MEDICAID REPORT 2015
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2014 SUMMARY

DCFS 2015 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 2014 for DCFS CMHS. It also includes the Performance and Quality Improvement Plan for 2015-2016 (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, 2015.

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)
Mobile Crisis Response Team	Mobile Crisis Response Team
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) 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: 2015-2016 (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 2798 children served by the DCFS Children's Mental Health Services in Fiscal Year 2014 (July 1, 2013 through June 30, 2014). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 2798 children served by DCFS programs, 1955 (69.8%) received services in Clark County and 843 (30.1%) were served in Washoe County/Rural.

Of all children served, 54.0% were 12 years of age or younger and 52.1% were male. Caucasian children accounted for 74.2% of all those served and African-American children 19.9%. Children of Hispanic origin came to 29.9%.

In FY14, 50.3% of the children admitted to mental health services statewide were in the custody of their parent or family, 44.8% were in Child Welfare custody, 3.1% were in the custody of their parent or family and on probation, and 0.3% were in Youth Parole custody.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY14. (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 31 through May 9 (Spring) of 2014. 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 358 parents/caregivers and 189 youth. Spring survey results indicated a statewide average of 90.3% parent/caregiver positive rating and an 82.9 % 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, including comments from respondents, can be found in the appended DCFS Community Based Services Parent/Caregiver – Youth Survey Results Statewide Spring 2014 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 2014 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. DWTC, FLH, ECMHS, SNCAS WIN and NNCAS WIN programs had no survey items with a 60% or less positive response in the most recent survey reports. Programs requiring a program improvement plan for one or more items were: Children's Clinical Services, NNCAS Outpatient, Oasis, and ATC. Program Managers submitted quality improvement plans to the PEU.

NNCAS Outpatient and Children's Clinical Services received 60% or less positive responses in several domains. The items common to both programs include satisfaction with family life, choice in treatment, and sense of belonging in the community. Here are the plans to address these items:

1. Satisfaction with family life (Youth perception only)
    - Review deficiencies in staff meetings, to address and brainstorm solutions and ideas surrounding family life, relationships, and interactions.
    - Continue to make ongoing efforts to include all family members in the therapeutic process, working on solution focused strategies to improve family life.
    - Increase working with youth and families throughout the therapeutic process in assessing and developing the family relationship and positive relationship outcomes.

2. Choice in treatment and services (Note-Parent responses were above 80%)
    - Clinicians will make an increased effort to engage the youth in choosing what services they feel are appropriate at intake, as well as throughout the life of the case whenever possible.

3. Sense of belonging in the community (Note-Applies to youth only)
    - Work closely with youth and families to assess the interests that youth have and whether they participate in those activities.
    - Increase efforts in linking and referring youth to community programs and activities when appropriate, monitoring throughout the life of the case.
    - Work on issues of self-esteem, motivation, and interpersonal relationships.

NNCAS also provided improvement plans for the following:

1. My child gets along better with family members (Youth perception only)
    - Address and brainstorm solutions and ideas surrounding family relationships and interactions.
    - Clinicians will continue to make ongoing efforts to include all family members in the therapeutic process.
    - Clinicians will increase working with youth and families throughout the therapeutic process in assessing and developing the family relationship and positive relationship outcomes.

2. My child is doing better in school (youth perception only)
    - NNCAS Outpatient clinicians will work with youth to assess areas in school they are struggling with and will work with youth and parents in addressing identified issues.

Children's Clinical Services provided an additional improvement plan for the following:

1. My child is better able to cope when things go wrong.

    - Clinicians will teach coping skills to the client and reiterate the importance of participation in family therapy so that the parents and family can support the child in using those strategies.

The Oasis program and ATC both received below 60% on the item related to staff showing respect to families. This was the youth's perception only and parental responses were 100% positive for this item.

