ Mostly just having someone available when needed. ♦ How to get along with siblings, know when to stop being abusive. ♦ Now he walks more happily. ♦ He is much improved in that he understands us better and listens to us more she has confidence in saying what she feels and going on and we love her everything in general. ♦ That she has learned to respect her brother and now speaks differently, with respect. ♦ That our family is better since we have been coming here and we continue to improve the understanding between him and his therapist; his behavior improved. ♦ Better behavior; improving grades in school, no more graffiti. ♦ The therapy of her therapist has helped because now she doesn't speak of hurting herself and the programs that her worker provided have helped us and the medications. ♦ She has not seen a psychiatrist yet but the counseling has been really helpful. ♦ She has someone to talk to. She appears to be happier. She better deals with tough situations. ♦ Everything has turned around for the better. ♦ Therapist is very caring and my daughter feels open to talk to her. ♦ Having her therapist to talk to. ♦ Learning to cope and develop his self esteem. ♦ She has learned coping skills. Also she knows there are others like her and she's not alone. Better communication with family. ♦ He is learning to deal with his anger. Because of his age he's still too young to control it but the foundation is being laid out. ♦ That she now can recognize when she makes a mistake and doesn't lie more to avoid more problems. ♦ The sincerity and the demeanor of the psychiatrist in dealing with my son's issues. ♦ The ability to identify and address my daughter's social issues. ♦ The involvement and immediate help. ♦ My child feels more relaxed in communication problems and	with any that need with all my problems about abuse and with my anger and about family to thank you for your services. ♦ To know that everything is going to be ok. ♦ They teach me new things. ♦ Learn to get along with siblings. Learn to be respectful. Have patience. ♦ Being in New Beginnings. ♦ They give you really helpful ways and techniques you could use. ♦ More help in the outdoors, because of the behavior problems I have in community, doing better at maturity as a young man. ♦ My therapist has understood my problems and has helped me. ♦ The ability to understand what is kinda wrong by listening, targeting the issue, and working on improving it. ♦ It gives me time to think and get knots in my head undone. ♦ I don't know. ♦ Being able to understand and be comfortable with my emotions. ♦ That I talk and they listen without judging. ♦ I get an explanation of things in life that I quite don't understand. ♦ Getting support from a therapist and the medication helped out my anxiety. ♦ Haven't seen a psychiatrist yet! ♦ Learning to cope with anger well. ♦ To control my emotions and don't be stressed. ♦ Everything has helped me. ♦ Talking to someone. ♦ A better life. ♦ She understood what I been in and never quit listening to me and she showed me to be more respectable. ♦ Learning to cope with certain things in life. ♦ I've been able to cooperate with the problems in life. ♦ Telling me what problem I have. ♦ My confidence is boosted and my cutting is over. ♦ Being able to speak with someone. ♦ Being able to find better solutions to my problems. ♦ Feeling better about myself. ♦ Guidance through my emotional problems and stressful ordeals. ♦ The fact that I have someone friendly that I can talk to and get advice from. ♦ That they push me to do the right thing. ♦ The most helpful thing was talking about my problems and he sorta understood. ♦ My psychiatrist helps me a lot. I feel good and proud of myself now. I love coming here and talk about my life-thank you or for all your attention - you helped me for school and my life. Thank you. ♦ Talking to people about my problems. ♦ Better communication with her and understanding her struggles

Parent/Caregiver comments	Youth comments
concerns and dealing with anxiety. ♦ Flexibility with appointments - extension of services beyond the therapy. ♦ Support and understanding from staff for our family has been helpful and has given me strength when times are rough. ♦ Case worker and team has made every effort to get my child the medications and support he needs. ♦ Improving in her academic, better communication with her and her teachers, son respects others. I'm learning parenting skills to help son. ♦	
2. What would improve services your child and the family received? ♦ Major communication. ♦ Having a psychiatrist/MD on staff to treat my son's illness and discuss treatment options and medications. ♦ My child has not seen a psychiatrist since Oct-Nov of 2012 - there was no psychiatrist available or on staff. ♦ Really in need of a new psychiatrist at this location to monitor medication and renew prescriptions as well as answer questions. ♦ Some more time with his counselor. ♦ Maybe a little more time. Two hours a week instead of one. ♦ Flexibility on session times, i.e. longer sessions. ♦ I can't think of anything! Everyone and everything is wonderful at the East Neighborhood Family Services. Keep up the great work! ♦ For a SED kid, Autistic kid more services that helped in daily living and vocational training. ♦ Support in other areas outside just therapy. ♦ Extend hours 1 X per week would be ideal for working parents etc. ♦ I am very satisfied except with the MD, so she never got on the correct meds. I feel groups of her age (group therapy may be helpful). ♦ Possibly learning how to cope with unresolved issues from the past. (abuse + separation anxiety) ♦ We just started. ♦ A better behavior. ♦ Improve communication and coexist more united. ♦ I would not change anything. ♦ I would not change anything - they do a very fine job. ♦ All being of one goal in mind. ♦ I would like help with implementing positive disciplines and rewards to single parents. I would also like some resources on other single parenting groups. ♦ Psychiatric care. ♦ Nothing needs to improve they all do a great job. ♦ Nothing. ♦ More workers so caseloads are smaller. More time could then be spent with each person. ♦ To get in touch with his legal guardian more convenient. ♦ More than $750.00 available to family. ♦ Our therapist is doing a great job and he offers me a wealth of resources I would not be able to find on my own. ♦ Our therapist is doing a great job and he offers me a wealth of resources I would not be able to find on my own. ♦ Check up on the kids after utilizing them. ♦ Phone calls and email response time. ♦ In time I think they will know what these sessions are about. ♦ Now if we want to go out with our son. ♦ Nothing, for now everything is going well. ♦ Knowing that she gets better every day and to see her happy and with good wishes. ♦ How you support them in their character. ♦ Nothing, because all the services given me have helped a lot. ♦ I think that the services I have been offered are very good and the therapist is a great person and has helped us have a better life.	2. What would improve services you received? ♦ I really don't know the service I get now is great. ♦ Nothing, it is very wonderful. ♦ No non-neutral therapists. ♦ WiFi for the waiting room. ♦ If I had a psychiatrist that will better understand my emotions and understand that I am a non-religious person. ♦ I don't know nothing. Everything is perfect. ♦ That the age didn't cut off the services. ♦ I just want to said thank you because I don't know if I could one day talk to my mother on the way that I don't feel sad or cry, this help me a lot. ♦ A prescription for the medicine I previously received. ♦ Nothing, services are very helpful and pleased. ♦ None, everyone is helpful and nice. ♦ I able to talk some and not be shy and stand-up for myself. ♦ Not to get that angry about things. ♦ Some kind of time management on when to meet. ♦ Putting people down a lot, and being late for my positive interactions and avoids others. ♦ Nothing, everything has helped me great fully. ♦ Nothing, it is perfect as it is. ♦ Nothing, I think they are perfect. ♦ Everything here is very good the best. ♦ Always feeling good. ♦ I think nothing because she helped me to be respectful. The only thing I need is to listen here. ♦ There is no need for improvement, I'm happy with my services. ♦ Everything seems perfect the way it is now with these services I am receiving. ♦ Hope the bad people change and realize there's not a reason to be that way. ♦ My services are great.

Parent/Caregiver comments	Youth comments
♦ Help with medications. ♦ Nothing because thanks to them my daughter has helped with what was bothering her. ♦ I don't think anything! I think they do a grate job! ♦ We received the best help from everyone. ♦ More information on community help. ♦ I think we're happy at this point. ♦ Can't think of anything that would need improvement. ♦ Don't change a thing. ♦ For now, nothing. The children are the ones who benefit more from the services they received. ♦ A closer location would be helpful, then we could attend more often and I would like that. ♦ At this time I can't think of one. My grandson is happy with his treatment. ♦ More time with the therapist. If our other family members were more involved. ♦ Everything has been positive and helped are family and my son. ♦ Services in place are wonderful. ♦ Therapist available on the weekends. ♦ Concentrate on her study, understanding her weaknesses. ♦ I would really like my son to be seen 1:1 with therapist or psychiatrist to talk about melt downs and see if they can talk him through his issues. His meltdowns are still severe, with talk of suicide / homicide thoughts. Not as frequent as before therapy, but 85% as severe.	
3. Additional Comments? ♦ There is no psychiatrist/MD available; my son has not been seen. He was prescribed medications in the inpatient facility, and then he ran out of meds and is left lingering. ♦ Thank you for everything - keep up the good work! ♦ We have received exceptional care and treatment by this facility and the therapist. We would give high recommendations - thank you!! ♦ My son would not be as emotionally grounded and stable as he is without these services. He would have a crisis after crises without ongoing help from our "team." ♦ You need more PSR workers, mine is a call away day or night. ♦ Mom needs a list of resources since we are without insurance. ♦ Many thanks for helping my daughter with her nightmares. Our therapist helped me so that my daughters had the freedom to talk about personal matters with me, so that in my manner of thinking I could give them the best advice for a future life. ♦ No, only thank you all. ♦ How do I teach time management skills and making healthy choices in a fun exciting way? ♦ Do not like format for questions. Questions should be framed in a given context to be answered accurately. ♦ I would recommend close friends and family to receive their services if needed. ♦ Thank you! ♦ My Counselor is friendly and supportive. That almost is enough even without the resources. ♦ Overall I have had a good experience with the services provided me. The staff members are willing to assist and answer questions. ♦ We were not happy with our first counselor, but we were able to request another. Since then, we have been extremely happy with services. ♦ Our therapist is making a tremendous difference in how my child behaves. ♦ Thanks for your services. ♦ Everything is good. My husband and I like it. Thanks. ♦ Nothing for now - thanks for asking. ♦ Thanks for your help and advice for my daughter and my family. ♦ Yes, I am grateful my daughter was allowed in this program	3. Any additional comments? ♦ I'm very happy I belong here and thank you. ♦ I am happy with my FLH staff. ♦ I like the services I receive. ♦ It's not Staffs fault - I just don't care. ♦ Thank you because now I found a real person to talk, and to be comfortable. ♦ I enjoy coming here, everyone is nice, helpful and respectful and they get their job done right and complete. ♦ One thing that I like about my Counselor is that she helps me learn how to control my anger. When sometimes I have bad dreams and how to think before I start screaming to my mom or my son. Then when I start thinking about the person who abused me my Counselor helps me how to not think about that person and to think about what makes me happy that my Counselor is thinking about me. And the problems I have with my mom it is over because right know that I can do is help my mom with everything and it makes my mom so happy and I know that my mom is the only one who could help me or when I need her and the thing I like about my mom is that when I am mad she tells me to go outside to take a breather or count to 1 to 20 or sometime she hugs me really hard and my mom is the best mom I have all these months and years. Thank you to my Counselor for all your help that you give- it makes me so happy. I will miss you a lot with all my love [Drew a Heart and Smiley Face]. ♦ The therapists have been overly helpful as far as transporting my kids to and from school to attend their session. ♦ No - thank you, but I'm doing the best I can in the household. ♦ I love this place. ♦ Thank you all for everything. ♦ I would like to say thank you to my Counselor she is wonderful she helps me a lot. I think before I say and act. ♦ Great Job!

Parent/Caregiver comments	Youth comments
because all the help we were offered has served all of us. Thanks. ♦ The therapist has always helped me and we have improved with that help. The staff here has always listened very well; they are very respectful and patient. ♦ Many thanks for your help. ♦ Thanks for everything, for being concerned with the health of my daughter, thank you all very much for everything. ♦ Great program and family life saving services... Keep up the great work. Thank You. ♦ Only to thank you for the help that parents of small means receive from the state in order to have a better family and good citizens. ♦ Have had some issues and concerns but I feel they are slowly being resolved. ♦ I feel my counselor is a very sensitive and fair. ♦ My child has made small improvements and I am very pleased. He can be a handful but through these services I feel like we are not in crisis mode all the time like before services were in place. ♦ My counselor has been really nice.	

SNCAS WIN Results Parent/Caregiver N=61; Youth N=55 Total Served = 215 Sample = 28%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	97	83
Services were scheduled at times that were right for us.	100	76
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	98	87
The people helping my child and family stuck with us no matter what.	92	78
I felt my child and family had someone to talk to when he/she was troubled.	98	84
The services my child and family received were right for us.	97	78
I received the help I wanted for my child.	97	76
My family got as much help as we needed for my child.	90	80
POSITIVE OUTCOMES		
My child is better at handling daily life.	76	78
My child gets along better with family members.	85	80
My child gets along better with friends and other people.	84	80
My child is doing better in school and/or work.	81	78
My child is better able to cope when things go wrong	74	69
I am satisfied with our family life right now.	84	71
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	58	78
I helped to choose my child and/or family's treatment goals.	93	80
I participated in my child's and family's treatment.	98	71
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	89
Staff respected our family's religious/spiritual beliefs.	94	89
Staff spoke with me in a way that I understood.	100	89
Staff was sensitive to my family's cultural and ethnic background.	98	78

SNCAS

WIN Results

Parent/Caregiver N=61; Youth N=55 Total Served = 215 Sample = 28%	Parent/Caregiver Positive Response %	Youth Positive Response %
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	93	N/A
I have people that I am comfortable talking with about my child's problems.	95	N/A
In a crisis, I would have the support I need from family or friends.	97	80
I have people with whom I can do enjoyable things.	98	89
I am happy with the friendships I have.	N/A	91
I feel I belong in my community.	N/A	80
FUNCTIONING		
My child is better at handling daily life.	76	78
My child gets along better with family members.	85	80
My child gets along better with friends and other people.	84	80
My child is able to do the things he/she wants to do.	77	71
My child is doing better in school and/or work.	81	78
My child is better able to cope when things go wrong.	74	69
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	95	84
Staff explained my child and my family's rights and confidentiality issues.	97	80
I receive support and advocacy from my Nevada PEP Family Specialist.	95	75
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	92	77
Our family is aware of people/ services in the community that support us.	92	75
I am better able to handle our family issues.	90	72
I am learning helpful parenting skills while in services.	90	80
I have information about my child's developmental expectations and needs.	94	81
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	95	90
My child's Psychiatrist/MD answered my questions.	92	90
My child's Psychiatrist/MD spends enough time with him/her.	84	83
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	89	83
My child's Psychiatrist/MD understood his/her problems and feelings.	89	86
My child's meetings with his/her Psychiatrist/MD were helpful.	87	90
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	92	84
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	90	92

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ Service is available and free. ♦ The support I felt I was provided and the additional information received for resources, also an unbiased educated person to help the children I care for. ♦ Learning about resources I didn't know about and ongoing support system. ♦ Seeing a therapist with my child. ♦ Staff support and help to give guidance to the child.	1. What has been the most helpful thing about the services you received? ♦ Medication and helpful skills. ♦ Working together to help me emotionally. ♦ That it helped me stay on task and so the thing I need to do. ♦ My Wrap Around worker is the most helpful cause I can tell her anything, and she will try to fix it anyway possible. ♦ It helps me get throw life now and for later on in life. ♦ That my foster parent is a good man. ♦ Health. Being more healthy.

♦ All the help from all workers. ♦ Sex and anger therapy. ♦ All of the supports, counseling and therapy. I would like for my children to receive Day Treatment Services which have been delayed. ♦ The support. ♦ My son and I get along a lot better due to the fact that my worker put us in contact with boy's town and was a huge advocate for us to get a therapist when we were without. ♦ The medication from the Psychiatrist, they have helped greatly to balance my child out and give him a better quality life. Also the help and support from the therapist and case workers makes all the difference in the world. ♦ My WIN worker is the glue that keeps us together and is good at getting our needs done. ♦ WIN helps me with finding good resources and services and help my kids come back home. ♦ She has improved her ability to cope with frustration and her other problems. ♦ Being able to get my kids back at home. ♦ Being able to have help in coordinating services. ♦ That they listen to us. ♦ Learning to communicate without exploding. ♦ Worker has been very patient and doesn't mind re-explaining things so everyone understands. ♦ Information provided, support, help, guidance, coping skills, management for stress, overall very helpful. ♦ We are just starting and finding services. ♦ Child is able to use his active listening skills and can control his emotions through expressing his thoughts, feelings and needs. ♦ That they show her that people really care about her, something she has admitted she has never had. ♦ Guidance and communication. ♦ My Worker takes her time with my son and I have seen change in him. ♦ Wraparound is getting us prepared for our children to come home. ♦ Being respectful and act like I am paying attention. ♦ The support I receive from the team. ♦ Jordan is improving a lot day to day. ♦ How to be more respectful to her mother and father. ♦ Therapy with her therapist and services with her social worker. ♦ PSR ♦ He went from being disrespectful to respectful, is doing better with friends and family. ♦ That he's becoming a better person. ♦ Keeping a strong team together to better meet his need now going into adulthood. ♦ Learn how to open and talk to people. ♦ Her WIN worker and the advocacy she supports gets. ♦ Some help has been good and our Worker has done wonders. ♦ Going to therapy every week having someone to talk to with my daughter and all the service available to us has helped. ♦ Working with the team. ♦ Coordinating visitation with natural family. ♦ My son is friendlier, happier and communicates more, better grades. ♦ Support, guidance, helps me with everyday parenting skills. ♦ Having supportive staff that have been very helpful. ♦ He has a therapist (not the MD) who he feels very comfortable with. ♦ People to talk to. ♦ Medication. ♦ WIN worker helps meet child's needs and find resources. ♦ Coping skills to get along with siblings.	♦ Helping to control my anger better and not lash out at people. ♦ That I have learned more that I can do and more that are available for me. ♦ Nothing, it only helped me mature. ♦ To help calm down when I'm angry. ♦ Someone to talk to. ♦ Help me find resources. ♦ I get to participate in activities. ♦ Got to live with my mom. ♦ Learning to calm myself down. ♦ The most helpful thing about the services I'm in right now is being with my little brother because I haven't been with him for about a year. ♦ Learning how to deal and cope with my anxiety. It helps me be more comfortable when in situations that I have to interact with others. ♦ Suggestions. ♦ The treatment. ♦ Medical treatment that has helped me cope with life and help me think clearer. Also my lawyer always able to provide encouragement and help when things at home go badly. ♦ About my anger. ♦ Money for my clothes and support. ♦ Candy and toys and books and knowledge. ♦ Control my anger. ♦ The money for things I need. ♦ Therapy. ♦ Helping me understand more my behavioral controls and family. ♦ I am getting the help I need and want from them and I thank them for doing that. ♦ WIN worker giving me rewards (food)! -Took me out of bad foster home. Gave me a break and time to think. ♦ Everything's good. ♦ Horse Playing. ♦ Ice Cream. ♦ I learned new things. ♦ I can get my feelings out without anyone judging me. ♦ Helping me grow up. ♦ Make sure I get to my meetings on time. ♦ My problems and trying to cope with them. ♦ I am provided with safety and stability. ♦ That they are so friendly and open. I can trust them and they feel like family. ♦ That I get to see mom and daddy. ♦ School. ♦ How to form and keep healthy relationships and how to cope and talk about my feelings. ♦ The fact that I know people on my team are here for me.
2. What would improve services your child and the family received? ♦ Male big brother or role model. ♦ It's all good. ♦ Day treatment program, continued services that he is currently receiving.	2. What would improve services you received? ♦ Taking more time to do things. ♦ Less workers. ♦ If I could get a job and a laptop and my allowance money. ♦ Nothing, everything is all good.

- Additional resources for children who have severe behaviors embedded.
- Boys are in Dr services.
- PCWS working Saturdays. It would be very helpful for single parent households.
- Hopefully, if we can stay with one therapist for a length of time.
- All workers answer your phone and return call. Not having to ask two or three time for things I need.
- Support.
- Larger per-child budget.
- Having more time with Worker, in both weekly visits as well as how long she remains with us.
- If it wasn't cut off at a certain age.
- More input from Nurse Case Manager about child's report and medical prescription suggestions when child talks with any doctor.
- My child will need a little more help and I think things will be fine.
- I couldn't ask for no better services then what I am getting.
- I think they r good as they are.
- The stuff we are doing now.
- Finance from day one of child moving into Foster Parent Home.
- Undecided.
- Nothing because they have offered advice in what my daughter needs.
- I think the services my child received were some of the best the staff at Family Services are some of the best and nicest people we have ever met.
- Him, to be able to keep until age 21.
- This family could benefit from family services to help them with community housing services.
- Support the family.
- Listening to all his therapy.
- Right now my opinion is that our services take care above and beyond our expectations and goals.
- More follow-up and not just at CFT meetings.
- My child needs more therapist support with his medication, understanding his diagnosis and a written treatment plan.

- If you give us the service that we want.
- Don't ask too many questions about my feelings.
- Give kids medication that they've started.
- That my workers will talk to each other and know what the case plan is.
- Need more music to calm.
- More Face time.
- If I can see my family.
- My behaviors at home.
- More money.
- Come for more hours.
- Staying the same or get better.
- Right now everything is good.
- Fire Dr. -Give kids more chores. More $ for books! (like to read).
- My Anger.
- Nothing, they are perfect.
- Things are very good here.
- I want my services to be more understanding to my situation, I feel like some of my workers don't have an emotional connection.
- Go back with my dad.

3. Additional Comments?

- No DFS involvement.
- My Counselor is awesome, very committed and helpful. I wish all people were like her!! Thanks!
- I am so very thankful for the services we receive here. We would be lost without it.
- Just remember, those kid are not criminals. They are children of criminals. Sometimes these kids get too many services, and are overwhelmed; give these kids a chance to settle down in a normal family atmosphere, sometimes that's all they need. Some case plans for kid are over the top, to mush.
- I am thankful for services.
- My Counselor is wonderful and very helpful. All of the goals that were set have been met, or close to achieving all goals. Any questions or concerns foster mom has had have been addressed and solved.
- I just want to give thanks for the time dedicated to my daughter and the attention given her and the services. Thanks.
- We would like to thank all of staff for everything hope we can stay in touch.
- Very nice and understanding. Girls don't mind at all working with them, we love them.
- The social worker was very responsible, we felt very special with her help. Thanks
- Love the therapist. Dr. is very quick to prescribe first and ask questions later.

3. Additional Comments?

- No maam.
- I think my wrap round is Awesome.
- Can you please find me a home?
- Case workers should not tell kids what they think of there parents.
- Only if I could get Taco's -Taco Bell.
- Fire Dr.! (I don't like him and am forced to see him). I did like my other Dr. He was good doctor. Give him a raise. I also like WIN!!
- Thanks for everything!
- Everyone is so nice here.
- I love my team they're awesome!