The improvement plan for Oasis is as follows:

- Meet prior to admission to discuss the program and clarify the expectation/opportunities for their participation. If in agreement, sign a participation agreement.
- Supply weekly e-mails and phone calls to note progress and elicit input on treatment for their child.
- Review how important shadowing is and strive to create a therapeutic relationship to make the activity more collaborative in dealing with the youth.
- Institute a monthly family fun day to allow for families to be involved in a non- threatening and more relaxed environment. Also allowing for opportunities to increase their ability to have fun together.

The improvement plan for ATC is as follows:

- Beginning at intake staff will reiterate that the family and the child will be treated with respect.
- Provide information to the family regarding who they can talk to if they don't feel they are being respected including the name and number of the Program Manager.
- Make sure clinicians are stressing to the family how important it is to be engaged in the child's treatment.

All Treatment Home programs will develop improvement plans to increase completion of parent/caregiver and youth surveys. Statewide there were a combined total of 317 parent/caregiver and 361 youth survey participants. The majority of participants were from Desert Willow. The other residential programs all had less than 40% of their discharged clients participating in the survey.

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 2015 that may also incorporate items related to Secondary Trauma.

Service Delivery Compliance

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

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

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

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 are to use the two DCFS/PEU developed service-specific case review checklists to help guide their feedback to staff when directing and improving direct service provider and/or targeted case management service provider adherence to relevant policy and documentation requirements. The Management Team has 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 will develop policies and a business process for supervisor use of the checklists. The checklists were updated and continue to be 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 management and staff. This will facilitate identification of training and staff development needs.

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 2014, DWTC served 240 children in its acute care programs and 74 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 December 2016. 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 and now Oasis also have nurses who review Medication Administration Records on a monthly basis. DCFS/PEU conducts reviews at least annually. At Oasis PEU conducted medication administration and management reviews monthly and provided consultation regarding this policy prior to the hiring of a nurse. Currently the nurses at the residential facilities provide training in proper handling and administration of medication.

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.

The data cleanup committee will again convene regularly to analyze and provide program area feedback on quarterly report results. PEU staff 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.
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.

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, 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 2014, 11 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 will again initiate attending Child and Family Teams to provide increased opportunities for observation and to obtain additional data and will again examine fidelity through use of the Wraparound Fidelity Instrument.

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 sociodemographic 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
[Plan Domain(s): I – II]

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. 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 Initiatives
[Plan Domain: I]

Mobile Crisis Response Team

The Mobile Crisis Response Team (MCRT) is a new program serving youth in the greater Las Vegas area and in the Reno/Carson City area who are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization. Information gathered from mobile crisis response

units in other US states indicates that in many cases when children and adolescents are in crisis, they can be safely de-escalated and stabilized in their home and community. This is a favorable outcome for families, preventing the unnecessary use of costly forms of mental health care such as hospitalization and allowing the family to remain united with their child while working through the current mental health crisis with the support of a crisis stabilization team. PEU has a Psychologist primarily dedicated to evaluating this program and providing clinical consultation. PEU has also coordinated all the training for MCRT staff including evidence based interventions such as Solution Focused Brief Therapy and Motivational Interviewing.

Trauma Informed Care

Since 2012, 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 1000 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. A PEU staff and a Children's Clinical Services supervisor are being trained as Supervisors and Trainers for this program by the model's developers.

Other Evidence Based Practices

DCFS Children's Mental Health continues to provide training opportunities for staff in evidence based interventions and models such as Dialectical Behavior Therapy, Parent-Child Interaction Therapy, Solution Focused Brief Therapy, and Motivational Interviewing. The Planning and Evaluation Unit will explore evaluation methods for these practices.

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 2015 DCFS Performance and Quality Improvement 2014 Summary and are pleased to submit it on behalf of all of our dedicated DCFS Children's Mental Health Services program managers and staff.