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=60; Youth = NA Total Served = 415 Sample = 14%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	89	N/A
Services were scheduled at times that were right for us.	94	N/A
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	98	N/A
The people helping my child and family stuck with us no matter what.	92	N/A
I felt my child and family had someone to talk to when he/she was troubled.	95	N/A
The services my child and family received were right for us.	94	N/A
I received the help I wanted for my child.	97	N/A
My family got as much help as we needed for my child.	90	N/A
POSITIVE OUTCOMES		
My child is better at handling daily life.	86	N/A
My child gets along better with family members.	87	N/A
My child gets along better with friends and other people.	86	N/A
My child is doing better in school and/or work.	83	N/A
My child is better able to cope when things go wrong	70	N/A
I am satisfied with our family life right now.	76	N/A
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	85	N/A
I helped to choose my child and/or family's treatment goals.	93	N/A
I participated in my child's and family's treatment.	95	N/A
CULTURAL SENSITIVITY		
Staff treated our family with respect.	98	N/A
Staff respected our family's religious/spiritual beliefs.	95	N/A
Staff spoke with me in a way that I understood.	98	N/A
Staff was sensitive to my family's cultural and ethnic background.	98	N/A
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	95	N/A
I have people that I am comfortable talking with about my child's problems.	97	N/A
In a crisis, I would have the support I need from family or friends.	94	N/A
I have people with whom I can do enjoyable things.	98	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.	86	N/A
My child gets along better with family members.	87	N/A
My child gets along better with friends and other people.	86	N/A
My child is able to do the things he/she wants to do.	81	N/A
My child is doing better in school and/or work.	83	
My child is better able to cope when things go wrong.	70	N/A
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	90	N/A
Staff explained my child and my family's rights and confidentiality issues.	94	N/A
I receive support and advocacy from my Nevada PEP Family Specialist.	97	N/A
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	95	N/A

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=60; Youth = NA Total Served = 415 Sample = 14%	Parent/Caregiver Positive Response %	Youth Positive Response %
Our family is aware of people/ services in the community that support us.	92	N/A
I am better able to handle our family issues.	97	N/A
I am learning helpful parenting skills while in services.	97	N/A
I have information about my child's developmental expectations and needs.	94	N/A
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	95	N/A
My child's Psychiatrist/MD answered my questions.	95	N/A
My child's Psychiatrist/MD spends enough time with him/her.	95	N/A
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	95	N/A
My child's Psychiatrist/MD understood his/her problems and feelings.	92	N/A
My child's meetings with his/her Psychiatrist/MD were helpful.	92	N/A
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	92	N/A
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	92	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ Therapy so he can talk. ♦ He learned to talk more, he is more sociable. ♦ Teaching me to deal with outbursts, helping him deal with outbursts - Kinship classes. ♦ Ideas for activities that have helped us improve communication skills relationship and mutual understanding. ♦ Learning how to handle situations at home and deal with them with the help of Counselor while my granddaughter has been in her care. Her therapist is the Best! ♦ The most helpful thing about the services is learning about the disorder my child has and understanding how to handle day to day changes in his moods and why they are happening. ♦ More patience and helped me teach and talk better. ♦ The sessions have really helped us bond. ♦ The relaxation exercises. ♦ Counseling, fostering. ♦ I am overall very pleased with the therapist and the services have been 'right On', thank You. ♦ Psychiatrist. ♦ They feel safe talking about their feelings. ♦ The location and schedule was very convenient. Also it was easy to get a hold of staff by telephone if we needed to speak to someone for advice. Staff was understanding and helpful. ♦ He is doing better in school. He is learning how to calm down a little and not get as upset or frustrated. Coping skills. ♦ Being able to learn ways to deal with child's behaviors. ♦ Everything. ♦ She has had someone to talk to besides family that guides her in a positive direction with positive tools to make proper choices in behavior. ♦ Are aware that people can/will help. Have grown emotionally and morally. For me, I have received support and education that I couldn't get anywhere else. ♦ The consistency re: schedule and information, the support for us as new (foster) parents, the tools suggested for coping, understanding and genuine concern, always as immediate	1. What has been the most helpful thing about the services you received? ♦ NA

response to emails and phone calls. ♦ My Counselor really helps me out no matter what. Thank you - she's understanding. ♦ My child enjoys the time he spends with the PBST worker. ♦ Having the therapist who knows the boys and has helped with the recent transition to our home. ♦ Learning to best handle his behaviors. ♦ Having the therapist assist the boys through the recent transition to our home. ♦ At any point in time if I need help all I have to do is ask and I get options to help me get what I need. ♦ I have learned how to treat his behavior issues. ♦ Understanding feelings, expressing feelings better. ♦ The support. ♦ Therapist comes to my home. ♦ He is being evaluated; we don't have the results yet. ♦ Talking to her about feelings. ♦ Assisting him in dealing with and talking about his feelings. ♦ New creative ways to calm, soothe and de-escalate emotional outbursts. ♦ Understanding my child better and knowing her feelings and wishes. ♦ Behavioral issues. ♦ My Counselor is very helpful and understanding. She is always willing to accommodate our busy schedule. ♦ Improving behavior. ♦ The Family Therapy. ♦ Our services are great. ♦ The Family Therapy. ♦ Coping Skills. ♦ Ruby has been very available and works hard to help us and the children with their mental health needs. ♦ Be helpful and caring. ♦ Answering all questions. ♦ Picking up on a lot of things like not having so many tantrums. ♦ Being able to truly understand what my child is going through in a different perspective. ♦ Behavior Management. ♦ That has been able to control himself more than what he was before and now he lets me know what's bothering. I like the way has been doing and there is a huge difference with the help we get at this location. ♦ Consistent, she feels special and cared about. ♦ She is flexible. Therapist is willing to answer questions, give us tips and do family sessions when necessary. It makes us feel involved and empowered. ♦ Coming up with ways to redirect and handle his behavior. ♦ Advice on how to handle behavior. ♦ Knowing I had help and support while searching for the right services for my grandchildren. ♦ Helping her express herself.	
2. What would improve services your child and the family received? ♦ He can communicate something and try to say what he feels. ♦ Much better, much help. ♦ Eventually we would like to have less sessions and do group sessions more regularly with siblings but we are working towards that. ♦ Saturday office hours. ♦ Communication with worker and worker communication. ♦ Do results that are best for the child. Sometimes re-unification isn't the answer but the law is wrong. ♦ Satisfactory. ♦ If the school district and teachers were educated more, possibly by DCFS Services so everyone is on the same page. ♦ Involving the birth parents with myself and children in clinical setting to improve our communication re old and new issues. ♦ As high as our expectations typically can be, we have had all of them met - with our experience things are going very, very well. ♦ I would love adopt my child and you all has been great help to	2. What would improve services you received? ♦ NA

me. He's doing a great job. Nothing to complain about. ♦ At this point I have everything I need, no improvements are necessary. ♦ Include parent in session intermittently, perhaps have family project to work on / discuss for next session. ♦ We are just beginning. ♦ I think everything you do is very good and helpful for our family, nothing at this time. ♦ In my opinion, the services that we receive are perfect. I enjoy the location and the service provider. ♦ More communication from therapy and PSR and BST. ♦ Reasonable location. ♦ Right now I am satisfied with what's going on. ♦ We are satisfied with services and appreciate the help we've received. ♦ Location is probably my largest issue. ♦ Help him with behavior in public places. ♦ If getting services wasn't such a lengthy process. ♦ To explain exactly what the process of her therapy was and what we were trying to achieve.	
3. Additional Comments ♦ Our therapist helped us a lot as a family with our son. ♦ Great services, great people in dealing with a difficult and emotional situation. ♦ Thank you for a job well done and being more than a source of information. ♦ Our therapist is great! Supportive and insightful. ♦ Transportation. ♦ I hit a brick wall because of law. When parents don't have enough $ for gas to visit child why would you even think of reunification. ♦ Our case worker has gone to all the limits we as a family have faced - above and beyond what the average person or worker would. If she didn't know the answer or way to help us she sought advice from others. I hope all case workers are trained and work as she does. She connects well with the children, at a level they understand and feel comfortable with. ♦ Have received an incredible amount of support, education and direction that I feel has made me a better person and grandmother/Parent. ♦ Our Therapist is extremely professional and has become someone we rely on due to her character and demeanor. ♦ Our Therapist is willing to take the time to listen and answer questions. ♦ Our Therapist is willing to listen and answer questions we have. ♦ Without these services that have been there for me, I would be in a worse place with my child. My child has improved remarkably because of all the services that have been offered to us. We hope to keep the improvements going. ♦ Our Therapist was great with my child. ♦ Our Therapist is always willing to take my calls and give feedback. ♦ So far everything has been good. I am sure the results will be very useful. Thanks. ♦ Thank you for all your help. ♦ Our Therapist is wonderful. ♦ Thanks. ♦ We appreciate our family being treated with respect and empathy. ♦ Dealing with the system can be very frustrating. It seems as if the right hand doesn't know what the left hand is doing. Our Therapist was a big help in coordinating the services to eliminate some of this. I appreciate her help and support through this trying time.	3. Any additional comments? ♦ NA

NNCAS Outpatient Services Results		
Parent/Caregiver N=76; Youth N=35 Total Served = 223 Sample = 34%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	86	85
Services were scheduled at times that were right for us.	93	86
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	93	92
The people helping my child and family stuck with us no matter what.	93	93
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.	88	83
I received the help I wanted for my child.	87	88
My family got as much help as we needed for my child.	84	90
POSITIVE OUTCOMES		
My child is better at handling daily life.	76	86
My child gets along better with family members.	77	81
My child gets along better with friends and other people.	74	83
My child is doing better in school and/or work.	76	82
My child is better able to cope when things go wrong	66	76
I am satisfied with our family life right now.	66	75
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	85	70
I helped to choose my child and/or family's treatment goals.	90	86
I participated in my child's and family's treatment.	96	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	96	94
Staff respected our family's religious/spiritual beliefs.	96	94
Staff spoke with me in a way that I understood.	95	92
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.	91	N/A
I have people that I am comfortable talking with about my child's problems.	91	N/A
In a crisis, I would have the support I need from family or friends.	86	88
I have people with whom I can do enjoyable things.	92	93
I am happy with the friendships I have.	N/A	88
I feel I belong in my community.	N/A	79
FUNCTIONING		
My child is better at handling daily life.	76	86
My child gets along better with family members.	77	81
My child gets along better with friends and other people.	74	83
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.	76	82
My child is better able to cope when things go wrong.	66	76
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	87	93
Staff explained my child and my family's rights and confidentiality issues.	92	90
I receive support and advocacy from my Nevada PEP Family Specialist.	84	86
My Nevada PEP Family Specialist supports me in leading my child's	85	85

NNCAS Outpatient Services Results		
Parent/Caregiver N=76; Youth N=35 Total Served = 223 Sample = 34%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
treatment planning or Child and Family Team meetings.		
Our family is aware of people/ services in the community that support us.	88	82
I am better able to handle our family issues.	85	72
I am learning helpful parenting skills while in services.	85	90
I have information about my child's developmental expectations and needs.	81	82
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	93	87
My child's Psychiatrist/MD answered my questions.	92	84
My child's Psychiatrist/MD spends enough time with him/her.	83	81
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	88	84
My child's Psychiatrist/MD understood his/her problems and feelings.	88	84
My child's meetings with his/her Psychiatrist/MD were helpful.	85	87
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	92	79
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	89	84

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ Her behavior has improved. ♦ Thanks for the help. Now I am not as aggressive with her and her brothers. ♦ Everything has been very good. ♦ The psychologist and talking with him and what he understands. ♦ That my grandson can better control his hyperactivity. ♦ The best thing is that my daughter is completely recovered for now. ♦ It has helped them open up and express their feelings. ♦ Coping skills! Behavior Modification. ♦ Child has someone they feel comfortable discussing things they would otherwise hold in and build up anger issues over. ♦ Just being able to talk to someone helped him. ♦ Ongoing therapy has been very helpful. ♦ Help me help child. ♦ The great help my Counselor is giving is just beautiful. She is doing an amazing job with my son. I will always be thankful to her and I am very proud of the progress my son has done and doing thanks to Counselor. ♦ Everything. ♦ Medication and therapy. ♦ Long term involvement since about age 3 or so. ♦ Help him deal with his emotions. ♦ The medication. ♦ Understanding what may or may not be going on with him. ♦ They have someone to talk to. ♦ They are just wonderful here. I am blessed to have help for my children. They trust them very much! Thank you CBS ♦ For her just having someone outside of the family to confide in. ♦ Stabilization & emotional support. ♦ So far, there has been no benefit to this treatment - his anxiety has increased. This is the last time we will be coming	1. What has been the most helpful thing about the services you received? ♦ Therapy in general. ♦ The support system that they have offered. ♦ Get to talk to someone about my feelings without feeling judged. ♦ They help me cope with situations, and help me to problem solve. ♦ A lot of my problems have been solved. ♦ Everything!! ♦ Anger management has had positive role models that helped in coping skills. ♦ My medication and therapy sessions. ♦ The hope that I could change the way I am. The hope that I may be stronger. ♦ The coping skills. ♦ Motivate how they talk to you. ♦ I have someone to talk to; meds that are helping, and my mom and I have a good relationship now. ♦ I feel better that I have someone to talk to and knowing that they care and that they will listen. ♦ Help with the behavioral problems. ♦ Are amazing family and my helpful friends who help with what I need and they understand. ♦ I control better my emotions. ♦ My therapy with my Counselor. She helps me a lot and shows me that there are people out there I can talk to and that understand me. ♦ Talking it out. ♦ Attention. ♦ Learning how to cope. ♦ Being able to control myself when getting worried or scared. ♦ Having someone to talk to and help with my problems. ♦ Someone to talk to. ♦ It has helped me cope with everything that's happen. ♦ My services were accommodated very well. ♦ I really like having someone to talk to without being judged. It

unless there is a significant change in approach. ♦ Being able to discuss difficult topics with our child and learning how to continue those conversations at home. ♦ Our therapist is always there for my daughter, she trusts her that has been most helpful. I am very happy that we were able to be connected to this organization. I think that if more people were aware of your services they could have some help and support as well. ♦ Things are explained in a way that makes sense. ♦ Daily management, consequences, rules, basic daily life. ♦ Skills to use at home and shared info of the school and therapist. ♦ She can cope better in stressful situations and I was taught how to help her through it. ♦ Just started today. ♦ The personal response of the therapist and psychologist. ♦ Someone with knowledge to talk too, and ADHD meds. ♦ That when I didn't have transportation her therapist went to her school, and answers my emails within 24 hours. ♦ She's doing a lot better. She looks great and happier. She's doing very well at school and other things like she loves when we visit with each other. ♦ Continued services through the years. ♦ He seems more content with himself. ♦ She is better able to handle daily issues, i.e. she's been taught skills to handle her stress and daily problems. ♦ Comparing home behaviors with what is seen in therapy. ♦ Day Treatment at CBS. ♦ The behavioral issues and dealing with him. ♦ Because of services my child is able to attend school without issues and family life is a little more bearable. ♦ My Counselors are very helpful. ♦ Having someone to bring up issues when they arrive. ♦ My child has someone she feels she can open up to. ♦ My Counselor rocks along with my Doctor, they are very helpful and understanding. ♦ Knowing there were people I could contact who could help me with my most unexpected questions or problems. ♦ Behavior has changed, is emotionally stable. ♦ Overall our family life is more peaceful. ♦ I have learned new skills to help my child cope with problems. ♦ Learning to be open. ♦ She is opening up her feelings more. ♦ Learning ways to improve my child's behaviors. Having support during difficult times.	helps me deal with the stressors in my life.
2. What would improve services your child and the family received? ♦ You have helped him a lot in controlling his anger. ♦ The relationship between us is better. ♦ Nothing needs improvement because everything is good. ♦ The services are good, awesome group. Thank you very much for all you guys do. 2 thumbs up! ♦ I respectfully feel that my child's current Psychologist is using philosophies based on Skinnerian reinforcement which seems backwards since behaviors respond to stimuli in a forward direction. Operant conditioning is not the only thing at play here. Behavior feeds forward and I would rather use a Psychologist who adopts philosophies other than Skinnerian thinking. ♦ It would have been wonderful to get him in earlier - our wait was about 7 months, but the results have been great. ♦ Don't know. ♦ Improved communication between psychiatrist and therapist. Therapist knows our child well and can help psychiatrist quickly gain background info. ♦ Home visits. ♦ From my point all the stuff is great!! Thank you with all my heart. ♦ I believe that everything perfect. ♦ Treatment closer to home.	2. What would improve services you received? ♦ They're great as they are. ♦ If the participants would trust more or willing to really discuss issues. ♦ Nothing they are okay. ♦ More information about my service plan. ♦ Nothing, I'm happy with all of the services. ♦ To improve the services there is nothing. ♦ I would like people to not push medication on me cause I feel that has happened. ♦ Help to receive the wants like help with computer or art classes. ♦ The services I am receiving are excellent and need no improving. ♦ Nothing would improve it because their all ready doing a great job. ♦ Overall I've had a really good service. ♦ I hate having a time restriction to communicate. I could go on forever trying to solve my problems. ♦ Not sure, how to have relationships that are healthy.

♦ Nothing at this time. ♦ If there was an office in the Carson Area. ♦ I'm fine right now. ♦ More information on programs out in the public that would work with treatment here. ♦ All is good as provided. The first CM (or maybe therapist) may not have been the best choice for the given situation. CBS was responsive to this and provided a more appropriate CM. ♦ The MD at West Hills was very unhelpful and when I questioned the advisability of depression RX in adolescents, he became very offensive and accusatory. He has only seen a counselor since. ♦ More ideas on communication with the child as time progresses on. Help with finding a part time job as the child gets older. ♦ I we can give the kids their medicals needed. ♦ We are okay now. Although I think her father needs medication sometimes. ♦ To help bring us back together, because she wants to come home with mom, and I also would love for her to come back home with me. ♦ Dr. and therapy appointments on the same day rather than two appointments in the same month. ♦ There needs to be training for the therapists to address the traumas of sexual abuse. I know the children are learning coping skills such as body boundaries, but there aren't any trained therapists to discuss the sexual abuse that many children that are in the care of social services may have endured. ♦ I don't feel we need any more improve. I am pleased with services. ♦ Switched med management to different provider because scheduling with Fellows' hours inconvenience. ♦ Therapy sessions without a parent in the room. ♦ Wasn't in the program very long so everything that we experienced was helpful and appropriate. ♦ For me our services were great. ♦ More Placement Options. ♦ I think the service has been very helpful. I haven't taken him to service for a while so we are starting over again with service. ♦ None known under present circumstances.	
3. Additional Comments? ♦ Only to give thanks for the services given my daughter that are of great help. ♦ All have done good work from the receptionist to the doctors. ♦ Nothing else. Many thanks to everyone who cares for the mental health of our children and for all the help that they offer for the families. ♦ Nothing else. I am grateful for the services my daughter and family received. They have helped us a lot. ♦ Some days he's good-amicable but other days he's sad without wanting to talk to anyone. ♦ This is a great program for children without insurance. My daughter's counselor is great with her. She really enjoys talking to him. ♦ More appointment times that don't conflict with school would be good as well. ♦ Thank you. Couldn't get by without your help! ♦ Thankful they were involved in this treatment. ♦ This is the first visit to this facility, and he has not yet been seen by this doctor. I am hoping for better care, but have been extremely unhappy so far. ♦ Have been bringing children here for over 8 years and always seen a benefit from the services here. ♦ Very happy with CBS. ♦ My kids get nervous when they see convicts doing work around building. ♦ Thank you for everything you have done.	3. Any additional comments? ♦ Your staff is wonderful. ♦ Bring back the yogurt covered pretzel 5 packs. ♦ My Counselor is one of the only people I can talk to. I really appreciate her.

NNCAS WIN Results		
Parent/Caregiver N=84; Youth N=63 Total Served = 187 Sample = 45%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	89	83
Services were scheduled at times that were right for us.	93	76
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	87
The people helping my child and family stuck with us no matter what.	92	78
I felt my child and family had someone to talk to when he/she was troubled.	96	84
The services my child and family received were right for us.	89	78
I received the help I wanted for my child.	90	76
My family got as much help as we needed for my child.	85	80
POSITIVE OUTCOMES		
My child is better at handling daily life.	73	78
My child gets along better with family members.	76	80
My child gets along better with friends and other people.	74	80
My child is doing better in school and/or work.	83	78
My child is better able to cope when things go wrong	68	69
I am satisfied with our family life right now.	70	71
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	88	78
I helped to choose my child and/or family's treatment goals.	98	80
I participated in my child's and family's treatment.	100	71
CULTURAL SENSITIVITY		
Staff treated our family with respect.	96	89
Staff respected our family's religious/spiritual beliefs.	93	89
Staff spoke with me in a way that I understood.	100	89
Staff was sensitive to my family's cultural and ethnic background.	95	78
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	98	N/A
I have people that I am comfortable talking with about my child's problems.	95	N/A
In a crisis, I would have the support I need from family or friends.	88	80
I have people with whom I can do enjoyable things.	93	89
I am happy with the friendships I have.	N/A	91
I feel I belong in my community.	N/A	80
FUNCTIONING		
My child is better at handling daily life.	73	78
My child gets along better with family members.	76	80
My child gets along better with friends and other people.	74	80
My child is able to do the things he/she wants to do.	75	71
My child is doing better in school and/or work.	83	72
My child is better able to cope when things go wrong.	68	69
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	90	84
Staff explained my child and my family's rights and confidentiality issues.	93	80

NNCAS WIN Results		
Parent/Caregiver N=84; Youth N=63 Total Served = 187 Sample = 45%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
I receive support and advocacy from my Nevada PEP Family Specialist.	89	75
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	86	77
Our family is aware of people/ services in the community that support us.	92	75
I am better able to handle our family issues.	90	72
I am learning helpful parenting skills while in services.	90	80
I have information about my child's developmental expectations and needs.	96	81
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	92	85
My child's Psychiatrist/MD answered my questions.	92	89
My child's Psychiatrist/MD spends enough time with him/her.	89	82
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	89	81
My child's Psychiatrist/MD understood his/her problems and feelings.	91	82
My child's meetings with his/her Psychiatrist/MD were helpful.	90	85
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	92	84
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	88	81

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ Working with Worker. ♦ Helping my family get home to Michigan. Great Support and understanding from my Worker. ♦ Can't say because it's all good the services and the people in his life and me. ♦ The team meetings are just great. ♦ Family Unity and Control. ♦ The ability for my daughter to see consistency in a team of members that work together to help provide her with services and support in all areas including her sexual orientations. ♦ Maintaining coordination of services. ♦ Team Work. ♦ Case Manager from Nevada. ♦ For the adults open communication. ♦ Help finding a psychiatrist and counselor that took Medicaid and Transformations continual support for the youth. ♦ Additional support for alternative agencies ♦ Getting the referral for Dr. and having verification why my child is struggling. ♦ Support for monthly communication. ♦ My worker is wonderful to work with. ♦ My child can vent and express his feelings and thoughts. He has been given a variety of 'tools' to help with his issues. ♦ Medical & emotional support. It's been a learning experience. ♦ The support. ♦ The Doctor. ♦ Having my Worker to coordinate all of his services and facilitate meetings has been great! She also helps tremendously with appointments and transportation whenever needed.	1. What has been the most helpful thing about the services you received? ♦ Having my worker has been helpful because we have built a stable relationship and I know I can always talk to her and that is helpful. ♦ My worker is a nice guy. ♦ I have people I can go to if needed. ♦ Everything I wanted or needed done was done. ♦ Coping skills learned, better family life. ♦ Therapy communication with my family, opening up more. ♦ They will give me a computer when I'm fifteen years old. ♦ The most helpful thing about the services I received will have to be the ever lasting support I was given. ♦ Can't remember anything. ♦ That I've learned to be more helpful with myself and others. ♦ Connection with Aunt in California. ♦ Getting me home to my mom. ♦ All the support and help from my team. ♦ Coming to Transformation even though I didn't want to come. ♦ The thing FLH staff taught me. ♦ Getting more information about my diagnosis and medication. ♦ Dealing with problems. ♦ I learned how to ignore better and trying not to hit people when I get mad. ♦ They help me get through life and they get me things I needs. ♦ People listening to me. ♦ People who know me for a long time. ♦ Boxing. ♦ Knowing what's wrong with me. ♦ Yes the team meetings help me get centered in my plan. ♦ The most helpful thing I have received is ways to cope with ADHD and the behavioral problems I have.

Parent/Caregiver comments	Youth comments
♦ W.I.N. ♦ Team worked to help my family live together again. ♦ Helping with my child's other services. ♦ Team Support. ♦ Supports that know and respect his needs, people who have been with him for a long time and consistent with him. My Worker has helped support him through many challenges and does a great job at keeping the team together. ♦ Having a team to approach with any problems that might come up. ♦ The Information. ♦ I believe the most helpful thing is having a very supporting WIN Worker. ♦ Having a [WIN] worker who actually listens to concerns and then addresses them in a timely and successful manner. ♦ WIN worker is willing to accommodate our schedule and meeting places. ♦ WIN - the worker's experience with children in foster care. ♦ Emotional support and emotional feelings. ♦ Helping with managing his behavior and getting help with school issues. ♦ I'm super happy with the help you guys made me because we work as a team! ♦ Someone to go to answer questions. ♦ Information about the past to help understand her needs and where she's coming from, my Worker is always so kind and helpful, her smile is great. She is as we call her The Boys Cheerleader. We are happy to have her. She is full of ideas and is always willing to help. ♦ Guidance for the kids. ♦ It helps when we are having issues for her to hear someone else's opinion and helps her understand why things are the way they are and helps us form a common ground. ♦ Grandparents receiving parenting classes, gymnastic classes, and clothes for both children, state financial assistance. ♦ Being sympathetic and compassionate when problems arise. ♦ I'm currently not sure if his psychiatrist has helped him at all yet with 'no child left behind'. ♦ Understanding more of what he is going through and what to do to help him learning to get along with peers. ♦ We were able to get a chore list done and other therapy that were expected from our family members to keep our daily lives on track. ♦ Working on social skills. ♦ Learning how we can not hurt each others feelings. ♦ The support - Helps with moneys needed for sport activities. ♦ Support. ♦ No child left behind, Intensive Family Services. ♦ Support team - a place to turn to for questions. ♦ All the support has been very helpful from a range of different services. ♦ Better understanding, being able to set goals for himself. ♦ The support for both us and the child - Becky has been an asset to us and without her things would be harder. ♦ The help and support we receive. ♦ His behavior and attitude have improved. ♦ All of the services were good. She has improved a lot. ♦ Consistent team approach.	♦ Having people give me chance after chance. ♦ I don't really know, because this is only my second meeting with my WIN worker. ♦ Nothing special. ♦ Helped my family and myself out as much as possible. ♦ A place to like. ♦ The counselor, my family and the services. ♦ I don't know. ♦ They the homies. ♦ They told me what was going on with my situation and my surroundings. ♦ I'm calmer at most times. ♦ Being able to understand some things. ♦ The most helpful thing I received was all the support I have gotten. ♦ Willow - Dr. - My P.O. - the DBT Skillz - talking to my sister - starting a new school - being able to become more active.
2. What would improve services your child and the family received? ♦ Getting the child's family to actually participate considering that never happened. The child received outstanding services. ♦ At this time we will have to see. He needs to see how camp goes. ♦ I think all is going pretty good. Most everything is up to our child and we are all hoping he steps up. ♦ I have no suggestions to better the program already in place.	2. What would improve services you received? ♦ Not getting rid of my WIN worker. ♦ Getting my anger under control. ♦ I am unsure. ♦ Just support me and help me more. ♦ To see my mom. ♦ Not much really. But I received a lot of services. ♦ A more relatable person.

Parent/Caregiver comments	Youth comments
♦ Pushing reunification with families - butting out. Stop causing problems with families. ♦ It went well. ♦ Youth needed to be held accountable for negative decisions. ♦ Currently have a WIN worker and not sure the effectiveness of these meetings. It did help with the referral for Dr., but other than that not sure what benefits we are seeing at this time. ♦ More communication with foster parents about issues. ♦ Transportation. ♦ Transportation - Same day combined treatment and/or visits. ♦ It would be extremely helpful to ensure that all team members are fully communicating and openly expressing what their intentions / goals are. ♦ Nothing at this point and time. ♦ Honesty and following through with promises. ♦ If the therapists would spend more time working on actual issues the children have and less on non-issues and playing games. ♦ After school, school break and summer programs for tweens (ages 10-14). Specific programs geared for girls or children transitioning from foster to adoption. ♦ Better comprehensive clearing house of services available. ♦ Trust. ♦ I can't think of anything. ♦ Nothing, I'm happy with my worker. ♦ I believe we have received every service that could be available to us, everyone has been very informative and generous to our grandchildren and us. ♦ The staff has been very helpful. ♦ Our Worker has been amazing and helped our family tremendously. I'm very thankful for all of her help. ♦ Not let our child control the situation with his emotional outbursts. ♦ All our needs have been met at this time. ♦ After hour and weekend phone availability. ♦ More counseling for problems. ♦ Nothing! Services that this family received have been nothing but helpful and they do all they can to help. ♦ Nothing. It's working great. ♦ That we get to continue to see our Worker.	♦ If I had an older brother. ♦ Being able to spend time with friends. ♦ Nothing, my team is amazing and they helped me better than anyone else ever could. ♦ Spending more time with my grandpa. ♦ Getting a punching bag. ♦ Being more calm. ♦ McDonalds. ♦ More activities. ♦ I think that I need more appointments or to schedule one when I am having a problem. ♦ Being able to want to get help but hard to get the help. ♦ Well, not really. I have only received services for two months. ♦ Seeing mom, not getting cops called on me for looking outside, not being grounded from own home. ♦ Cheerleading. ♦ The group is good that helps me. ♦ Everything is good. ♦ What would I improve is a little bit more communication with friends and family. Talk to people like counselors that would help me to talk it out. ♦ Go out more. See my family more. ♦ Give me money for my restitution and get me off parole ASAP. ♦ If they told me the truth and nothing but the truth. ♦ Not much really. But I received a lot of services. ♦ NCIR! ♦ Communication with Dr. ♦ All is well as it is. ♦ During CRT's need more improvement first, and then successes. If my WIN worker would visit me more. And if I could do something like this to show if negative or positive has occurred. ♦ Get me off probation faster.
3. Additional Comments? ♦ Thank you for all your help. ♦ Our Worker is awesome - very helpful & supportive - we (our family) loves him. ♦ I'd like to see a change in behavioral [?] without [?] stealing [?] on the door etc... ♦ Our son's team is in his corner and that is great! ♦ Thank You. ♦ I liked wraparound I am very pleased. ♦ It has been a long and difficult road until I found these services. I feel I have a team dedicated to my son and helping to achieve the ultimate goal of transitioning my son into a responsible and healthy man. ♦ Our Worker is absolutely amazing! ♦ I feel that the Judge was accurate when she said the CPS worker needed to be more honest and forthright with information concerning children! ♦ We need a clearing house for resources, so people are better able to know what is available and ask for what they need. Better coordination between non-profit, state, local and federal agencies. ♦ Better coordination between non-profits, federal, local and state resources. ♦ Nothing, but I know if anything comes up in the future I have somewhere and someone to turn to. ♦ Thanks for allowing my family all the help and support of WIN Services.	3. Any additional comments? ♦ I love my worker she is awesome! ♦ This is ridiculous, not having a therapist for a long time. I used to have the best therapist. ♦ Addressing issues is good at Child Family Team meeting with my worker, I feel she is good with explaining what needs to be explained. I have no concerns at this time that need to be addressed. Thank you. ♦ I should be home schooled so I am not in town or get cops called on me. ♦ Off parole ASAP. ♦ My worker does a great job. ♦ Thank you for letting me fill out this survey. And besides WIN Worker visiting more everything else is good. Thanks again.

NNCAS Early Childhood Mental Health Services Results		
Parent/Caregiver N=50; Youth N=NA Total Served = 153 Sample = 33%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	80	NA
Services were scheduled at times that were right for us.	98	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	NA
The people helping my child and family stuck with us no matter what.	94	NA
I felt my child and family had someone to talk to when he/she was troubled.	100	NA
The services my child and family received were right for us.	96	NA
I received the help I wanted for my child.	100	NA
My family got as much help as we needed for my child.	94	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	92	NA
My child gets along better with family members.	88	NA
My child gets along better with friends and other people.	82	NA
My child is doing better in school and/or work.	86	NA
My child is better able to cope when things go wrong	86	NA
I am satisfied with our family life right now.	73	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	100	NA
I helped to choose my child and/or family's treatment goals.	98	NA
I participated in my child's and family's treatment.	98	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	NA
Staff respected our family's religious/spiritual beliefs.	100	NA
Staff spoke with me in a way that I understood.	100	NA
Staff was sensitive to my family's cultural and ethnic background.	100	NA
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	100	NA
I have people that I am comfortable talking with about my child's problems.	100	NA
In a crisis, I would have the support I need from family or friends.	96	NA
I have people with whom I can do enjoyable things.	96	NA
I am happy with the friendships I have.	N/A	NA
I feel I belong in my community.	N/A	NA
FUNCTIONING		
My child is better at handling daily life.	92	NA
My child gets along better with family members.	88	NA
My child gets along better with friends and other people.	82	NA
My child is able to do the things he/she wants to do.	88	NA
My child is doing better in school and/or work.	86	NA
My child is better able to cope when things go wrong.	86	NA
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	98	NA
Staff explained my child and my family's rights and confidentiality issues.	94	NA
I receive support and advocacy from my Nevada PEP Family Specialist.	88	NA
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	93	NA
Our family is aware of people/ services in the community that support us.	90	NA

NNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=50; Youth N=NA Total Served = 153 Sample = 33%	Parent/Caregiver Positive Response %	Youth Positive Response %
I am better able to handle our family issues.	92	NA
I am learning helpful parenting skills while in services.	98	NA
I have information about my child's developmental expectations and needs.	96	NA
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	96	NA
My child's Psychiatrist/MD answered my questions.	96	NA
My child's Psychiatrist/MD spends enough time with him/her.	94	NA
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	93	NA
My child's Psychiatrist/MD understood his/her problems and feelings.	96	NA
My child's meetings with his/her Psychiatrist/MD were helpful.	96	NA
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	96	NA
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	96	NA

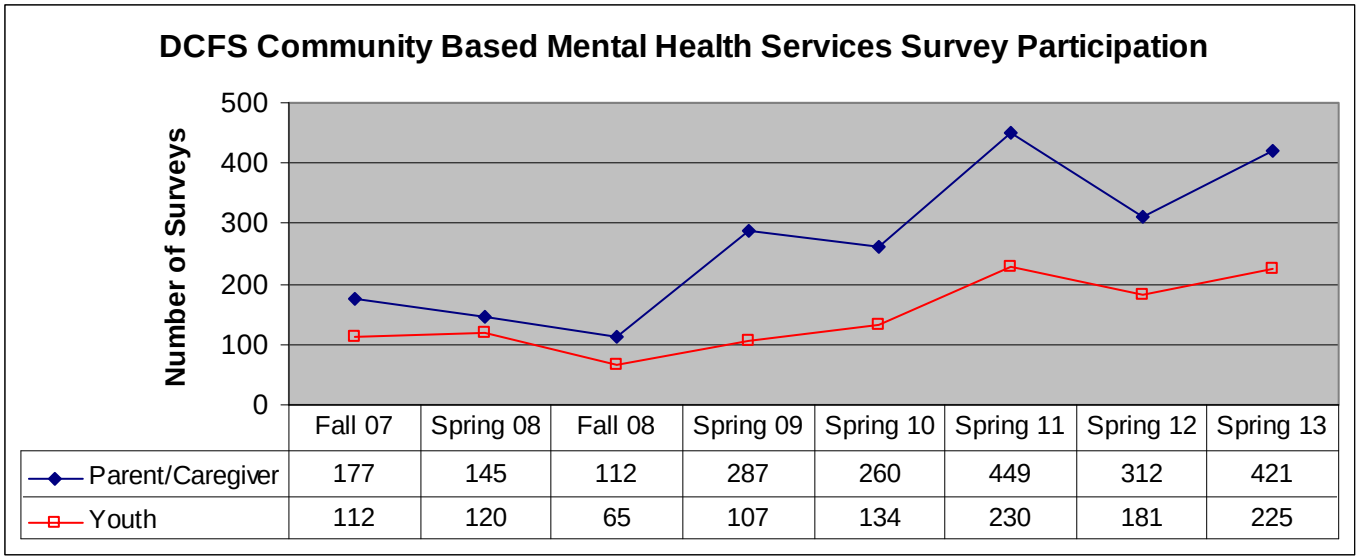
Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ Pays more attention. ♦ That the child says what he is thinking and feeling. ♦ That he can understand about why he is with me. ♦ Child has shown much growth in appropriate behaviors. ♦ Weekly support, as I have a large and ever changing family. ♦ The one on one service for the child is great. ♦ The connections he has been able to connect with and open up to. ♦ Parenting suggestions, support for my child, medication. ♦ Knowing the child is on track and knowing any delays the child may have. ♦ We have only started bringing our child in, but I believe the people here are going to be very helpful to us. ♦ Behavioral therapy and Medications. ♦ Getting the help to redirect my child when needed. ♦ They have someone to talk to. ♦ The support and guidance given when situations have arisen. ♦ The services she receives help her to better cope with things. ♦ The weekly services and Counselor talks everything out with me. ♦ Only been a few services but at the moment, the information provided has been most helpful. ♦ The close relationship they have grown to have. The help they have given all of us. The wonderful tools. Thank you CBS. ♦ Providing me and my son with suggestions or alternative directions when problems do arise. ♦ Gives us a better understanding on how to handle daily problems and what they need. And we are not the only ones with a problem child. ♦ Feedback, ways to deal with coping and behavioral issues. ♦ They teach me new ways to handle my foster child. ♦ Talking to Dr and therapy. ♦ Psychologist listens to my concerns and gives helpful advice. ♦ Learning to connect with my son better. ♦ Him learning coping skills. ♦ Learning helpful parenting tips. ♦ The overall support has been very good and helped in dealing with tantrums. ♦ The way the therapist is re-teaching me how to talk to my	1. What has been the most helpful thing about the services you received? ♦ NA

daughter. ♦ That I can call and talk to my child's therapist. ♦ Has helped with tantrums. ♦ Bonding with my son has improved. ♦ A listening ear and skills on how to communicate or control his emotions / behavior. ♦ Managing his temper (on-going process); communicating his feelings and needs; learning the skills to communicate better and recognize his feelings better. ♦ Getting a deeper understanding of how she thinks and feels in order to help her. ♦ Meds are helping 100%. ♦ The counselor is great. ♦ Learning to modify their own behavior. ♦ With her, her therapist has been instrumental in helping us deal with her anger and alienation. ♦ Stability/security with his therapist, caretakers learning better skills. ♦ Medication. ♦ Learning ways to help my children cope with their feelings to better handle situations. ♦ Someone to talk to.	
2. What would improve services your child and the family received? ♦ Follow rules better. ♦ I think everything is good. ♦ Services are needed in Carson City. Lack of available services has been deterrent to full-time family placement. ♦ Continued services. ♦ More schedule availability of psychiatrist who is currently available one afternoon per week ♦ The staff at all locations are very knowledgeable and giving. ♦ I am happy with the services we receive and unsure of how it could be improved. ♦ More accurate diagnosis on his behavior. ♦ More communication with county regarding children behaviors, and etc ♦ I feel the services she receives are very helpful. I feel that what is being done is excellent. ♦ Ability to bill private insurances. Our granddaughter (currently in our home under foster care) will not be able to receive services from your location once legal guardianship is established. ♦ You are doing a great job. Thank you. ♦ Foster parents giving children meds instead of waiting for workers. ♦ I am satisfied with the way things are. ♦ I am not sure, I haven't had any issues. ♦ There is nothing I can think of. They are always there and able to be reached at any time. ♦ Everything is great. ♦ Call returned if a voicemail is left when regarding concerns for my child. ♦ More peer based programs so that they can use the skills they're learning in real-life situations that are being closely monitored. ♦ Nothing I can think of - this experience has been very helpful, all positive. ♦ I don't know of anything, it's been a completely positive experience for us all. ♦ The staff members my children see are fabulous and very beneficial, I wouldn't improve anything.	2. What would improve services you received? ♦ NA

3. Additional Comments? ♦ Everything is very professional. Thanks ♦ I believe that our Counselor and Dr. have saved my child's life and our family. They were there for the toughest time and always able and willing to help and answer any questions or address any concerns. ♦ This is our child's 2nd visit and she already feels comfortable here, usually she's shy at first. ♦ Our family LOVES our Counselor! She is a true asset to this program. ♦ LOVE both our Counselors - they are wonderful! ♦ Wonderful staff - thank you!	3. Any additional comments? ♦ NA

Survey participation

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



	Fall 07	Spring 08	Fall 08	Spring 09	Spring 10	Spring 11	Spring 12	Spring 13
Parent/Caregiver	177	145	112	287	260	449	312	421
Youth	112	120	65	107	134	230	181	225

The current survey shows a statewide increase (35%) in parent/caregiver participation and a corresponding increase (24%) in youth participation when compared to the same survey conducted in the spring of last year. Statewide there were a combined total of 646 agency parent/caregiver and youth survey participants. There was an overall statewide participation increase of (31%) from the Spring 12 survey.

A Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 421 parent/caregiver surveys returned statewide, 37 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 – SNCAS
(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**
Las Vegas: East Neighborhood Family Services Center	☐	☐
Las Vegas: West Neighborhood Family Services Center	☐	☐
Las Vegas: Central Neighborhood Family Services Center	☐	☐
Las Vegas: North Neighborhood Family Services Center	☐	☐
Las Vegas: South Neighborhood Family Services Center	☐	☐

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.

DCFS COMMUNITY BASED SERVICES
YOUTH SURVEY - SNCAS
(Youth 11 years and older)

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 are 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.						

DCFS COMMUNITY BASED SERVICES
YOUTH SURVEY - SNCAS
(Youth 11 years and older)

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.						

DCFS COMMUNITY BASED SERVICES
YOUTH SURVEY - SNCAS
(Youth 11 years and older)

Psychiatrist/MD:

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Does Not Apply
43.	My Psychiatrist/MD was respectful and helpful?						
44.	My Psychiatrist/MD answered my questions?						
45.	My Psychiatrist/MD spends enough time with me?						
46.	My Psychiatrist/MD provides guidance and support in my treatment?						
47.	My Psychiatrist/MD understood my problems/feelings?						
48.	My meetings with my Psychiatrist/MD were helpful?						
49.	The medications that my Psychiatrist/MD prescribed (**If Applicable**) were explained to me (side effects, effectiveness, and expectations of outcomes)?						
50.	Overall- I am pleased with the services I have received from my Psychiatrist/MD.						

51. 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

52. 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

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

_____

_____

_____

DCFS COMMUNITY BASED SERVICES
YOUTH SURVEY - SNCAS
(Youth 11 years and older)

54. 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
FY 2013

DCFS Residential Discharge Survey Report
Parent / Caregiver – Youth Survey Results
Statewide FY 2013

From July 1, 2012 to June 30, 2013, 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.

The survey instrument used at Desert Willow Treatment Center was somewhat different than what was used by the other programs. The responses have been associated with the same domains in the tables that follow with one exception: questions pertaining to staff have been grouped in their own domain, replacing the Functioning domain used in the others.

Survey Results Format

For this report, residential services survey results are in table format and are presented by type of service: Desert Willow Treatment Center and 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. Desert Willow Treatment Center, 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. These remarks were not collected on the Desert Willow Treatment Center survey. 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 27 parent/caregivers and 34 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 Discharged	Survey Sample Percent	Number of Surveys
SNCAS				
Desert Willow Treatment Center	240	269	89%	245
Oasis On Campus Treatment Homes	4	24	17%	6
SNCAS Total	244	293	83%	251
NNCAS				
Adolescent Treatment Center	16	46	35%	23
Family Learning Homes	7	41	17%	5
NNCAS Total	23	87	26%	28
Statewide Total	267	380	70%	279

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 FY 2013

SNCAS Desert Willow Treatment Center (DWTC) **Parent/Caregiver N=240; Youth N=245** **Total Discharged = 269 Sample = 89%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Buildings in which services were provided are safe.	93	94
Buildings in which services were provided are comfortable.	95	88
Buildings in which services were provided are well cared for.	93	94
Staff members were available to discuss treatment services.	93	93
Staff made efforts to work with the scheduling needs of parents and/or significant others (i.e., meetings, medications reviews, IEPs, phone contacts).	92	94
GENERAL SATISFACTION		
DWTC met the needs stated during the course of treatment.	87	89
DWTC met my expectations.	89	87
I am satisfied with the care and treatment provided by DWTC.	90	91
POSITIVE OUTCOMES		
Youth's school needs were addressed.	85	87
Progress was made on treatment issues.	80	93
I would recommend DWTC services to others in need of treatment.	88	88
PARTICIPATION IN TREATMENT		
I am satisfied with my opportunity to have input into treatment.	88	89
CULTURAL SENSITIVITY		
Treatment provided was sensitive to my cultural and spiritual needs.	91	90
STAFF		
Staff that provided treatment services were caring and professional.	93	93
Staff protected personal privacy.	93	96
Staff protected confidentiality.	92	96
INTEREST ITEMS		
I am satisfied with the information that I was provided regarding medication, diagnosis, prognosis, unit programs, rights and safety.	93	95

SNCAS Oasis On Campus Treatment Homes **Parent/Caregiver N=4; Youth N=6** **Total Discharged = 24 Sample = 17%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	75	83
Visitation rooms were comfortable and provided privacy with my child.	67	67
Services were scheduled at times that were right for us.	75	83
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	75	33

SNCAS

Oasis On Campus Treatment Homes

Parent/Caregiver N=4; Youth N=6 Total Discharged = 24 Sample = 17%	Parent/Caregiver Positive Response %	Youth Positive Response %
The people helping my child and family stuck with us no matter what.	75	83
I felt my child and family had someone to talk to when troubled.	75	67
The services my child and family received were right for us.	75	83
My family got the help we wanted for my child.	75	50
My family got as much help as we needed for my child.	75	100
POSITIVE OUTCOMES		
My child's educational needs were met during residential services.	75	67
My child is better at handling daily life.	75	80
My child gets along better with family members.	75	60
My child gets along better with friends and other people.	75	100
My child is doing better in school and/or work.	75	60
My child is better able to cope when things go wrong	75	100
I am satisfied with our family life right now.	75	100
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	100	67
I helped to choose my child and/or family's treatment goals.	75	83
I participated in my child's and family's treatment.	75	83
CULTURAL SENSITIVITY		
Staff treated our family with respect.	75	83
Staff respected our family's religious/spiritual beliefs.	100	83
Staff spoke with me in a way that I understood.	75	33
Staff was sensitive to my family's cultural and ethnic background.	100	50
FUNCTIONING		
My child is better at handling daily life.	75	80
My child gets along better with family members.	75	60
My child gets along better with friends and other people.	75	100
My child is doing better in school.	75	60
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	67
Staff explained my child and family's rights, safety and confidentiality issues.	75	67
Our family is aware of people and services in the community that support us.	75	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.	75	N/A

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received/ ♦ The staff was positive and always willing to help. ♦ The staff really worked with my son on his specific needs. ♦ He was always provided the support he needed. ♦ Treatment of behavioral issues.	1. What has been the most helpful thing about the services you received? ♦ The straight forwardness of the staff. ♦ Learned to help in the house- put away food. ♦ Meeting new staff. ♦ The staff tending to my specific needs, ♦ Staff in the house but last and the least I learned from a staff Member – AKA I hate him.