Approved by:

_____	_____
Katherine Mayhew, Clinical Program Planner 3 Planning and Evaluation Unit, DCFS	Date
_____	_____
Kelly Wooldridge, Deputy Administrator Children's Mental Health, DCFS	Date
_____	_____
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 2015
DCFS PERFORMANCE AND QUALITY IMPROVEMENT
2014 SUMMARY

ATTACHMENT INDEX

ATTACHMENT A

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

DIVISION OF CHILD AND FAMILY SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
PERFORMANCE AND QUALITY IMPROVEMENT PLAN: 2015-16

PURPOSE

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

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

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

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

SERVICE COMPLIANCE	Quality Assurance and Regulatory Standards. CMHS activities are to be conducted in compliance with relevant Statutory, Regulatory, Medicaid; Commission approved DCFS policy and professional best practice standards.
SERVICE EFFECTIVENESS	Are CMHS clients benefiting from the services provided them? Outcome indicators include such measures as client functioning, symptom reduction and quality of life indices.
SERVICE EFFICIENCY	Focus is on CMHS operational and functional efficiency as it relates to client services accessibility, availability and responsiveness.

SERVICE QUALITY

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

PLAN FUNCTIONAL DETAILS

SERVICE COMPLIANCE

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

		improvement (PQI) monitoring strategies, procedures, result sharing and reporting to include the Deputy Administrator. **SC 1.2.3** Work together with identified program area personnel in designing PQI processes for addressing selected areas found in need of remediation. **SC 1.2.4** Work with identified program area personnel in developing agreed upon plan for re-assessment of remediated areas. **SC 1.2.5** Be available to the Deputy Administrator to respond to Legislative requests for data **SC 1.2.6** Develop annual quality assurance plans to report to Medicaid.
SC 2. CMHS programs will be in compliance with applicable federal, state and Division policy, regulation and standards of care.	**SC 2.1** Review and update/revise program policies on service delivery for compliance with standards of care	**SC 2.1.1** Program policy review and update occurs as a standard component of the CMHS Program Managers administrative group. A list of needed policies and policies requiring revision will be developed and prioritized.
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 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 6.2** Evaluate the wraparound Child and Family Team process using the Team Observation Measure. PEU to also observe teams and complete TOMS.	**SC 6.1.1 1.** The PEU will partner with program managers and supervisors to plan for WFI implementation. **SC 6.1.1.2** Interview service youth, parent/caregivers and Wraparound facilitators by utilizing the WFI. **SC 6.1.1.3** Analysis of data for feedback on strengths and areas needing improvement in order to increase adherence to the service delivery model. **SC 6.1.1.4** Develop a report with recommendations. **SC 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
SE2. Support DCFS treatment home efforts toward achieving effective outcomes	**SE 2.1** Conduct DCFS treatment home outcome reviews	**SE 2.1.1** Develop and promulgate standard set of program outcome indicators **SE 2.1.2** Develop standard set of tools for capturing review

		data **SE 2.1.3** Schedule and conduct provider reviews **SE 2.1.4** Compile and assess review data results **SE 2.1.5** The PEU will conduct reviews on the implementation of the Policy on Medication Administration and Management with DCFS treatment homes. **SE 2.1.6** The PEU will conduct reviews on the physical condition of the treatment homes using Physical Plant Checklist. **SE 2.1.7** The PEU will provide training on medication administration and management at Oasis and trauma informed care for all treatment homes. **SE 2.1.8** The PEU will conduct documentation reviews on open Oasis cases. **SE 2.1.9** Draft and report review results
SE 3. Provide performance measure data as required for the DCFS budget process	**SE 3.1** Establish an efficient method of regularly reporting on required performance measures	**SE3.1.1** Develop a protocol for reporting on performance measure data **SE 3.1.2** 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	**SEF 2.1** Ensure that the Avatar database contains	**SEF 2.1.1** Track and report on client cases open>= 6 months

accurately captures, maintains and reports client clinical, financial, demographic and other service related information	accurate, complete and timely information	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 3.2** DCFS practitioners will be trauma-informed and will be trained in evidence based practices	**SEF 3.1.1** CMHS direct service staff are trained in all standardized assessment tools used by CMHS **SEF 3.2.1** CMHS direct service staff will receive trauma informed training and will be provided training in evidence based practices as needed/available. **SEF 3.2.2** PEU will conduct evaluations regarding training and designate outcome measures for treatment models.
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	**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