2. What would improve services your child and the family received? ♦ ability to tailor it even more and perhaps longer ♦ Continue to work with OASIS or contact them as needed for Support and advice and guidance.	2. What would improve services you received? ♦ More individualized consequences ♦ If program managers would know <u>everything</u> about the program because they don't even know simple point system. ♦ Staff member to speak Spanish. Watching movies helps feel safe. Riding the bike cycle helps. - helmets keep me safe - Helped me get more clothes for school. ♦ If it was not a program - if it was actually a real house. ♦ If the home was more of a family setting and more award system. ♦ Cursing, lying and bad behavior.
3. What would improve client safety? ♦ None, all is great.	3. What would improve client safety? ♦ Move location. ♦ Helmets keep me safe - safe hands - calm voice learned. ♦ No not really - felt safe - going to have more freedom now - I can hang out with other people now. ♦ I felt very safe nothing needed. ♦ Please don't restrain people.
4. Additional Comments ♦ I believe my son is in a much better place since he has been at OASIS than he ever has been upon discharge from anywhere before. ♦ Thank you for treating my family with understanding and kindness.	4. Any additional comments? ♦ I would not recommend this program. ♦ DD client- answers written by AA w/cooperation of the client. ♦ No, but thank you for the right amount of treatment. I hate the place with all my heart.

NNCAS Adolescent Treatment Center **Parent/Caregiver N=16; Youth N=23** **Total Discharged = 46 Sample = 35%**	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	91
Visitation rooms were comfortable and provided privacy with my child.	64	70
Services were scheduled at times that were right for us.	94	70
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	94	96
The people helping my child and family stuck with us no matter what.	100	78
I felt my child and family had someone to talk to when troubled.	100	83
The services my child and family received were right for us.	94	91
My family got the help we wanted for my child.	94	65
My family got as much help as we needed for my child.	75	86
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	94	86
My child is better at handling daily life.	88	83
My child gets along better with family members.	87	100
My child gets along better with friends and other people.	88	82
My child is doing better in school and/or work.	86	65

NNCAS

Adolescent Treatment Center

Parent/Caregiver N=16; Youth N=23 Total Discharged = 46 Sample = 35%	Parent/Caregiver Positive Response %	Youth Positive Response %
My child is better able to cope when things go wrong	81	100
I am satisfied with our family life right now.	79	100
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	93	78
I helped to choose my child and/or family's treatment goals.	93	87
I participated in my child's and family's treatment.	94	78
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	91
Staff respected our family's religious/spiritual beliefs.	75	86
Staff spoke with me in a way that I understood.	100	91
Staff was sensitive to my family's cultural and ethnic background.	82	73
FUNCTIONING		
My child is better at handling daily life.	88	83
My child gets along better with family members.	87	100
My child gets along better with friends and other people.	88	82
My child is doing better in school.	86	65
My child is better able to cope when things go wrong.	81	100
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	94	96
Staff explained my child and family's rights, safety and confidentiality issues.	88	83
Our family is aware of people and services in the community that support us.	87	100
I am better able to handle our family issues.	80	N/A
I am learning helpful parenting skills while in services.	73	N/A
I have information about my child's developmental expectations and needs.	88	N/A

Parent/Caregiver comments

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

- Our child has talked more freely about his feelings.
- Monthly team meetings.
- Helping him deal with his anger, take or accept responsibility for his actions, and schoolwork.
- A very supportive, caring, understanding staff yet firm, air, direct while receiving treatment.
- Security of my daughters well being.
- Continuation of working with child when first admitted. He was definitely not ready to come into the program and was proud of what he had gotten out of the services.
- He appears to have gained the skills to manage his anger better and focus on the positive.
- Helping him to realize his potential by being safe and sober.
- Counseling sessions that showed us how to work through disagreements.
- They have been very supportive about having parent/child contact and visits.
- Communication.
- Her therapist.
- My child has learned the necessary value of self-care and self respect.
- The support I received to help my son with his anger.
- Continuation of working with child when first admitted. He was definitely

Youth comments

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

- They helped me to realize to become more understanding of others.
- Getting myself away from drugs.
- Sleeping.
- I learned new things.
- The groups with team leaders and A.R.T. groups.
- School.
- My anger management structures and understanding the feelings of others.
- Me being able to learn coping skills for my anger.
- They got me back on track for school.
- I have a better relationship with my dad and family.
- My attitude changed in a good way.
- Controlling my anger.
- Groups – 1 on 1 with staff- consequences.
- It made me fix my life from bad to good.
- Learning self-control
- Expressing my feelings.

not ready to come into the program. He came around and ended up enjoying the program and was proud of what he had gotten out of the services. ♦ Getting CLIENT to a place to understand the things that she is able to control and understand those that she isn't able to control, but that those things that she isn't able to control such as her family she has developed some coping skills	♦ The staff and the things they told me when I needed help. ♦ Interacting with my peers and staff with activities. ♦ All the support from staff. ♦ Everything was helpful. ♦ Having “emdr” eye movement desensitization and reprocessing with my therapist. ♦ My therapist understands me.
2. What would improve services your child and the family received? ♦ We believe the services are sufficient as they have been provided. ♦ Nothing at this time the services great and helped a lot. ♦ Better food quality. ♦ Not sure- mainly that we are made aware of changes in advance and given reasoning as to why they change. ♦ Great job. ♦ If the testing we request upon intake had been done. ♦ The services are already top notch. I can’t think of a way to actually improve. ♦ Can’t think of anything at this time.	2. What would improve services you received? ♦ Realizing the things I should of learned earlier. ♦ Nothing but more money. ♦ Less room time during the day! ♦ If staff would focus on all the clients instead of certain ones they favor. ♦ Staff take their own advice. ♦ Everyone should be treated fairly with no favoritism. ♦ Me deciding on if I am ready to finally do the right thing. ♦ Nothing. The services I received were perfect for me. ♦ Staff not being so rude at time and picking sides. ♦ We get more food. ♦ Be treated with more respect ♦ The food. ♦ Staff opening their ears to listen to the kids more. ♦ Happier staff. Sometimes their mood brings me down. ♦ Seconds on meals, more staff/peer interactions. ♦ To be honest, a bit more strict. Staff watching kids more.
3. What would improve client safety? ♦ Gated between buildings. ♦ Have staff keep keys to building and doors more secure. ♦ Great job. ♦ All safety measures are already in place. Can’t think of any	3. What would improve client safety? ♦ Have none. ♦ Put cameras up. ♦ In my opinion client safety is good here. ♦ Help with peer meeting when having issues. ♦ I think staff should not talk about certain situations about clients with other staff. ♦ Keeping your eye on kids more. ♦ Watch them more!!! ♦ Keep a better eye out for sneaky behavior. ♦ Not give kids the option to steal staff keys!! And inform parents when they are missing. ♦ Make it so the windows can’t be kicked out. ♦ Be more active and talk. ♦ Treat all kids fair.
4. Additional Comments ♦ I am very thankful for the staff; services at ATC for help my child. He was heading down the wrong road and now he is on the right one and I'm grateful for that. Thank You. ♦ I am cautiously optimistic that he will succeed and excel at his new school with the support and "foundation" provided to use the "tools" he learned while at ATC. ♦ Thank you. ♦ I have seen a lot of positive changes in my daughter, thank you. ♦ This is a great program. It has done wonderful things for two of my children. ♦ Thank you!	4. Any additional comments? ♦ I have learned a lot from the program and thank you for the help. ♦ Goodbye. ♦ Yes, this place is a really good place if you give the people the chance to help. ♦ Nope! – I am just ninja. ♦ My therapist is good and everybody should get her.

NNCAS

Family Learning Homes

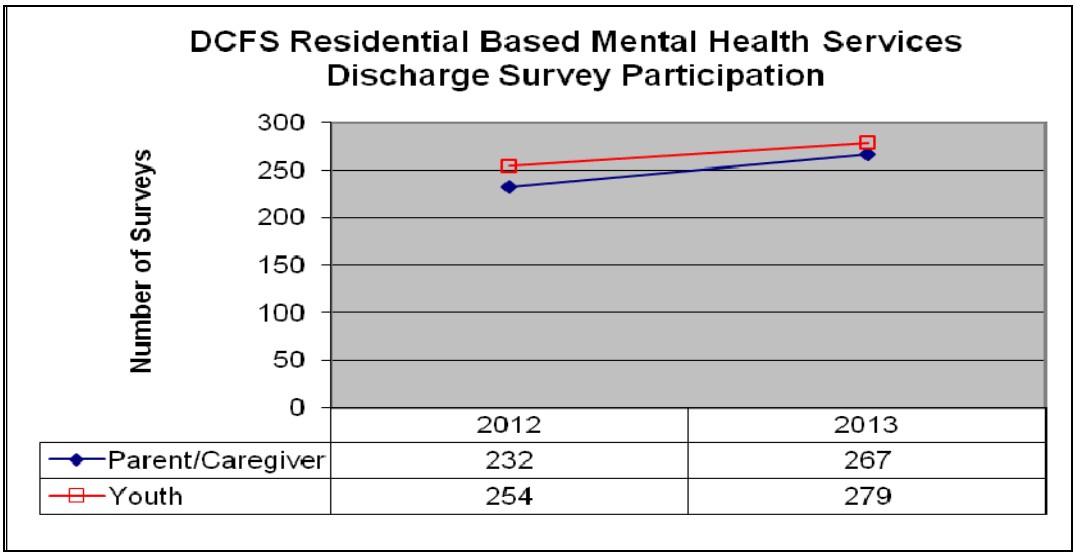
Parent/Caregiver N=7; Youth N=5 Total Discharged = 41 Sample = 17%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	86	100
Visitation rooms were comfortable and provided privacy with my child.	100	100
Services were scheduled at times that were right for us.	86	80
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	86	100
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 he/she was troubled.	100	80
The services my child and family received were right for us.	86	100
My family got the help we wanted for my child.	86	100
My family got as much help as we needed for my child.	86	100
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	86	80
My child is better at handling daily life.	100	100
My child gets along better with family members.	67	80
My child gets along better with friends and other people.	86	100
My child is doing better in school and/or work.	57	100
My child is better able to cope when things go wrong	83	100
I am satisfied with our family life right now.	71	100
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	40	80
I helped to choose my child and/or family's treatment goals.	83	80
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	80
Staff spoke with me in a way that I understood.	100	100
Staff was sensitive to my family's cultural and ethnic background.	100	75
FUNCTIONING		
My child is better at handling daily life.	100	100
My child gets along better with family members.	67	80
My child gets along better with friends and other people.	86	100
My child is doing better in school.	57	100
My child is better able to cope when things go wrong.	83	100
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	100	100
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.	86	100
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.	86	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received?	1. What has been the most helpful thing about the services you received?

♦ It was good ♦ He improved in handling his anger, using coping skills. ♦ Providing an environment where he learned structure, accountability and earned allowance for good behavior and following household rules, chores etc. ♦ Paula [OP therapy had good insight. Learning center point program worked for client. ♦ Kelly's parent training was extremely helpful, specific and professional. ♦ The parenting training was great and taught me new techniques.	♦ Coping skills. ♦ Everything. ♦ ART ♦ Learning to follow instructions and anger control. ♦ Staff teaching me stuff.
2. What would improve services your child and the family received? ♦ Good ♦ Flexibility ♦ If you had been able to provide DBT and you offered computers to do the homework on. ♦ I thing that everything is correctly in place.	2. What would improve services you received? ♦ Nothing more money ♦ Everything ♦ Therapy ♦ Don't know More video game time and be able to have thirds at meals.
3. What would improve client safety? ♦ Good ♦ You are doing good. ♦ Drug test the girls periodically. ♦ Get all you r staff on the same page and to have them be more consistent. ♦ I thing that everything is ok.	3. What would improve client safety? ♦ Keep better eyes on them. ♦ Everything ♦ IDK ♦ Don't Know ♦ No you are super safe- watch where we are and have to ask to go.
4. Additional Comments ♦ Only that I am grateful with the help we got during his stay here. ♦ Taking away the phone when child is deregulated. ♦ Working with CBS staff was a wonderful and truly informative experience. I learned many things that I can do better. ♦ Thanks for your help.	4. Any additional comments? ♦ I felt safe ♦ Staff are really nice and try to help us. Staff show us and teach us instead of just give a consequence.

Survey participation

This current survey is the second statewide children's residential discharge survey to date conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past two surveys.



The current survey shows a statewide increase (14%) in parent/caregiver participation and a corresponding increase (9%) in youth participation when compared to the same survey conducted last year. Statewide there were a combined total of 546 agency parent/caregiver and youth survey participants. There was an overall statewide participation increase of (11.6%) from the 2012 survey.

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

Thanks to all!

ATTACHMENT F

Risk Measures / Departure Conditions Report:
Oasis

Division of Child and Family Services
Risk Measures and Departure Conditions
2013 Oasis On-Campus Treatment Homes (Oasis) Report

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 2013 report is the sixth year of data collection for risk measures an departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2013 through December 2013. Oasis submitted a timely and complete data set in 2013. Oasis is to be commended for their willingness to share this very important information.

The data continues to be self-reported and therefore 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

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were: suicide, AWOL (runaways), medication errors, and restraint and manual guidance.

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

Collecting departure conditions data for analysis is a way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice: treatment completion at discharge, restrictiveness level of next living environment, and Child and Family Team decision making.

The following is the data and analysis of the risk areas for which data was submitted and departure conditions. (Please note if no incidents were reported in a risk area, only risk measure and departure condition incidents, definitions, and best practice guidelines will be provided in the conclusion of the report.) The report also includes information on training provided to staff and parents in Trauma Informed Care.

OASIS PROGRAM INFORMATION

This report for Oasis is the analysis of risk measure and departure conditions data collected from January 2013 through December 2013. 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 all reporting periods are reflected in the table to the right.

How many children were served?

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
2013	27.17 Range: 26 to 28	2013	14.83 Range: 10 to 17
2012	25.83 Range: 22 to 28	2012	16.67 Range: 10 to 25
2011	25.75 Range: 22 to 27	2011	24.83 Range: 21 to 28
2010	27 Range: none	2010	29.09 Range: 19 to 33
2009	27 Range: none	2009	30.33 Range: 27 to 35

Suicidal Behavior

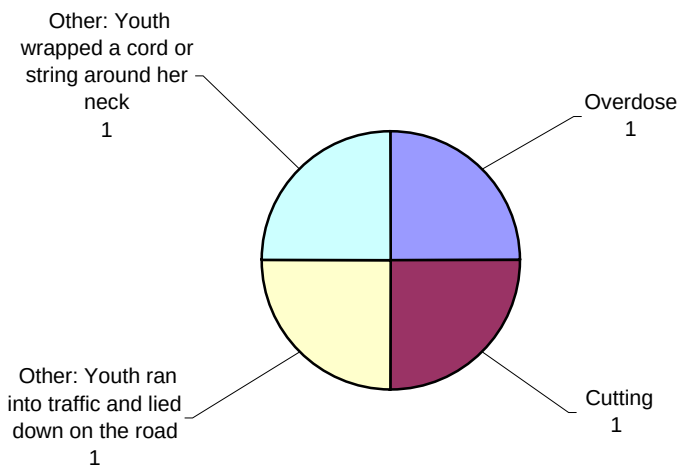
Descriptive Information:

- All were female.
- Average age was 16 (range: 15 - 17 years)
- Race
  All were Caucasian
- None were Hispanic.
- Custody Status
  2 were Parental Custody and no Juvenile Probation involvement
  2 were Parental Custody on Probation

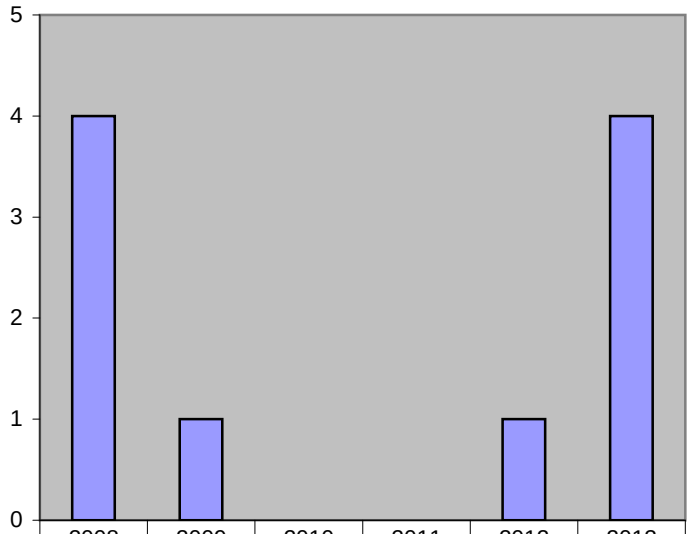
Clinical and Suicide Attempt Information:

- Major Depressive Disorder (2 youth) and Bipolar Disorder (2 youth) were the most frequent diagnoses.
- All of the youth had a history of suicide attempt.
- All of the suicide attempts were reported to the youth's legal guardian.

Attempted Suicide Means

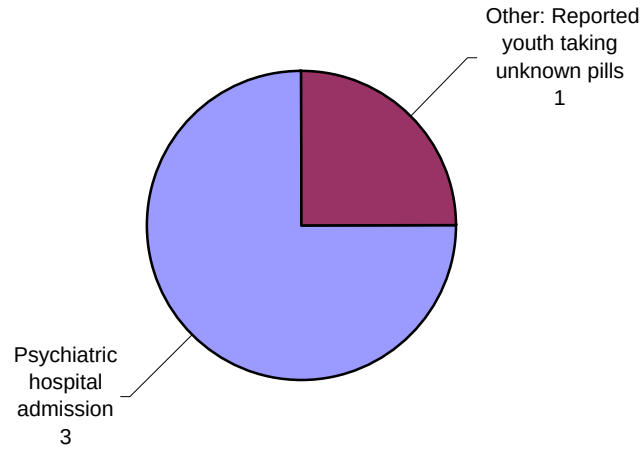


Suicidal Behavior Incidents



	2008	2009	2010	2011	2012	2013
Number of Suicide Attempts	4	1	0	0	1	4

Attempted Suicide Outcome



Medication Errors

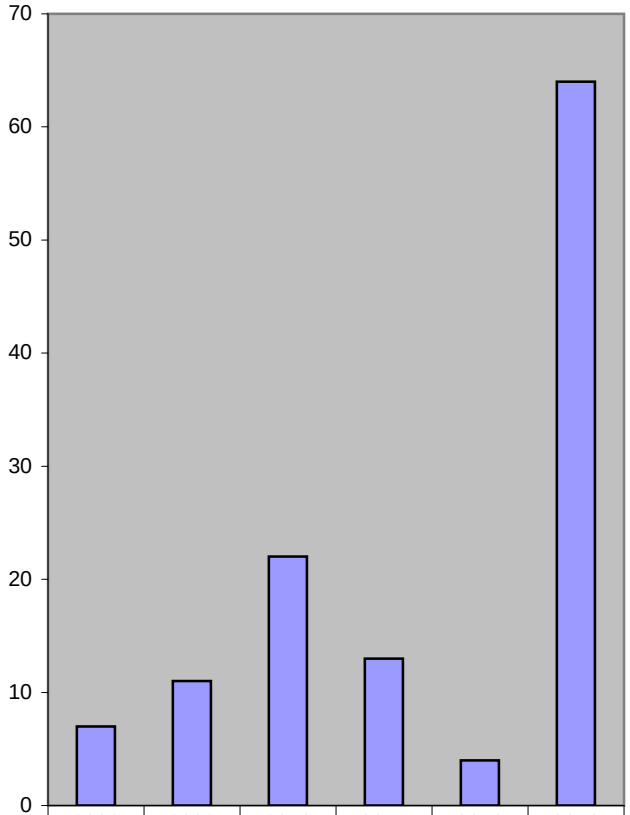
Descriptive Information:

- Custody Status
  24 (37%) Child Welfare Custody
  17 (27%) Parental Custody on Probation
  1 (2%) DCFS Youth Parole Custody/Supervision
  22 (34%) Parental Custody and no Juvenile Probation involvement

Clinical and Medication Error Information:

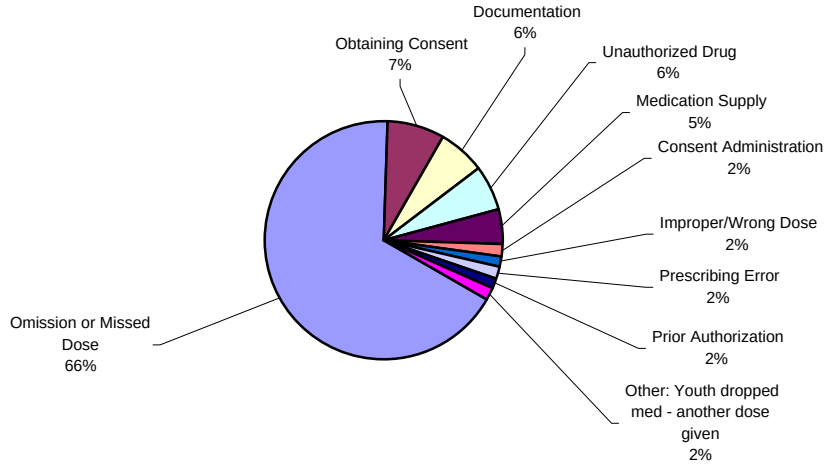
- Major Depressive Disorder (19 or 30% of youth) was the most frequent diagnosis.
- 7 (11%) of the medication errors were with non-psychotropic medication.
- 57 (89%) of the medication errors were with psychotropic medication.
- 59 (92%) of the medication errors were reported to the youth's legal guardian.