	staff to support and enhance service productivity	supervisors **SEF 5.2.1** Supervisors use available Avatar reports for collaborating with staff on ways to maintain/enhance their levels of service
SEF 6 New clients applying to CMHS will receive those services in a timely manner	**SEF 6.1** Programs will maintain wait lists that track the date of new client intake/referral contact and the first face to face contact with practitioner	**SEF 6.1.1** Program wait lists will be kept current and reported regularly to the State Mental Health Commission **SEF 6.1.2** Program wait lists will be available for budget planning purposes
SEF 7 Ensure that treatment interventions reflect treatment plans that are fluid, flexible and appropriate to the needs of the individual child	**SEF 7.1** Review active cases open for more that 24 months to ensure that case documentation is complete and indicates movement	**SEF 7.1.1** Download for review Avatar report for cases open longer than 24 months **SEF 7.1.2** Group report data into 2-3 years, 4-5 years, and 6 years or more **SEF 7.1.3** Provide a detailed monthly report to CMHS managers on each child and his/her practitioner for each group by program area

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	**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

	services	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
SFY 14

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

CONTENTS

INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2014, from July 1, 2013 through June 30, 2014. The FY 2014 Descriptive Summary provides an expanded analysis of DCFS programs. This report examines served client data statewide and by program area. Children served are those who received a service sometime during the fiscal year.

This descriptive report summarizes demographic and clinical information on the 2798 children served by mental health services across the State of Nevada in DCFS Children's Mental Health Services. DCFS Children's Mental Health Services are divided into Southern Nevada Child and Adolescent Services (SNCAS), with locations in southern Nevada, and Northern Nevada Child and Adolescent Services (NNCAS), with locations in northern Nevada. NNCAS includes the Wraparound in Nevada program serving the rural region. DCFS Children's Mental Health Mobile Crisis Response Team (SNCAS) information is also included in this report.

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

SNCAS	NNCAS
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) (includes rural)
Mobile Crisis Response Team (MCRT)	MCRT *(Beginning in fiscal year 2015)*
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

Total Number of Children Served

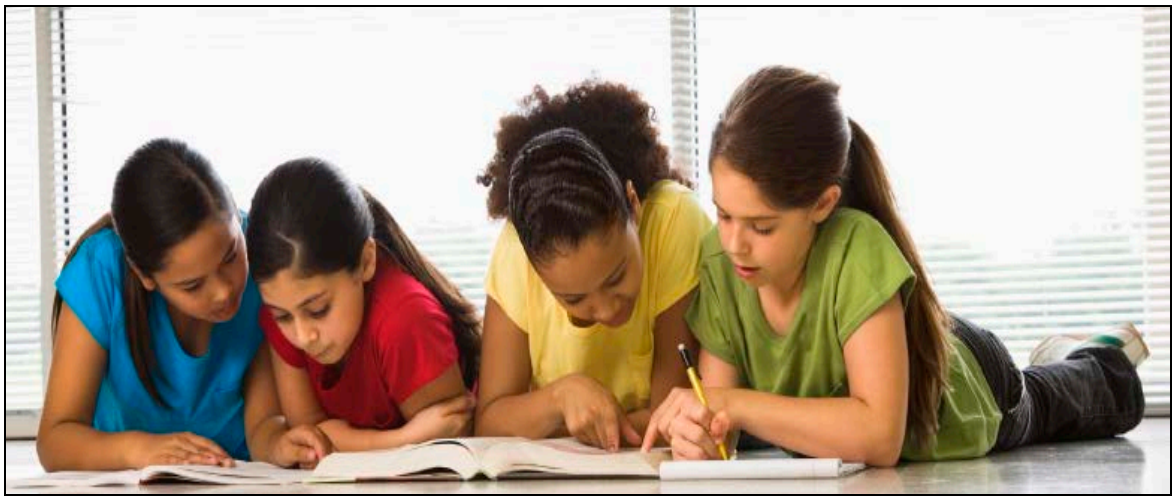
Statewide	NNCAS	SNCAS
2798	843	1955

Admissions

Statewide	NNCAS	SNCAS
1903	553	1350

Discharges

Statewide	NNCAS	SNCAS
2000	575	1425



CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

Statewide and by Region

Age

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

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

Gender

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

Race and Ethnicity

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

Custody Status

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

Severe Emotional Disturbance Status

Statewide	NNCAS	SNCAS
2295	726	1569

Demographics by Program

Community Based Programs:

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

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

Number of Children Served

Statewide	OPS	CCS
1267	408	859

Age

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

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

Gender

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

Race and Ethnicity

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

Custody Status

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

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

Number of Children Served

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

Age

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

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

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

Gender

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

Race and Ethnicity

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

Custody Status

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

WIN Statewide and by Region

Number of Children Served

Statewide	North	Rural	South
654	203	94	357

Age

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

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

Gender

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

Race and Ethnicity

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

Custody Status

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

Treatment Homes

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

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

Number of Children Served

Statewide	ATC	FLH	OCTH
137	53	55	29

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

Age

The average age of children served Statewide was 14.52, ATC was 15.95, FLH was 13.12, and OCTH was 14.54.

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

Gender

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

Race and Ethnicity

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

Custody Status

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

Residential Facility and Psychiatric Hospital:

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

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

Number of Children Served

Acute	RTC
240	74

Age

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

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

Gender

	Acute	RTC
Male	82	42
Female	157	32
Unknow	1	0

Race and Ethnicity

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

Custody Status

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

CHILDREN'S CLINICAL CHARACTERISTICS AND OUTCOMES

Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their children have encountered. Of the 51 presenting problems listed, the 6 identified below (and listed in order of prevalence) accounted for 44.70% of all primary presenting problems reported for admissions in FY2014.

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

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

Diagnosis

In FY 2014, 35.4 percent of children served met criteria for more than one diagnostic category. The tables below show the most prevalent Axis I diagnoses of children by age category and gender.

Age Group 0-5.99

Overall- Both Male and Female
Neglect of Child
Disruptive Behavior Disorder NOS
Anxiety Disorder NOS
Anxiety Disorder NOS

Age Group 6-12.99

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

Age Group 13-17.99

Female	Male
Posttraumatic Stress Disorder	Mood Disorder NOS
Major Depressive Disorder, Single Episode , Severe, Without Psychotic Features	Oppositional Defiant Disorder
Mood Disorder NOS	Posttraumatic Stress Disorder
Oppositional Defiant Disorder	Attention-Deficit/Hyperactivity Disorder/Combined Type
Depressive Disorder NOS	Attention-Deficit/Hyperactivity Disorder NOS

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

The Child and Adolescent Functional Assessment Scale (CAFAS)[1] is designed to assess in children ages 6 to 18 years the degree of functional impairment regarding emotional, behavioral, psychiatric, psychological and substance-use problems. There are eight subscales reflecting the client's functioning in that area. Subscale scores can range from Minimal or No Impairment (0) to Severe Impairment (30). Total CAFAS scores can range from 0 to 240, with higher total scores reflecting increased impairment in functioning.