Medication Error Incidents

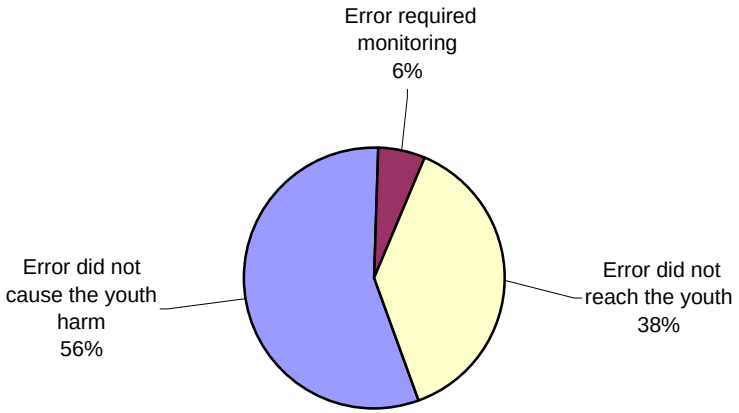


	2008	2009	2010	2011	2012	2013
Number of Medication Errors	7	11	22	13	4	64

Type of Medication Error



Medication Error Outcome



AWOL

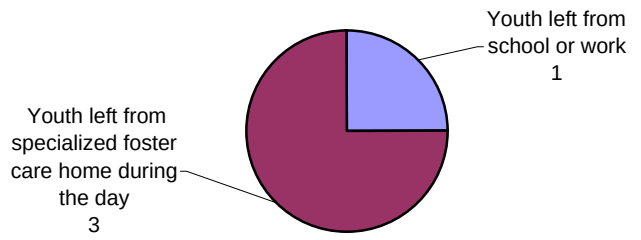
Descriptive Information:

- 4 were female and 1 was male.
- Average age was 15.40 (range: 15 - 16 years)
- Race
  2 were Caucasian
  3 were African American
- None were Hispanic.
- Custody Status
  2 Child Welfare Custody
  1 Parental Custody on Probation
  2 DCFS Youth Parole Custody/Supervision

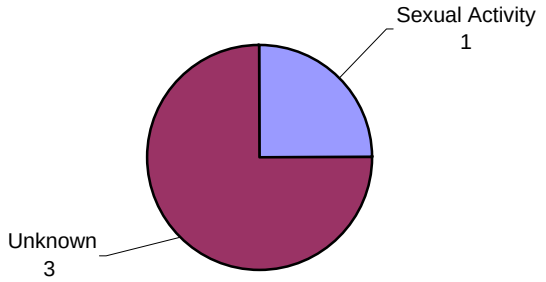
Clinical and AWOL Information:

- Bipolar Disorder (2 or 40% of youth) was the most frequent diagnosis.
- 6.60 (range: 1 - 11) of days AWOL days
- All of the youth had a history of AWOL.
- All of the AWOLs were reported to the youth's legal guardian.

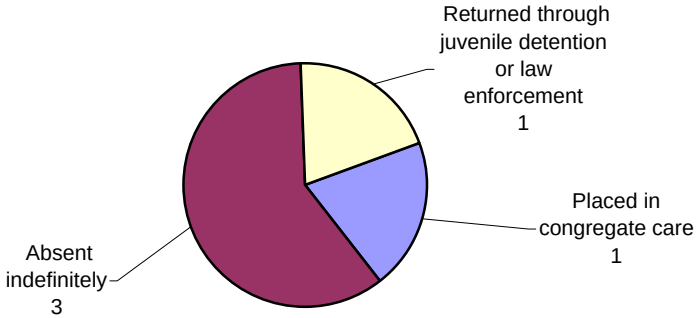
Type of Supervision at AWOL



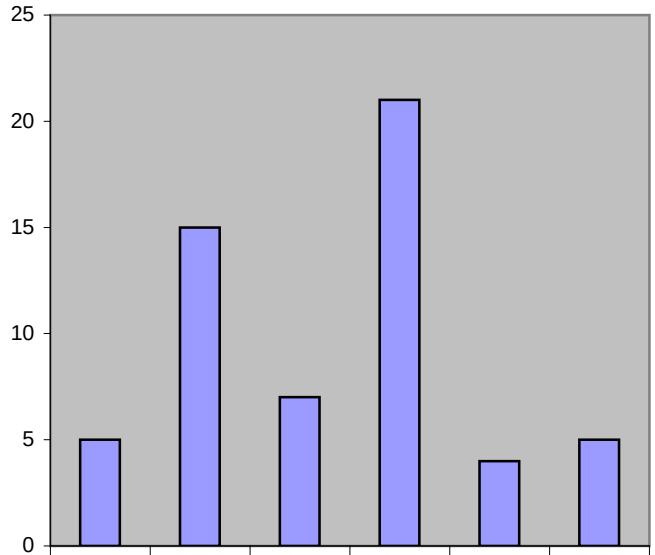
Behavior During AWOL



Outcome of AWOL



AWOL Incidents



	2008	2009	2010	2011	2012	2013
Number of AWOL Incidents	5	15	7	21	4	5

Restraint and Manual Guidance

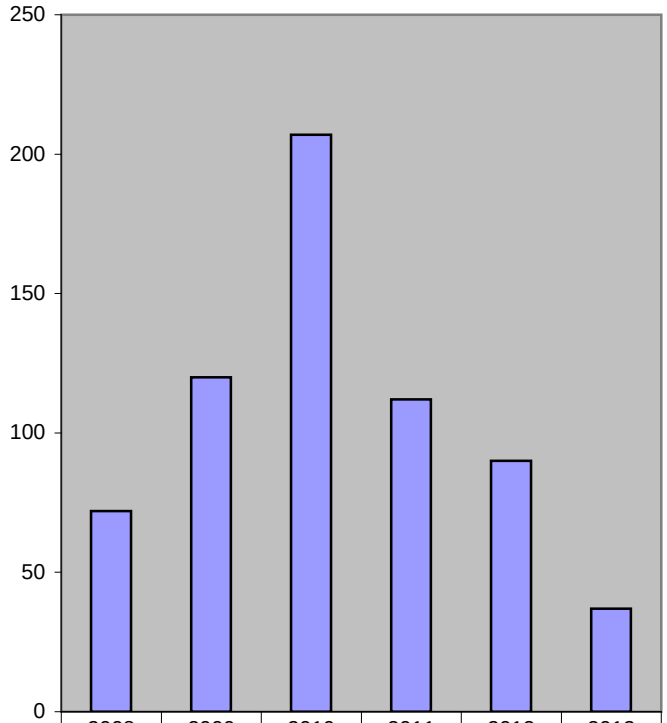
Descriptive Information:

- 9 (24%) were female and 28 (76%) were male.
- Average age was 13.41 (range: 7 - 17 years)
- Race
  18 (49%) Caucasian
  14 (38%) American Indian/Alaskan Native
  3 (8%) African American
  2 (5%) Native Hawaiian/Other Pacific
- 3 (8%) were Hispanic.
- Custody Status
  27 (73%) Child Welfare Custody
  7 (19%) Parental Custody on Probation
  3 (8%) Parental Custody and no Juvenile Probation involvement

Clinical and Restraint and Manual Guidance Information:

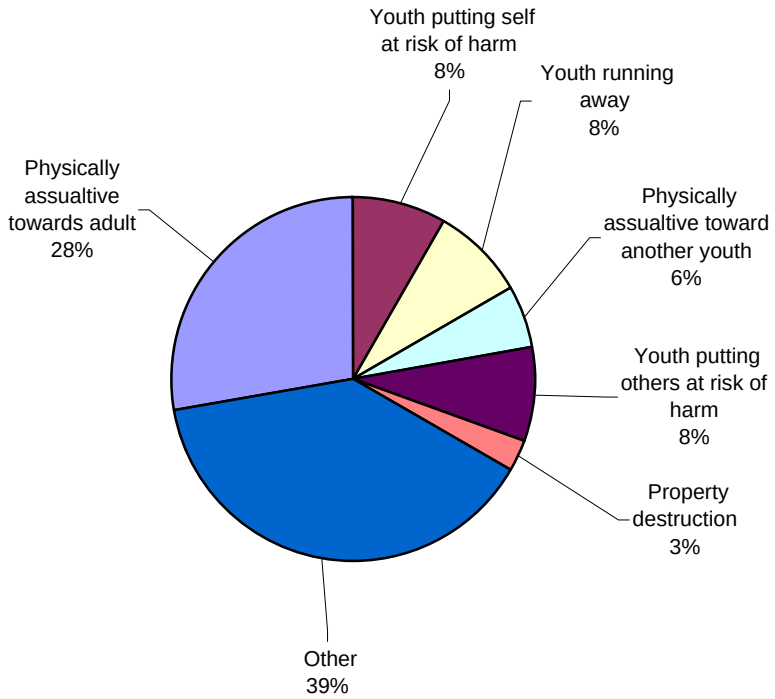
- Mood Disorder (24 or 67% of youth) was the most frequent diagnosis.
- 35 (95%) of the youth had a history of restraint and manual guidance
- 29 (78%) the average number of times a manual guidance used per incident.
- 32 (86%) of restraints occurred.
- 12.03 (range: 0 - 80) average length of restraint in minutes
- All restraint and manual guidance reported to the youth's legal guardian.

Restraint and Manual Guidance Incidents



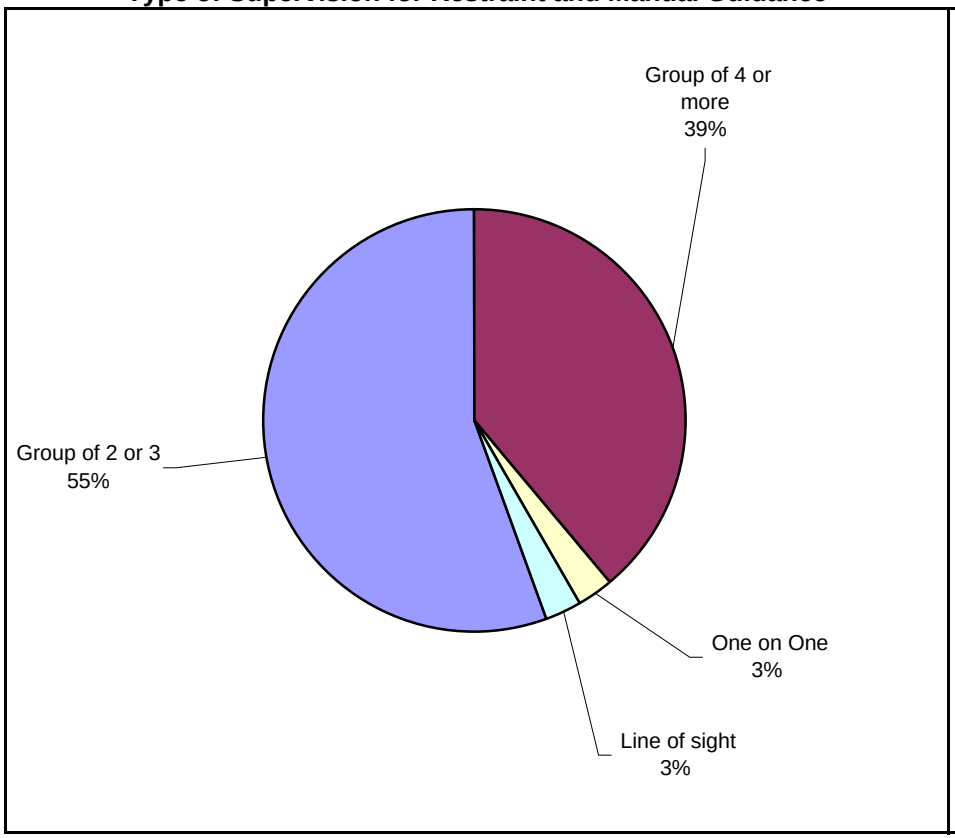
	2008	2009	2010	2011	2012	2013
Number of restraint and manual guidance incidents	72	120	207	112	90	37

Restraint and Manual Guidance Event

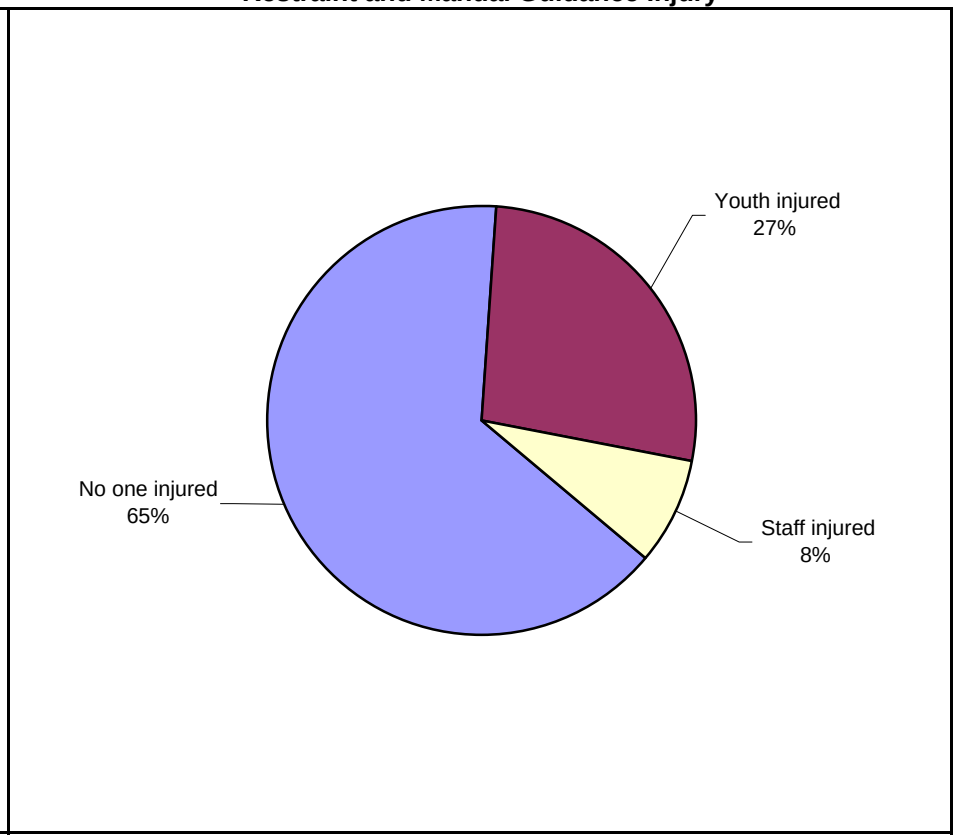


Restraint and Manual Guidance (Continued)

Type of Supervision for Restraint and Manual Guidance



Restraint and Manual Guidance Injury



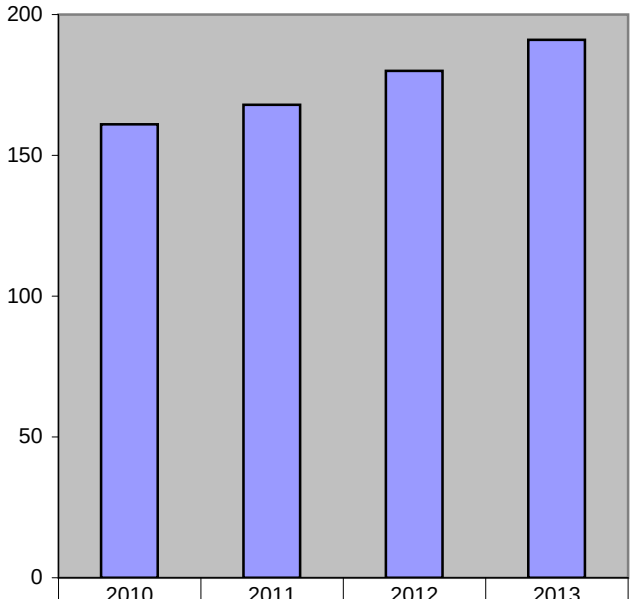
Departure Conditions

Oasis reported 24 discharges in the 2013 reporting period.

Descriptive Information:

- 10 (42%) were female and 14 (58%) were male.
- Average age was 13.29 (range: 7 - 17 years)
- Race
  13 (54%) Caucasian
  9 (38%) African American
  1 (4%) American Indian/Alaskan Native
  1 (4%) Native Hawaiian/Other Pacific
- 1 (4%) were Hispanic.
- Custody Status
  12 (50%) Child Welfare Custody
  5 (21%) Parental Custody on Probation
  2 (8%) DCFS Youth Parole Custody/Supervision
  5 (21%) Parental Custody and no Juvenile Probation involvement
- All youth were Medicaid recipients.
- The average length of stay at Oasis was 191.17 days, ranging from 0 days to 463 days (1.27 years).

AVERAGE LENGTH OF STAY



	2010	2011	2012	2013
Average length of stay (days)	161	168	180	191

Clinical and Departure Information:

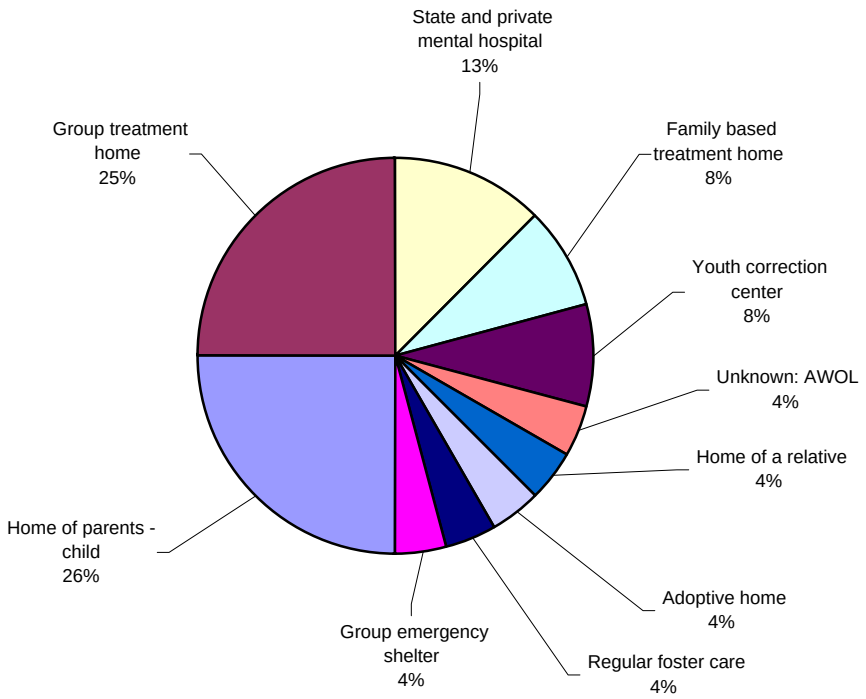
- Bipolar Disorder (16 or 67% of youth) was the most frequent diagnosis at admission followed by Major Depressive Disorder (3 or 13% of youth).
- Bipolar Disorder (15 or 63% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (3 or 13% of youth).
- The average CASII composite score at admission was 23.33.
- The average CASII composite score at discharge was 20.79.
- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	13	Family based treatment home
2012	13	Family based treatment home
2011	11	Specialized foster care
2010	11	Specialized foster care
2009	11	Specialized foster care
2008	11	Specialized foster care

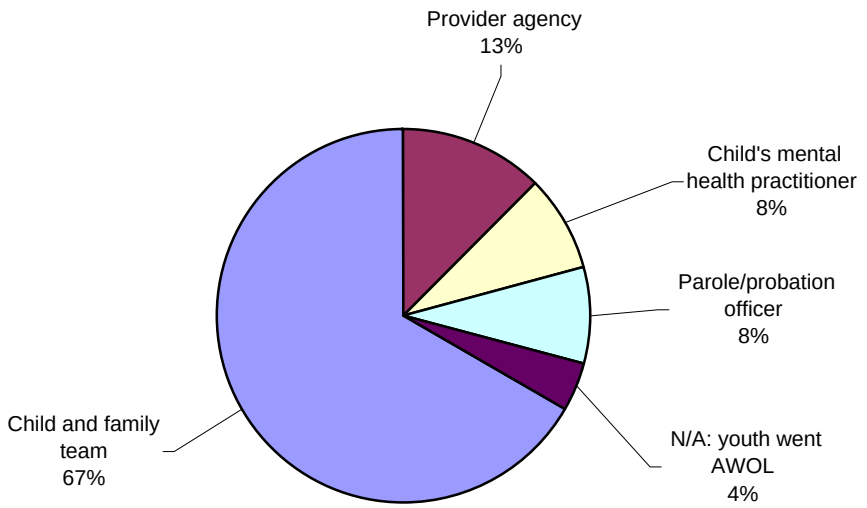
- In 2013, the ROLE score resulted in an average of 12.57, which equals the restrictiveness score of Family-based treatment home.

Departure Conditions (Continued)

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



WHO RECOMMENDED DEPARTURE



- 13 (54%) of youth completed treatment prior to discharge.
- 17 (71%) of the youth had appropriate transition plans.
  Explanations for the youth not having appropriate transition plans include:
  No transition plan for the youth.
  Youth was AWOL.
  Youth violated parole.
  No transition plan - youth was hospitalized.

- 21 (88%) of the youth had appropriate discharge plans.
  Explanations for the youth not having appropriate discharge plans include:
  Youth was AWOL.
  Youth violated parole.
  No transition plan - youth was hospitalized.

- None of the departures recommended by the provider agency gave 14 calendar days notice.

Departure Conditions - Youth in Child Welfare Custody

Of the 24 discharges reported by Oasis in the 2013 reporting period, 12 (50%) were in the custody of a public child welfare agency.

Descriptive Information:

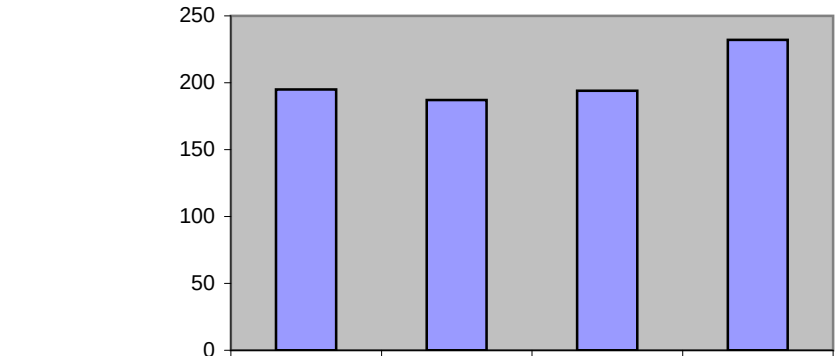
- 4 (33%) were female and 8 (67%) were male.
- Average age was 12.50 (range: 7 - 16 years)
- Race
  8 (67%) Caucasian
  2 (17%) African American
  1 (8%) American Indian/Alaskan Native
  1 (8%) Native Hawaiian/Other Pacific
- 1 (8%) was Hispanic.
- The average length of stay at Oasis was 231.58 days, ranging from 0 days to 463 days (1.27 years).

- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	12	Individual home emergency shelter
2012	13	Family based treatment home
2011	12	Individual home emergency shelter
2010	14	Group treatment home

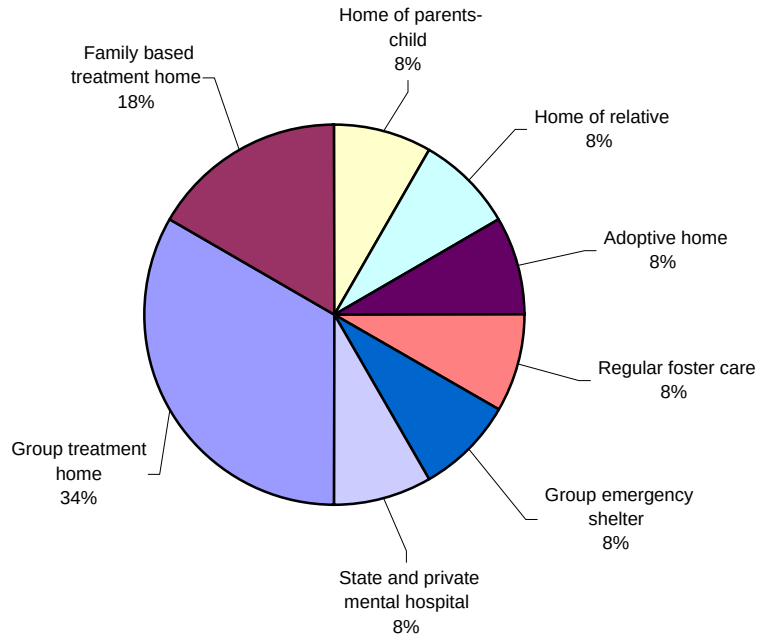
- In 2013, the ROLE score resulted in an average of 12, which equals the restrictiveness score of Individual home emergency shelter

AVERAGE LENGTH OF STAY



	2010	2011	2012	2013
Average length of stay (days)	195	187	194	232

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



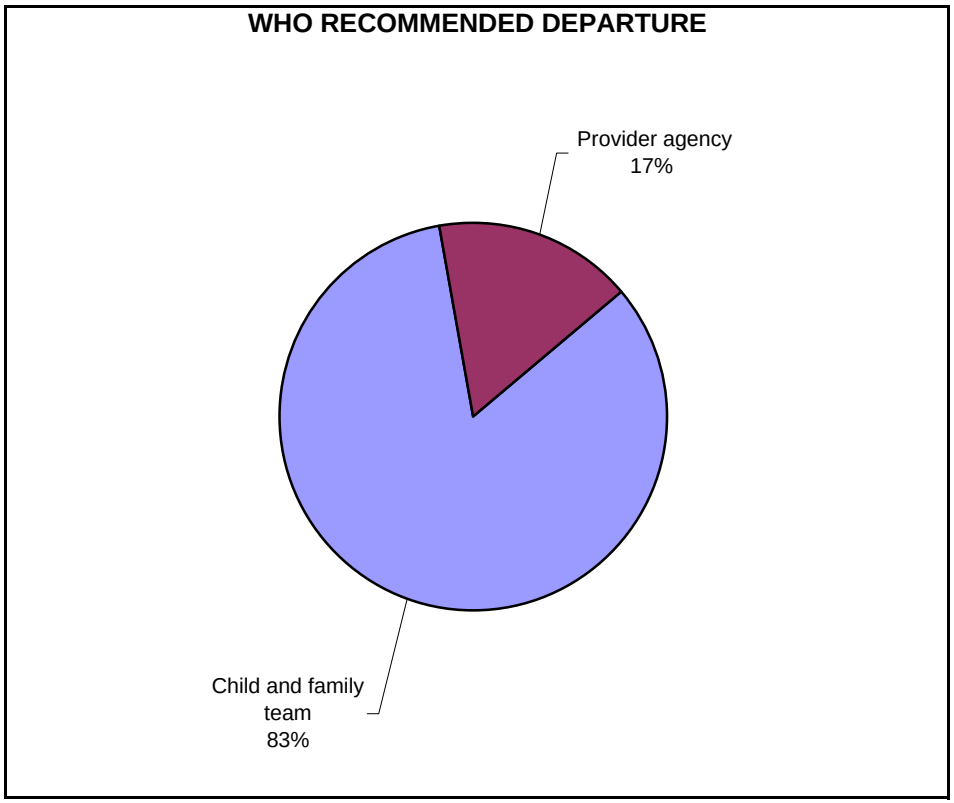
Clinical and Departure Information:

- Bipolar Disorder (7 or 58% of youth) was the most frequent diagnosis at admission followed by Major Depressive Disorder (2 or 17% of youth).
- Bipolar Disorder (7or 58% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (2 or 17% of youth).
- The average CASII composite score at admission was 22.
- The average CASII composite score at discharge was 20.

- 8 (67%) of youth completed treatment prior to discharge.
- 10 (83%) of the youth had appropriate transition plans.
  Explanations for the youth not having appropriate transition plans include:
  Youth was AWOL.
  Youth was hospitalized.

Departure Conditions - Youth in Child Welfare Custody (Continued)

- All of the youth had appropriate discharge plans.



- None of the departures recommended by the provider agency gave 14 calendar days notice.

Suicidal Behavior

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.

Highlights:

- The staff informed the legal guardian of the suicide attempts.
- The staff followed the suicide protocol in all for incidents.
- The 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

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).

Highlights:

- The staff informed the legal guardian of the medication errors.
- 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:

- 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.
- For “other” errors (unable to get an appt. with psychiatrist, unable to reach psychiatrist by phone, unable to get authorization, unable to verify PLR consent): 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).
- 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.

AWOL

An AWOL (runaways) is defined as a child or adolescent who is absent from the specialized foster care home for more than 24 hours.

Highlights:

- The staff informed the legal guardian of the AWOL incidents.
- AWOL incidents have continued to decline as compared to previous years.

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).
- 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

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).

Highlights:

- The staff informed the legal guardian of the restraint and manual guidance incidents.
- The staff received initial and refresher training on restraint and manual guidance.
- In the past three 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 2013, there were 3.08 incidents of restraint and manual guidance per month as compared to 7.5 incidents of restraint and manual guidance per month in 2012 and 9.3 incidents per month in 2011.

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).
- 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.

Discharge Conditions

A departure 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 specialized foster care home within the same agency.

Overall Highlights:

- Upon discharge, 11 (46%) of youth returned to a less restrictive environment.

Children in Child Welfare Custody Highlights:

- Upon discharge, 4 (33%) of youth returned to a less restrictive environment.
- Upon discharge, 4 (33%) of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- Of the 12 departures for children in the custody of a child welfare agency 10 or 83% were recommended by a CFT. In 2012, 14 or 61% of departures for children in the custody of a child welfare agency were recommended by a CFT. This represents an increase in decisions regarding departure being made by the CFT.

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.

Trauma Informed Care Training

Using curriculum from the Chadwick Center as part of the National Child Traumatic Stress Network, the Trauma Informed Care training workshop discusses the trauma children and their families experience as well as secondary traumatic stress that can result from working with traumatized individuals. In 2013, Oasis had 29 treatment home staff, a therapist, and a program director complete the Trauma Informed Care training.

Summary

Oasis submitted all of its 2013 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 2013 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of medication errors and restraint and manual guidance.

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 2013 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
Risk Measures and Departure Conditions
2013 Adolescent Treatment Center Agency Report

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 2013 report is the sixth year of data collection for risk measures an departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2013 through December 2013. Adolescent Treatment Center (ATC) submitted a timely and complete data set in 2013. ATC is to be commended for their willingness to share this very important information.

The data continues to be self-reported and therefore 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

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were: suicide, AWOL (runaways), medication errors, and restraint and manual guidance.

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

Collecting departure conditions data for analysis is a way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice: treatment completion at discharge, restrictiveness level of next living environment, and Child and Family Team decision making.

The following is the data and analysis of the risk areas for which data was submitted and departure conditions. (Please note if no incidents were reported in a risk area, only risk measure and departure condition incidents, definitions, and best practice guidelines will be provided in the conclusion of the report.) The report also includes information on training provided to staff and parents in Trauma Informed Care.

ATC PROGRAM INFORMATION

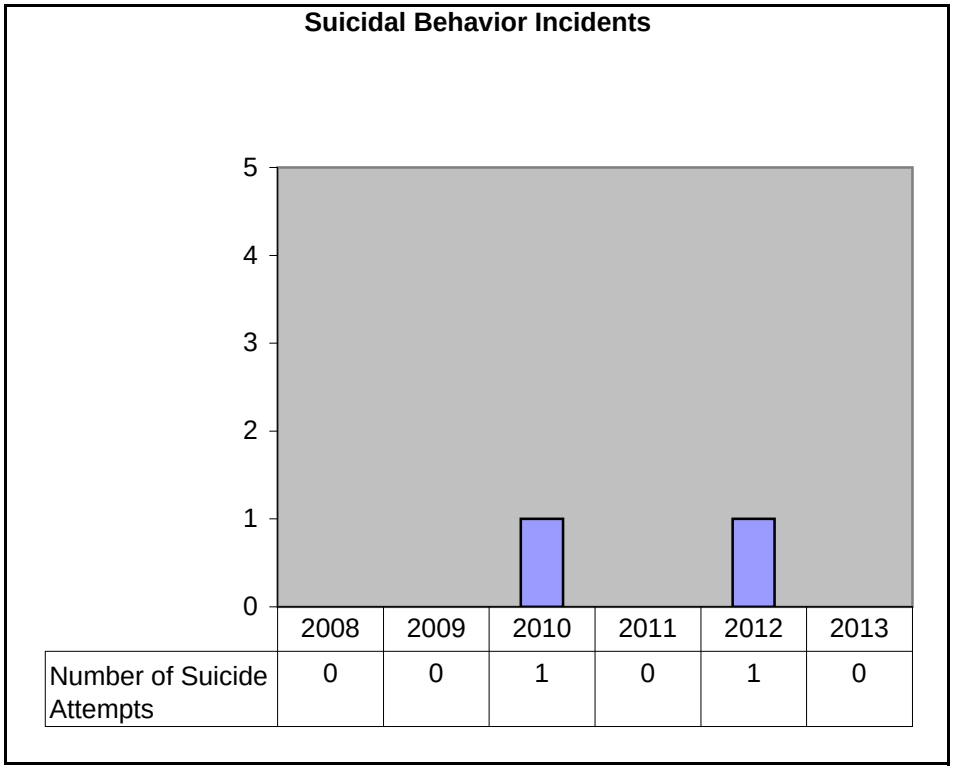
This report for ATC is the analysis of risk measure and departure conditions data collected from January 2013 through December 2013. Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served for all reporting periods are reflected in the table to the right.

How many children were served?

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
2013	16 Range: 16 to 16	2013	19.42 Range: 17 to 22
2012	15.5 Range: 14 to 16	2012	18.92 Range: 16 to 22
2011	15.6 Range: 14 to 18	2011	19.2 Range: 17 to 23
2010	15.25 Range: 13 to 16	2010	18.83 Range: 17 to 22
2009	15.5 Range: 13 to 16	2009	18.25 Range: 16 to 21

Suicidal Behavior

There were no attempted or completed suicides during the 2013 reporting period.



	2008	2009	2010	2011	2012	2013
Number of Suicide Attempts	0	0	1	0	1	0

Medication Errors

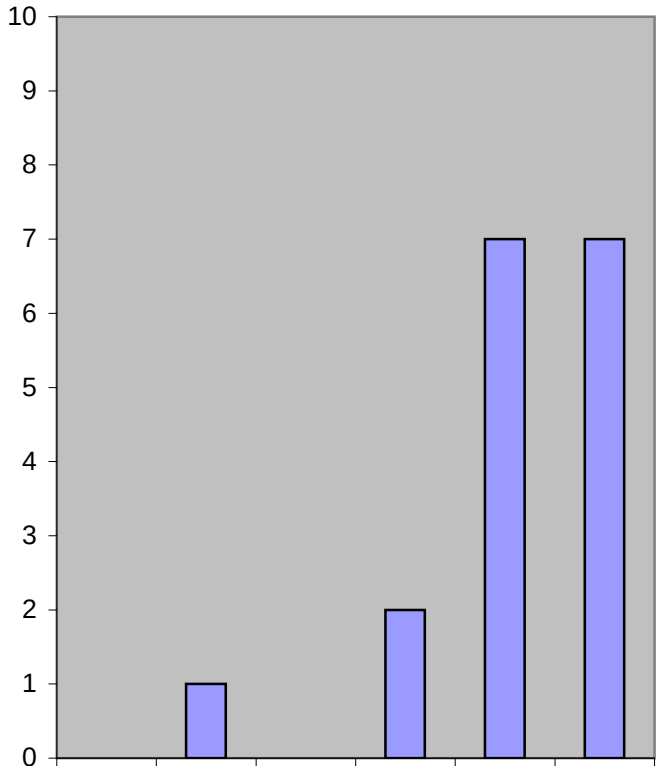
Descriptive Information:

- Custody Status
  3 Child Welfare Custody
  3 Parental Custody on Probation
  1 Parental Custody and no Juvenile Probation involvement

Clinical and Medication Error Information:

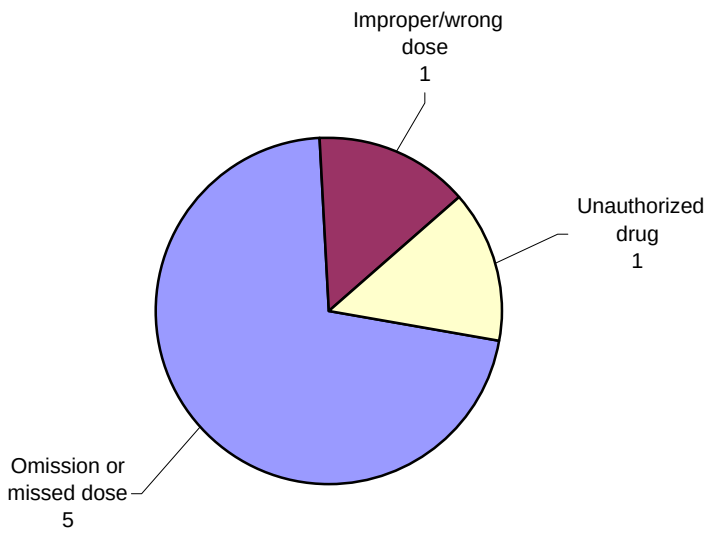
- Posttraumatic Stress Disorder (2 or 28.57% of youth) was the most frequent diagnosis.
- All 7of the medication errors were with psychotropic medication.
- All 7 of the medication errors were reported to the youth's legal guardian.
- None of the medication errors caused the client harm.

Medication Error Incidents



	2008	2009	2010	2011	2012	2013
Number of Medication Errors	0	1	0	2	7	7

Type of Medication Error



AWOL

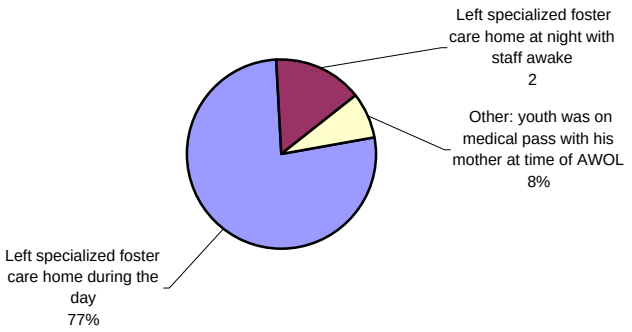
Descriptive Information:

- 5 (38.46%) were female and 8 (61.54%) were male.
- Average age was 15.31 (range: 13 - 17 years)
- Race
  11 (84.62%) Caucasian
  1 (7.69%) African American
  1 (7.69%) Mixed
- 3 (23.08%) were Hispanic.
- Custody Status
  7 (53.85%) Child Welfare Custody
  5 (38.46%) Parental Custody on Probation
  1 (7.69%) Parental Custody and no Juvenile Probation involvement

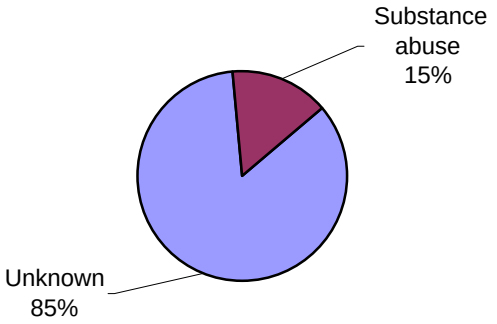
Clinical and AWOL Information:

- Posttraumatic Stress Disorder (6 or 46.15% of youth) was the most frequent diagnosis.
- 5 (range: 1 -18) of AWOL days
- 10 (76.92%) of the youth had a history of AWOL.
- All 13 of the AWOLs were reported to the youth's legal guardian.

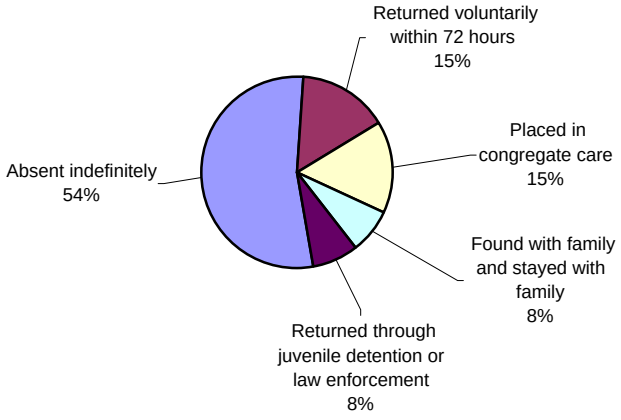
Type of Supervision at AWOL



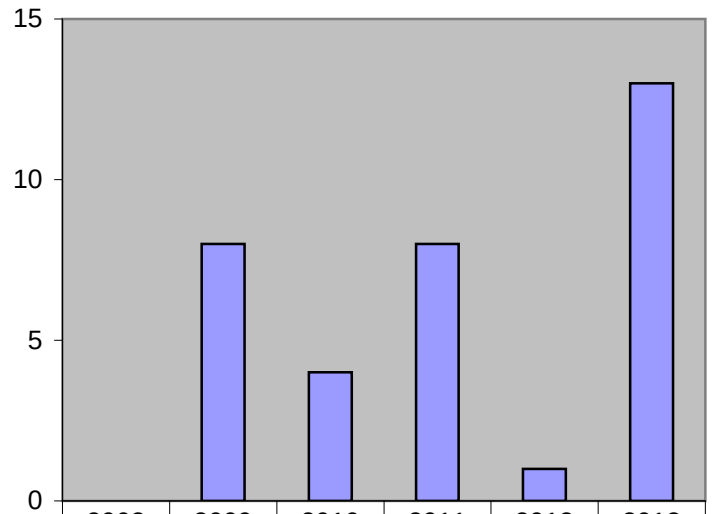
Behavior During AWOL



Outcome of AWOL



AWOL Incidents



	2008	2009	2010	2011	2012	2013
Number of AWOL Incidents	0	8	4	8	1	13

Restraint and Manual Guidance

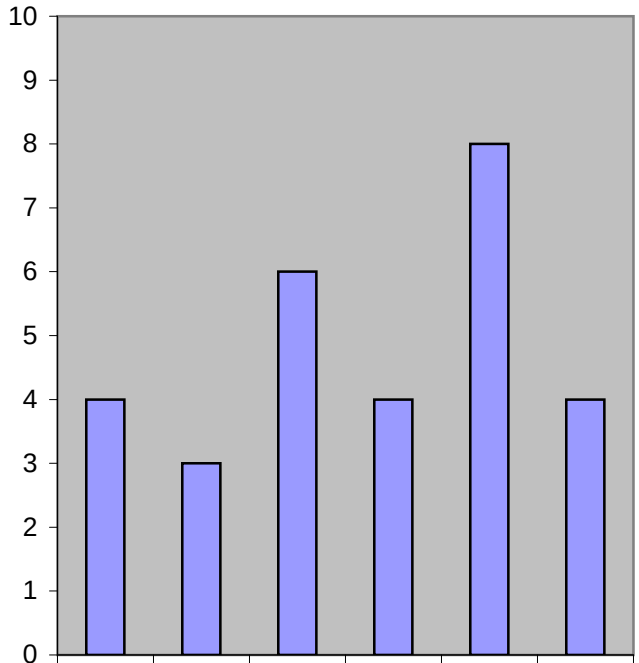
Descriptive Information:

- All 4 were female.
- Average age was 15.75 (range: 15 -16 years)
- Race
  All 4 were Caucasian
- 3 were Hispanic.
- Custody Status
  1 Parental Custody on Probation
  3 Parental Custody and no Juvenile Probation involvement

Clinical and Restraint and Manual Guidance Information:

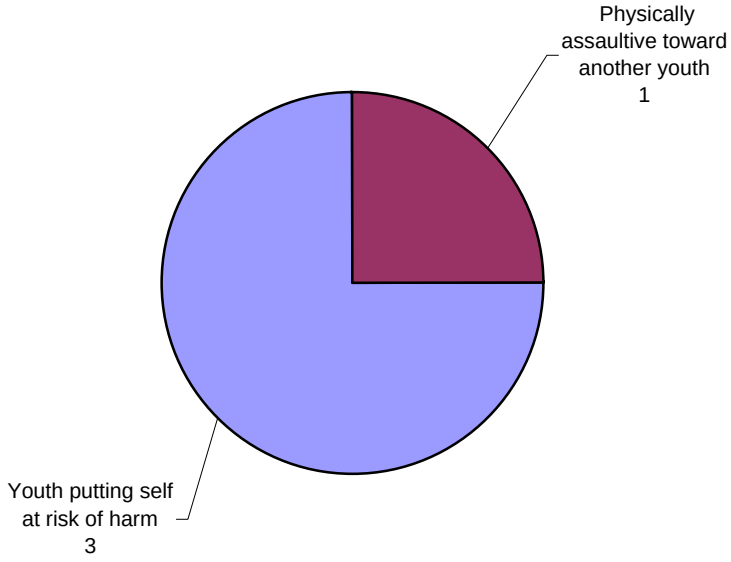
- Major Depressive Disorder (2 of youth) was the most frequent diagnosis.
- All 4 of the youth had a history of restraint and manual guidance
- 1 restraint was used per incident.
- 2 (range: 1 - 5) average length of restraint in minutes
- All restraints reported to the youth's legal guardian.
- No one was injured in any of the restraints.

Restraint and Manual Guidance Incidents

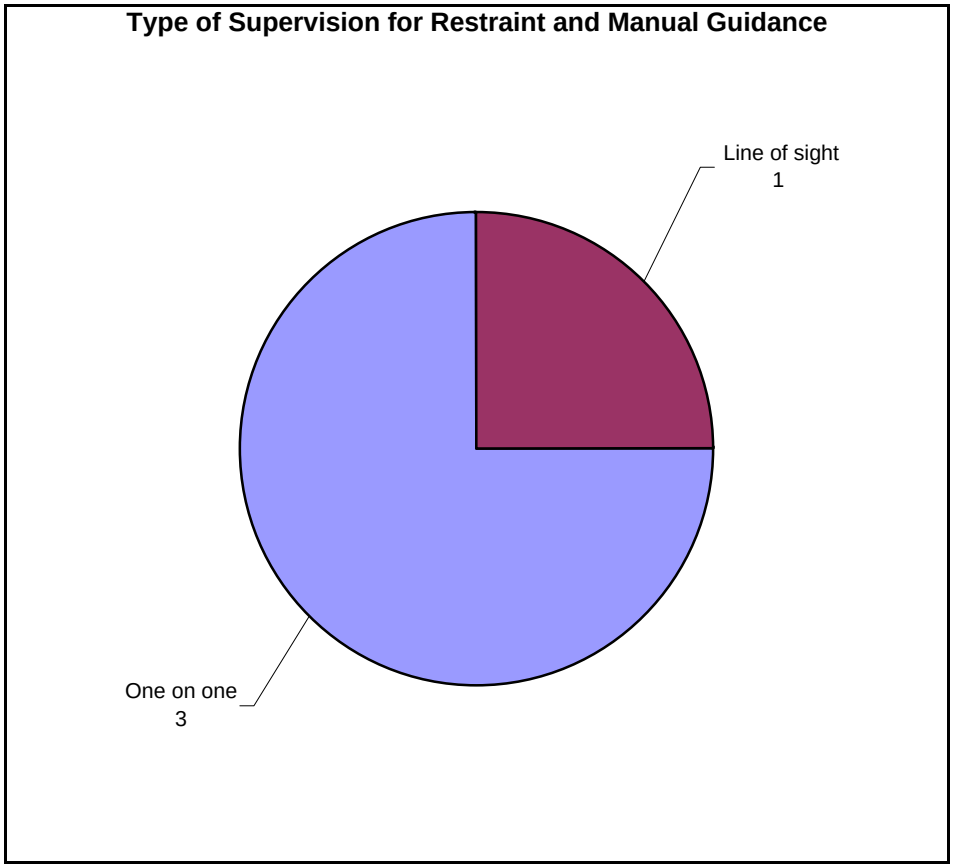


	2008	2009	2010	2011	2012	2013
Number of restraint and manual guidance incidents	4	3	6	4	8	4

Restraint and Manual Guidance Event



Restraint and Manual Guidance (Continued)



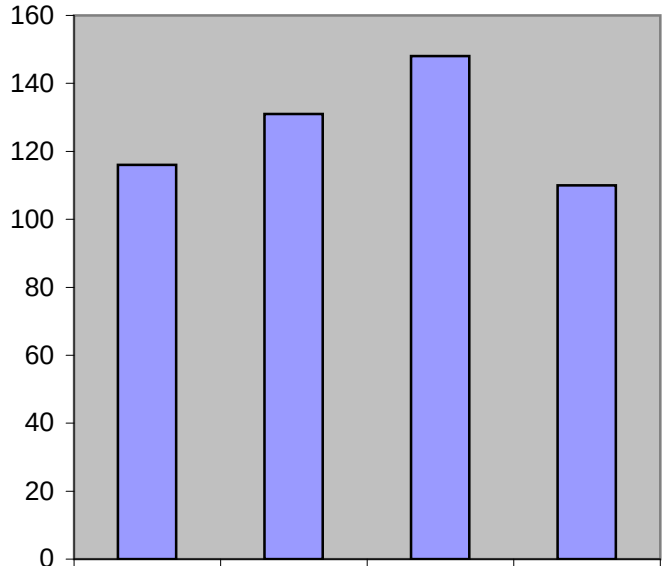
Departure Conditions

ATC reported 49 discharges in the 2013 reporting period.

Descriptive Information:

- 26 (53.06%) were female and 23 (46.94%) were male.
- Average age was 15.41 (range: 13 - 18years)
- Race
  44 (89.80%) Caucasian
  4 (8.16%) African American
  1 (2.04%) Mixed
- 9 (18.37%) were Hispanic.
- Custody Status
  15 (30.61%) Child Welfare Custody
  18 (36.73%) Parental Custody on Probation
  2 (4.08%) DCFS Youth Parole Custody/Supervision
  14 (28.57%) Parental Custody and no Juvenile Probation involvement
- 44 (89.80%) were Medicaid recipients.
- The average length of stay at ATC was 110.31 days, ranging from 5 days to 290 days.

AVERAGE LENGTH OF STAY



	2010	2011	2012	2013
Average length of stay	116	131	148	110

Clinical and Departure Information:

- Bipolar Disorder (15 or 30.61 % of youth) was the most frequent diagnosis at a at admission followed by Posttraumatic Stress Disorder (11 or 22.45% of youth).
- Posttraumatic Stress Disorder and Bipolar Disorder (16 or 32.65% of youth each) were the most frequent diagnoses at discharge.
- The average CASII composite score at admission was 23.55.
- The average CASII composite score at discharge was 21.71.

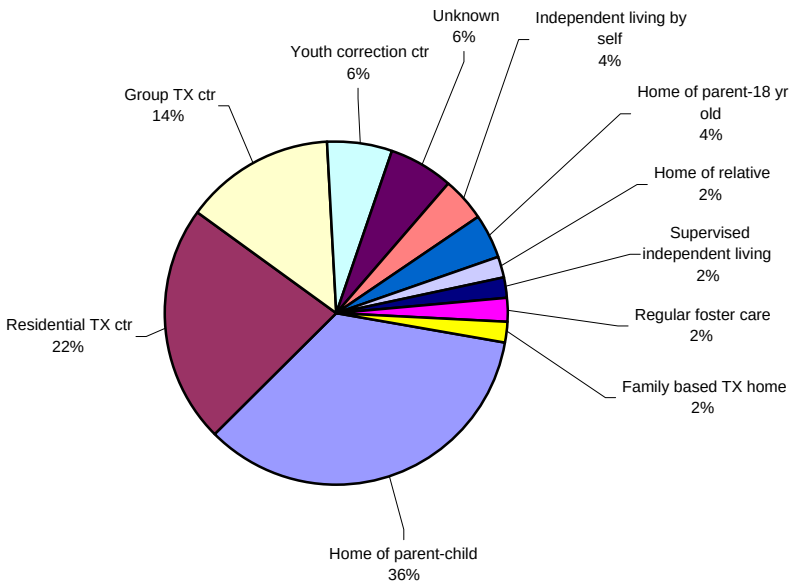
- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	10.11	Regular foster care
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

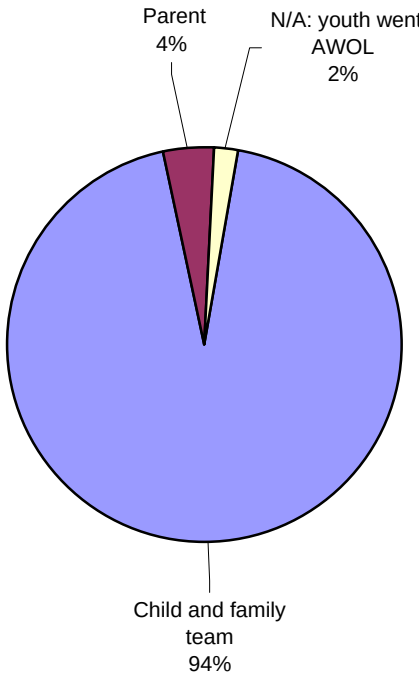
- In 2013, the ROLE score resulted in an average of 10.11, which equals the restrictiveness score of regular foster care.

Departure Conditions (Continued)

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



WHO RECOMMENDED DEPARTURE



- 30 (61.22%) of youth completed treatment prior to discharge.
- 46 (95.92%) of the youth had appropriate transition plans.
  Explanations for the youth not having appropriate transition plans include:
  2 (4.08%) Agency disagreed with transition plan
- 46 (95.92%) of the youth had appropriate discharge plans.
  Explanations for the youth not having appropriate discharge plans include:
  2 (4.08%) Agency disagreed with discharge

- All of the departures recommended by the provider agency gave 14 calendar days notice.

Departure Conditions - Youth in Child Welfare Custody

Of the 49 discharges reported by ATC in the 2013 reporting period, 15 (30.61%) were in the custody of a public child welfare agency.

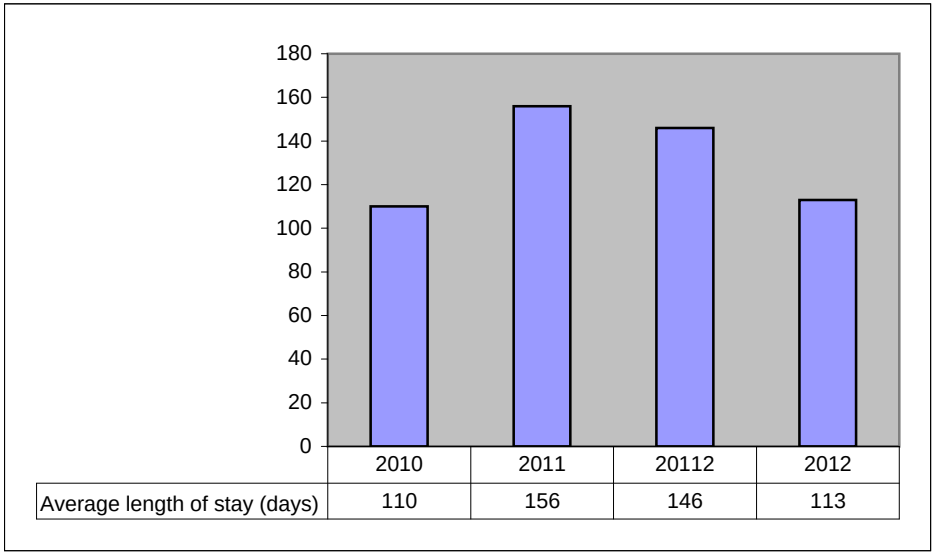
Descriptive Information:

- 7 (46.67%) were female and 8 (53.33%) were male.
- Average age was 15.33 (range: 13 - 18 years)
- Race
  13 (86.67%) Caucasian
  1 (6.67%) African American
  1 (6.67%) Mixed
- None were Hispanic.
- The average length of stay at ATC was 112.93 days, ranging from 35 days to 290 days.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	12.5	Family Based Treatment Home
2012	11.4	Regular Foster Care
2011	11.6	Specialized Foster Care
2010	12.9	Family Based Treatment Home

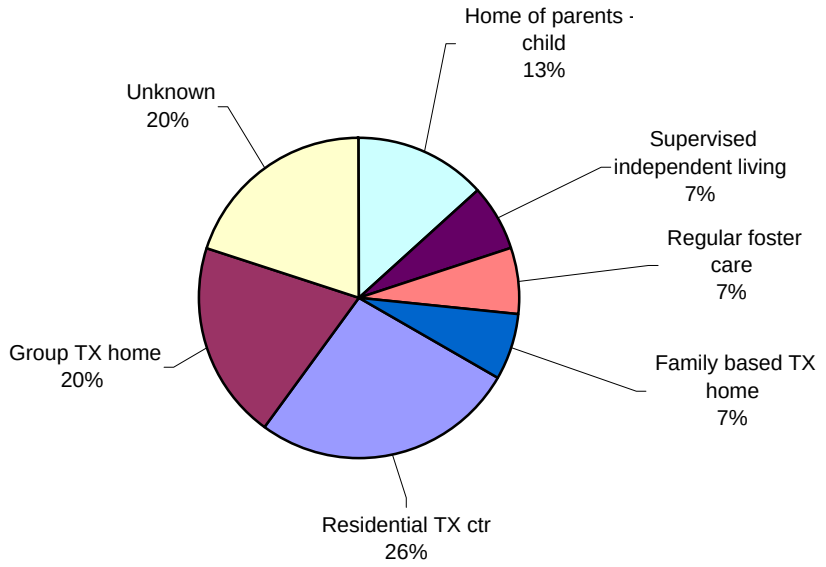
- In 2013, the ROLE score resulted in an average of 12.5, which equals the restrictiveness score of Family Based Treatment Home.

AVERAGE LENGTH OF STAY



	2010	2011	20112	2012
Average length of stay (days)	110	156	146	113

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



Clinical and Departure Information:

- Posttraumatic Stress Disorder (7 or 46.67% of youth) was the most frequent diagnosis at admission followed by Major Depressive Disorder (5 or 33.34% of youth).
- Posttraumatic Stress Disorder (8 or 53.33% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (5 or 33.34% of youth).
- The average CASII composite score at admission was 24.20.
- The average CASII composite score at discharge was 22.60.
- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.
- 8 (53.33%) of youth completed treatment prior to discharge.
- All of the youth had appropriate transition plans.
- All 15 of the youth had appropriate discharge plans.
- All 15 departures were recommended by the Child and Family Team.
- 1 (100%) of the departures recommended by the provider agency gave 14 calendar days notice.

Suicidal Behavior

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.

Highlights:

- There were no attempted or completed suicides in the 2013 report period.

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

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).

Highlights:

- The staff informed the legal guardian of the medication errors.
- 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.
- The are few errors and none caused harm to the patient.

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.
- For “other” errors (unable to get an appt. with psychiatrist, unable to reach psychiatrist by phone, unable to get authorization, unable to verify PLR consent): 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).
- 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.

AWOL

An AWOL (runaways) is defined as a child or adolescent who is absent from the specialized foster care home for more than 24 hours.

Highlights:
- The staff informed the legal guardian of the AWOL incidents.

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).
- 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

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).

Highlights:
- There were no injuries to youth, peers or staff during any of the restraint incidents.
- The staff informed the legal guardian of the restraint and manual guidance incidents.
- The staff received initial and refresher training on restraint and manual guidance.
- There were less incidents of restraint in the 2013 reporting period as compared to 2012.

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).
- 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.

Discharge Conditions

A departure 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 specialized foster care home within the same agency.

Overall Highlights:

- Upon discharge, 24 of the youth were placed in less restrictive settings.
- More than half of the youth completed treatment (30 or 61.22%).
- Almost all (46 or 93.88%) discharges were recommended by the Child and Family Team (CFT).

Children in Child Welfare Custody Highlights:

- Upon discharge, 4 of the youth returned to a less restrictive environment.
- Upon discharge, 3 of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- Of the 15 departures for children in the custody of a child welfare agency all 15 or 100% were recommended by a CFT. In 2012, 94 % of departures for children in the custody of a child welfare agency were recommended by a CFT. This represents an increase in decisions regarding departure being made by the CFT.

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.

Trauma Informed Care Training

Using curriculum from the Chadwick Center as part of the National Child Traumatic Stress Network, the Trauma Informed Care training workshop discusses the trauma children and their families experience as well as secondary traumatic stress that can result from working with traumatized individuals. In 2013, ATC had 2 Therapists complete the Trauma Informed Care training.

Summary

ATC submitted all of its 2013 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 2013 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of medication errors, AWOLs and restraint and manual guidance.

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 2013 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
Risk Measures and Departure Conditions
2013 Family Learning Homes Agency Report

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 2013 report is the sixth year of data collection for risk measures an departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2013 through December 2013. Family Learning Homes submitted a timely and complete data set in 2013. Family Learning Homes is to be commended for their willingness to share this very important information.

The data continues to be self-reported and therefore 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

Four areas of risk were selected for reporting. These high-risk areas were determined to be the most salient and, when monitored, could be used for risk prevention. The four risk areas were: suicide, AWOL (runaways), medication errors, and restraint and manual guidance.

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

Collecting departure conditions data for analysis is a way to measure the effectiveness of specialized foster care treatment and adherence to best practice principles. Specialized foster care agencies are providing data on the following indicators of effective treatment and best practice: treatment completion at discharge, restrictiveness level of next living environment, and Child and Family Team decision making.

The following is the data and analysis of the risk areas for which data was submitted and departure conditions. (Please note if no incidents were reported in a risk area, only risk measure and departure condition incidents, definitions, and best practice guidelines will be provided in the conclusion of the report.) The report also includes information on training provided to staff and parents in Trauma Informed Care.

FAMILY LEARNING HOMES PROGRAM INFORMATION

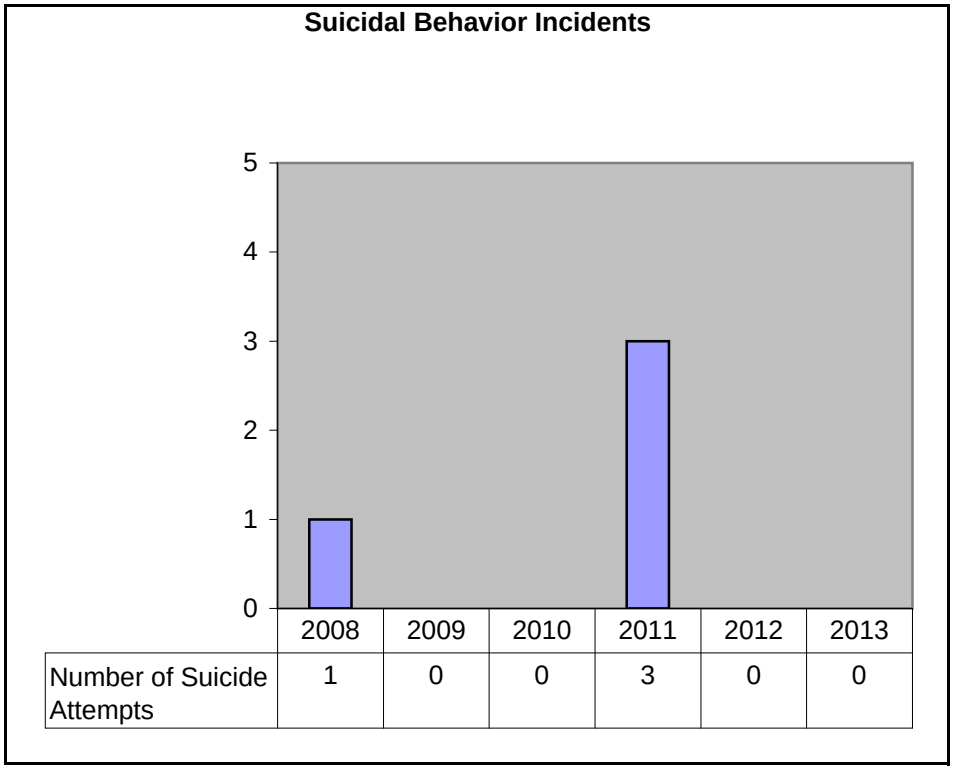
This report for Family Learning Homes is the analysis of risk measure and departure conditions data collected from January 2013 through December 2013. Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served for all reporting periods are reflected in the table to the right.

How many children were served?

AVERAGE MONTHLY BED CAPACITY		AVERAGE MONTHLY NUMBER OF YOUTH SERVED	
2013	19.08 Range: 16 to 20	2013	22.5 Range: 21 to 24
2012	20 Range: 20 to 20	2012	21.67 Range: 20 to 24
2011	18.9 Range: 16 to 20	2011	20.8 Range: 19 to 24
2010	15.25 Range: 13 to 16	2010	18.83 Range: 18.25
2009	15.5 Range: 13 to 16	2009	18.25 Range: 16 to 21

Suicidal Behavior

No incidents of suicidal behavior were reported for 2013.



	2008	2009	2010	2011	2012	2013
Number of Suicide Attempts	1	0	0	3	0	0

Medication Errors

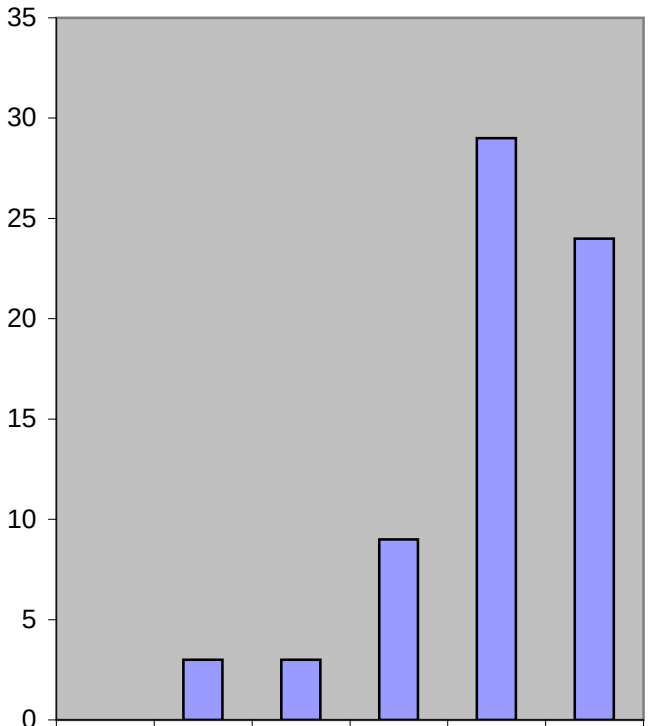
Descriptive Information:

- Custody Status
  2 (8.33%) Child Welfare Custody
  16 (66.67%) Parental Custody on Probation
  6 (25%) Parental Custody and no Juvenile Probation involvement

Clinical and Medication Error Information:

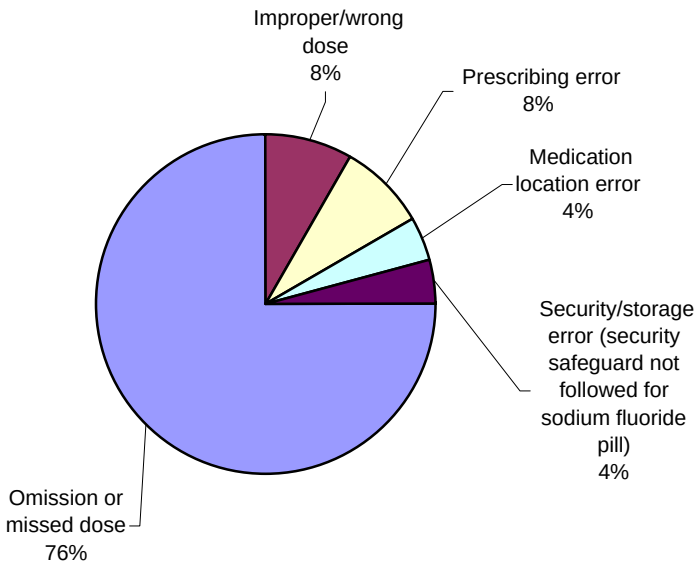
- Adjustment Disorder (8 or 33.33% of youth) was the most frequent diagnosis.
- All of the medication errors were with psychotropic medication.
- All of the medication errors were reported to the youth's legal guardian.