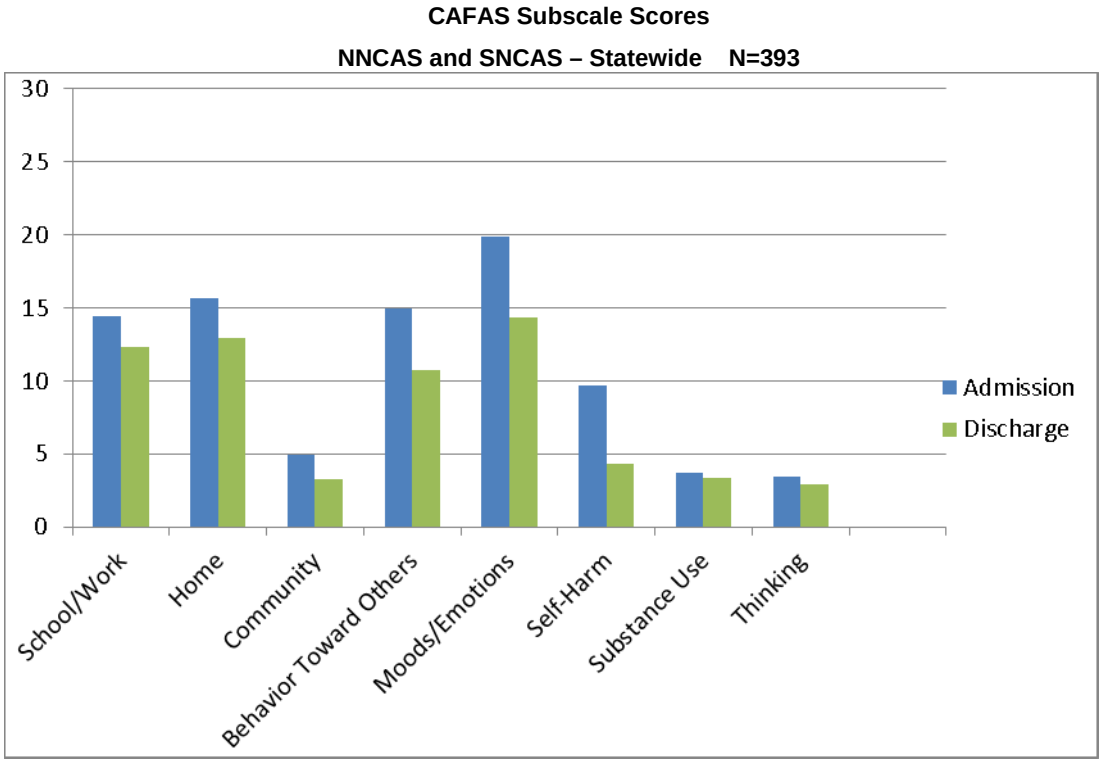
The Preschool and Early Childhood Functional Assessment Scale (PECFAS)[2] was also designed to assess degree of impairment in functioning of children ages 3 to 7 years with behavioral, emotional, psychological or psychiatric problems. Total PECFAS scores range from 0 to 210, with a higher total score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

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

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

Outpatient and Children's Clinical Services

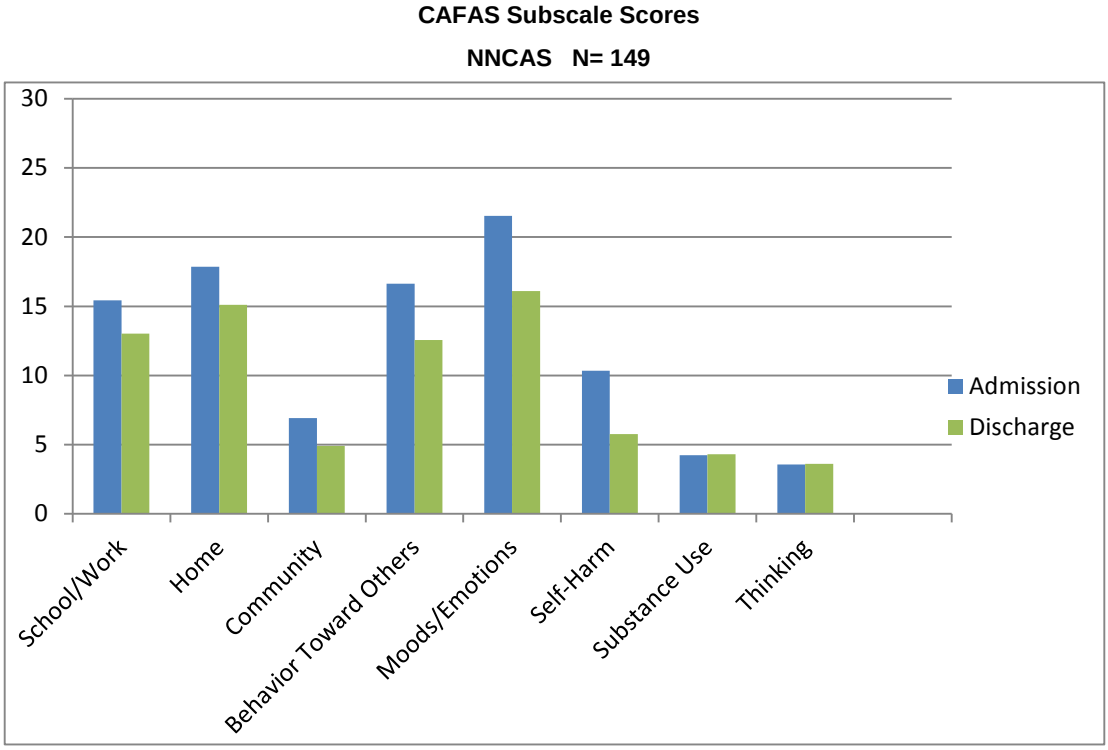
The graph below shows the admission and discharge CAFAS subscale scores for Outpatient (NNCAS) and Children's Clinical Services (SNCAS) statewide.