Medication Error Incidents

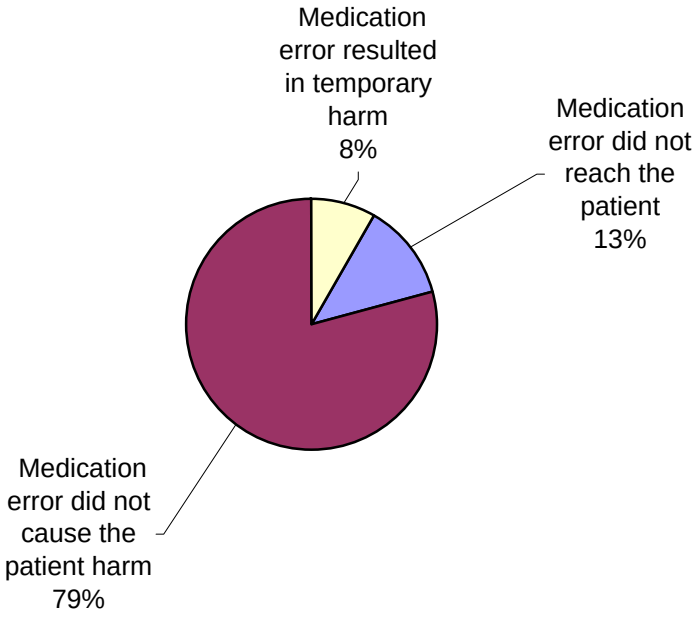


	2008	2009	2010	2011	2012	2013
Number of Medication Errors	0	3	3	9	29	24

Type of Medication Error



Medication Error Outcome



AWOL

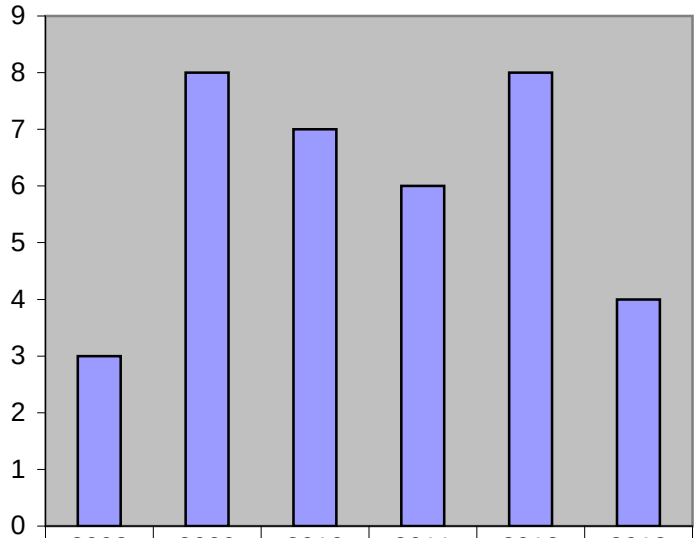
Descriptive Information:

- 3 were female and 1 was male.
- Average age was 15 (range: none)
- Race
  2 Caucasian
  2 African American
- None were Hispanic.
- Custody Status
  3 Parental Custody on Probation
  1 Parental Custody and no Juvenile Probation involvement

Clinical and AWOL Information:

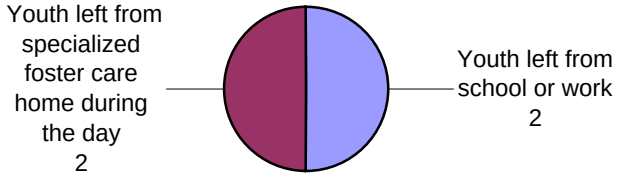
- Bipolar Disorder (3 of youth) was the most frequent diagnosis.
- 5.5 (range: 1 - 12) of days AWOL
- 2 of the youth had a history of AWOL.
- All of the AWOLs were reported to the youth's legal guardian.

AWOL Incidents

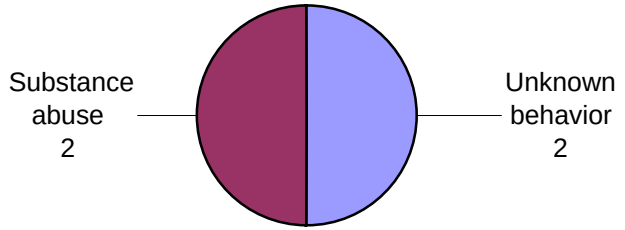


	2008	2009	2010	2011	2012	2013
Number of AWOL Incidents	3	8	7	6	8	4

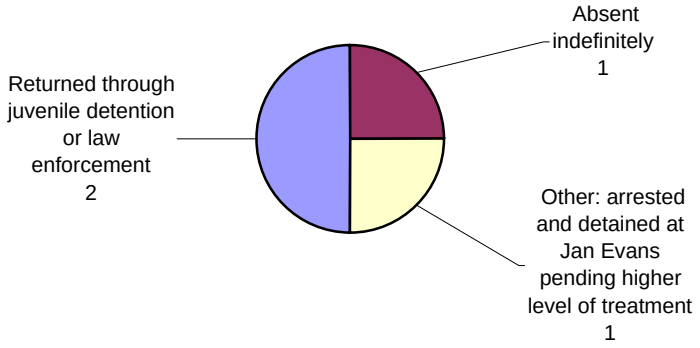
Type of Supervision at AWOL



Behavior During AWOL



Outcome of AWOL



Restraint and Manual Guidance

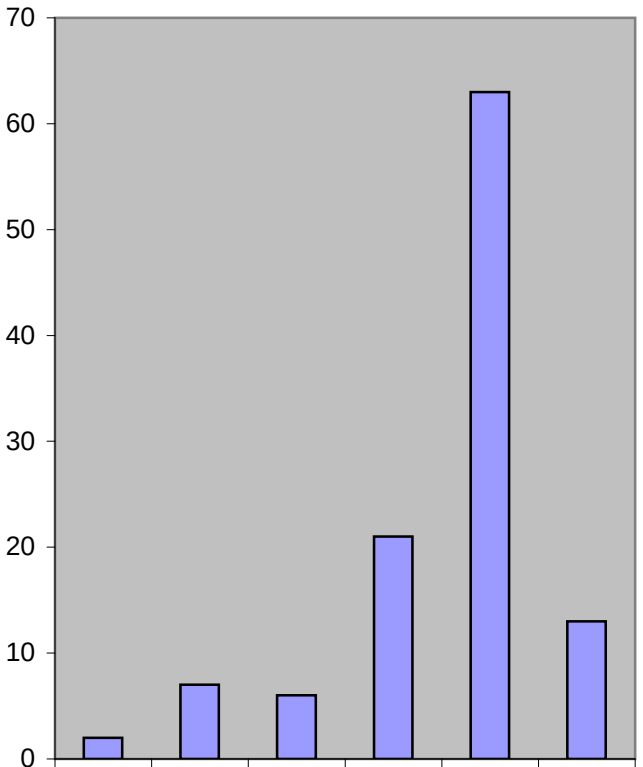
Descriptive Information:

- 4 (30.77%) were female and 9 (69.23%) were male.
- Average age was 9.54 (range: 5 - 17 years)
- Race
  10 (76.92%) Caucasian
  1 (7.69%) American Indian/Alaskan Native
  1 (7.69%) African American
  1 (7.69%) Mixed
- 2 (15.38%) were Hispanic.
- Custody Status
  7 (53.85%) Child Welfare Custody
  1 (7.69%) DCFS Youth Parole Custody/Supervision
  5 (38.46%) Parental Custody and no Juvenile Probation involvement

Clinical and Restraint and Manual Guidance Information:

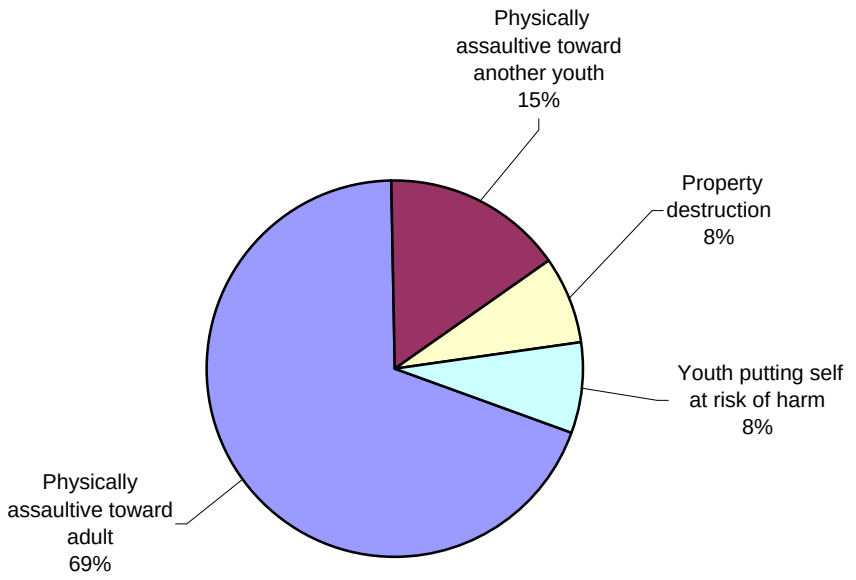
- Major Depressive Disorder (6 or 46.15% of youth) was the most frequent diagnosis.
- 8 (61.54%) of the youth had a history of restraint and manual guidance
- 4 (100%) the average number of times a manual guidance used per incident
- 6.83 (range: 1 - 10) average length of restraint in minutes
- All of the restraint and manual guidance were reported to the youth's legal guardian.

Restraint and Manual Guidance Incidents



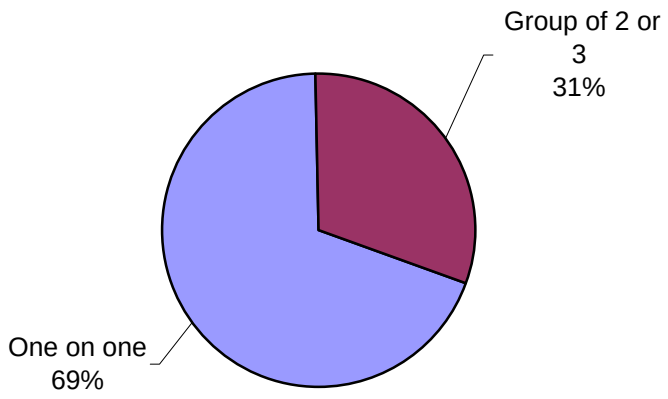
	2008	2009	2010	2011	2012	2013
Number of restraint and manual guidance incidents	2	7	6	21	63	13

Restraint and Manual Guidance Event

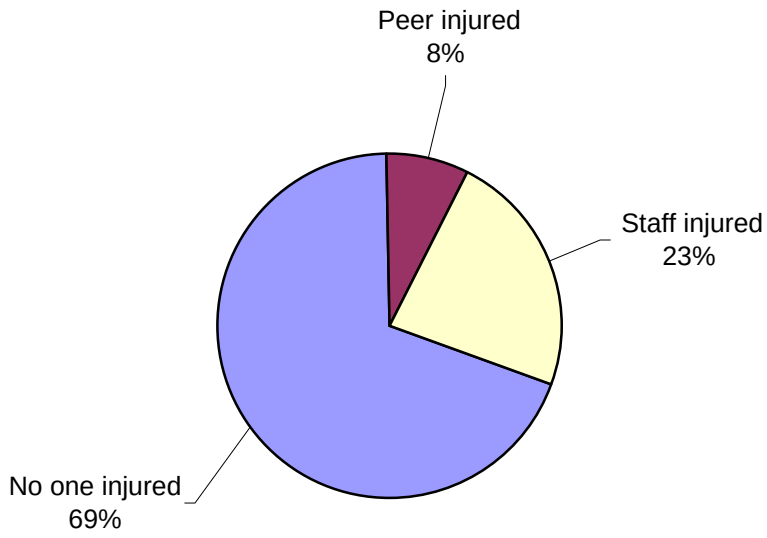


Restraint and Manual Guidance (Continued)

Type of Supervision for Restraint and Manual Guidance



Restraint and Manual Guidance Injury



Departure Conditions

Family Learning Homes reported 47 discharges in the 2013 reporting period.

Descriptive Information:

- 21 (44.68%) were female and 26 (55.32%) were male.
- Average age was 13.06 (range: 8 - 17 years)
- Race
  38 (80.85%) Caucasian
  8 (17.02%) African American
  1 (2.13%) Mixed
- 10 (21.28%) were Hispanic.
- Custody Status
  18 (38.30%) Child Welfare Custody
  11 (23.40%) Parental Custody on Probation
  18 (38.30%) Parental Custody and no Juvenile Probation involvement
- 45 (95.74%) were Medicaid recipients.
- The average length of stay at Family Learning Homes was 162.55 days, ranging from 36 days to 377 days (1.03 years).

Clinical and Departure Information:

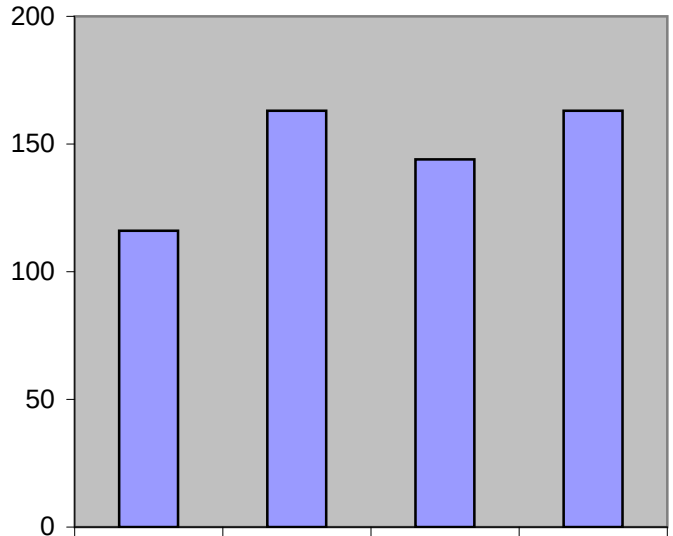
- Posttraumatic Stress Disorder (8 or 17.02% of youth) was the most frequent diagnosis at admission followed by Attention Deficit Hyperactivity Disorder (7 or 14.9% of youth).
- Bipolar Disorder (8 or 17.02 % of youth) was the most frequent diagnosis at discharge followed by Mood Disorder (7 or 14.89% of youth).
- The average CASII composite score at admission was 23.17.
- The average CASII composite score at discharge was 20.34.

- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	8.6	Supervised Independent Living
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

- In 2013, the ROLE score resulted in an average of 8.6, which equals the restrictiveness score of Supervised Independent Living.

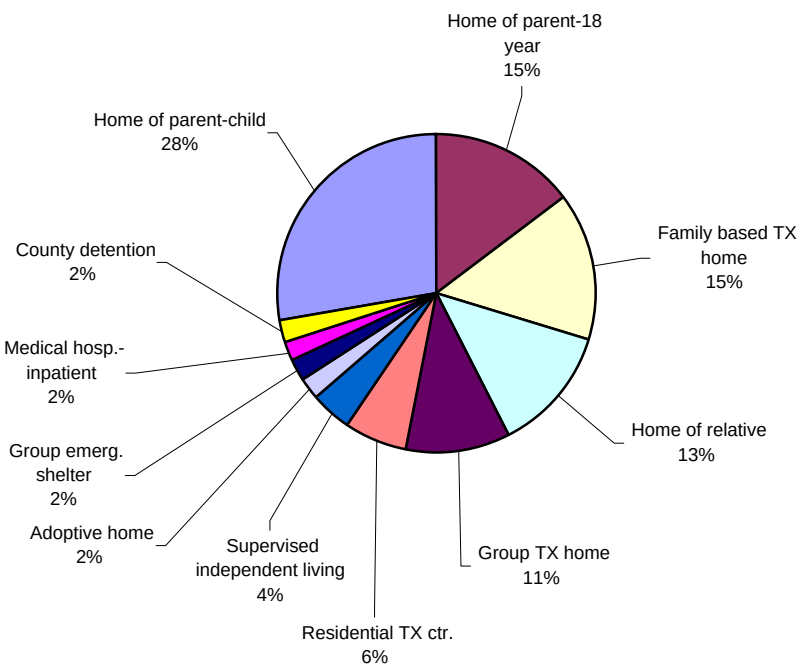
AVERAGE LENGTH OF STAY



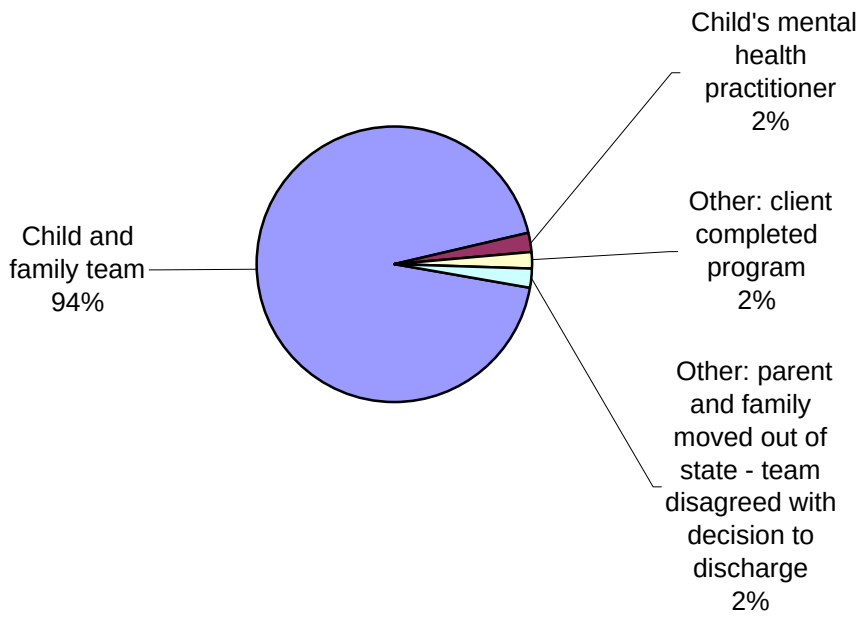
	2010	2011	2012	2013
Average length of stay (days)	116	163	144	163

Departure Conditions (Continued)

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



WHO RECOMMENDED DEPARTURE



- 42 (89.36%) of youth completed treatment prior to discharge.
- 46 (97.87%) of the youth had appropriate transition plans.
  Explanations for the youth not having appropriate transition plans include:
  1 (2.13%) Parent and family moving out of state; team disagreed with decision to discharge.
- 46 (97.87%) of the youth had appropriate discharge plans.
  Explanations for the youth not having appropriate discharge plans include:
  1 (2.13%) Parent and family moving out of state; team disagreed with decision to discharge.

Departure Conditions - Youth in Child Welfare Custody

Of the 47 discharges reported by Family Learning Homes in the 2013 reporting period, 18 (38.3%) were in the custody of a public child welfare agency.

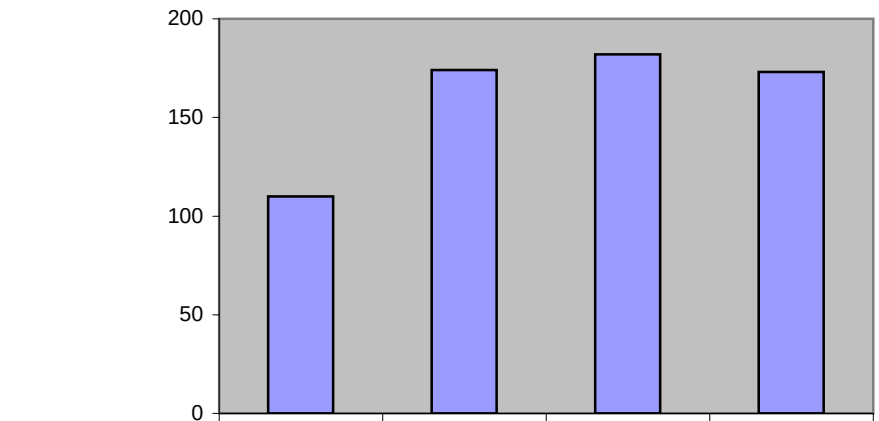
Descriptive Information:

- 7 (38.89%) were female and 11 (61.11%) were male.
- Average age was 12.89 (range: 9 - 17 years)
- Race
  14 (77.78%) Caucasian
  3 (16.67%) African American
  1 (5.56%) Mixed
- 3 (16.67%) were Hispanic.
- The average length of stay at Family Learning Homes was 172.50 days, ranging from 99 days to 285 days.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2013	9.56	Regular foster care
2012	11.5	Specialized foster care
2011	11.3	Specialized foster care
2010	12.9	Family based treatment home

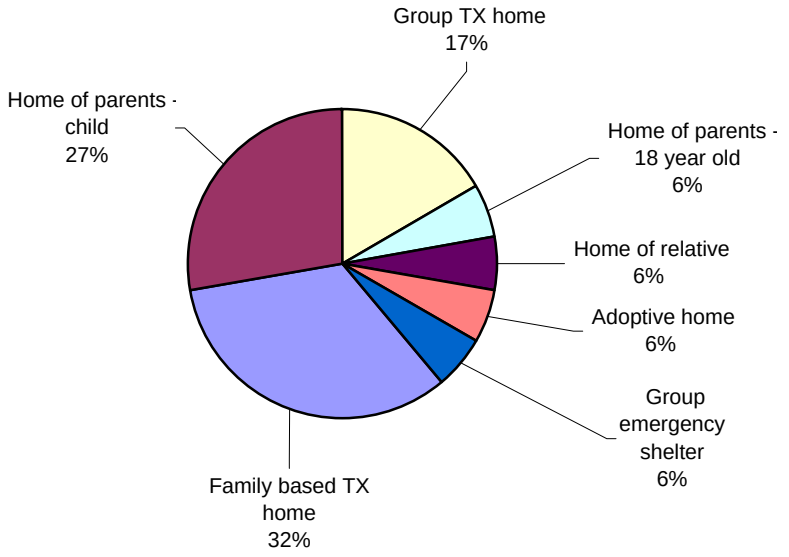
- In 2013, the ROLE score resulted in an average of 9.56, which equals the restrictiveness score of Regular Foster Care.

AVERAGE LENGTH OF STAY



	2010	2011	2012	2013
Length of stay (days)	110	174	182	173

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



Clinical and Departure Information:

- Posttraumatic Stress Disorder (3 or 16.67% of youth) and Mood Disorder (3 or 16.67% of youth) were the most frequent diagnoses at admission.
- ADHD (3 or 16.67% of youth) and PTSD (also 3 or 16.67%) were the most frequent diagnoses at discharge.
- The average CASII composite score at admission was 23.56.
- The average CASII composite score at discharge was 19.06.

- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

- All of youth completed treatment prior to discharge.
- All of the youth had appropriate transition plans.
- All of the youth had appropriate discharge plans.
- All of the departures were recommended by the Child and Family Team

Suicidal Behavior

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

Highlights:

- There were no attempted or completed suicides.

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

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).

Highlights:

- The staff informed the legal guardian of the medication errors.
- 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:

- 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.
- For “other” errors (unable to get an appt. with psychiatrist, unable to reach psychiatrist by phone, unable to get authorization, unable to verify PLR consent): 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).
- 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.

AWOL

An AWOL (runaways) is defined as a child or adolescent who is absent from the specialized foster care home for more than 24 hours.

Highlights:

- The staff informed the legal guardian of the AWOL incidents.
- AWOL incidents have declined as compared to four out of five previous years.

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).
- 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

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).

Highlights:

- In most incidents, no one was injured.
- The staff informed the legal guardian of the restraint and manual guidance incidents.
- The staff received initial and refresher training on restraint and manual guidance.

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).
- 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.

Discharge Conditions

A departure means either a child is discharged from a specialized foster care agency or a child is discharged from one specialized foster care home and

Overall Highlights:

- Upon discharge, 29 of the youth were placed in less restrictive settings.

Children in Child Welfare Custody Highlights:

- Upon discharge, 8 of youth returned to a less restrictive environment.
- Upon discharge, 8 of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- Of the 18 departures for children in the custody of a child welfare agency 18 or 100% were recommended by a CFT. In 2012, 14 or 100 % of departures for children in the custody of a child welfare agency were recommended by a CFT.

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.

Trauma Informed Care Training

Using curriculum from the Chadwick Center as part of the National Child Traumatic Stress Network, the Trauma Informed Care training workshop discusses the trauma children and their families experience as well as secondary traumatic stress that can result from working with traumatized individuals. In 2013, FLH had 15 Psychosocial Rehabilitation/Basic Skills Training workers complete the Trauma Informed Care training.

Summary

Family Learning Homes submitted all of its 2013 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 2013 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of medication errors, AWOLS and restraint and manual guidance.

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 2013 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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