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

Outpatient (NNCAS)

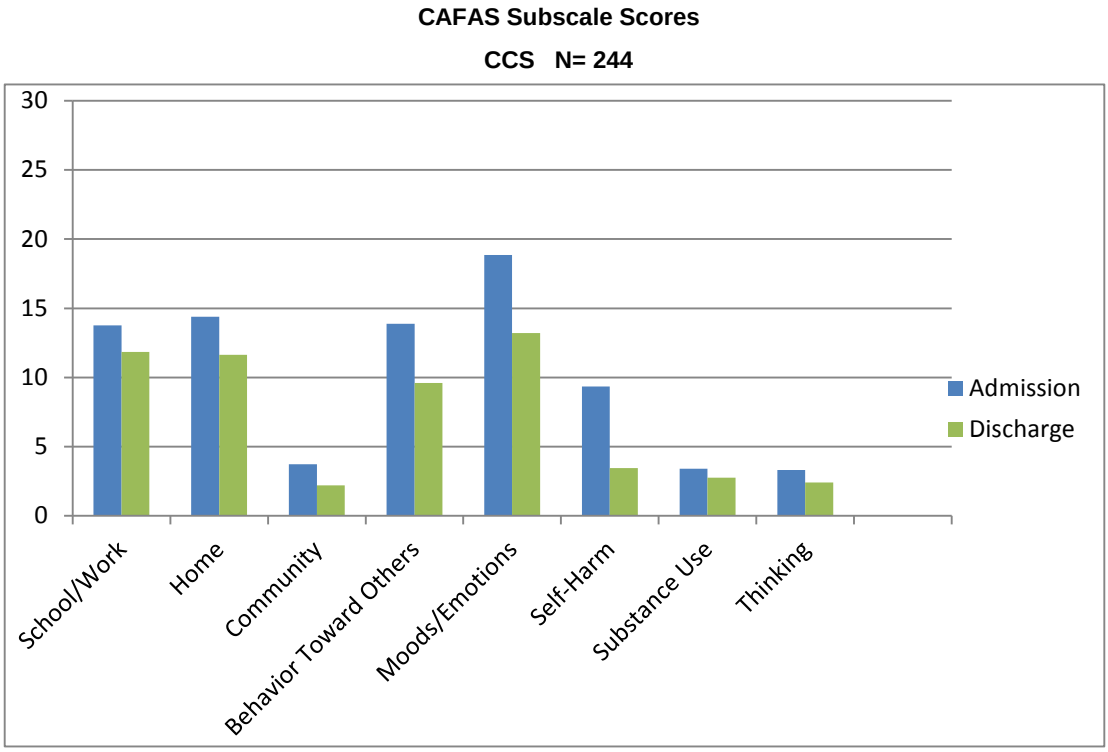
Admission and discharge CAFAS subscale scores for NNCAS Outpatient Services are depicted in the following graph.



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

Children's Clinical Services (SNCAS)

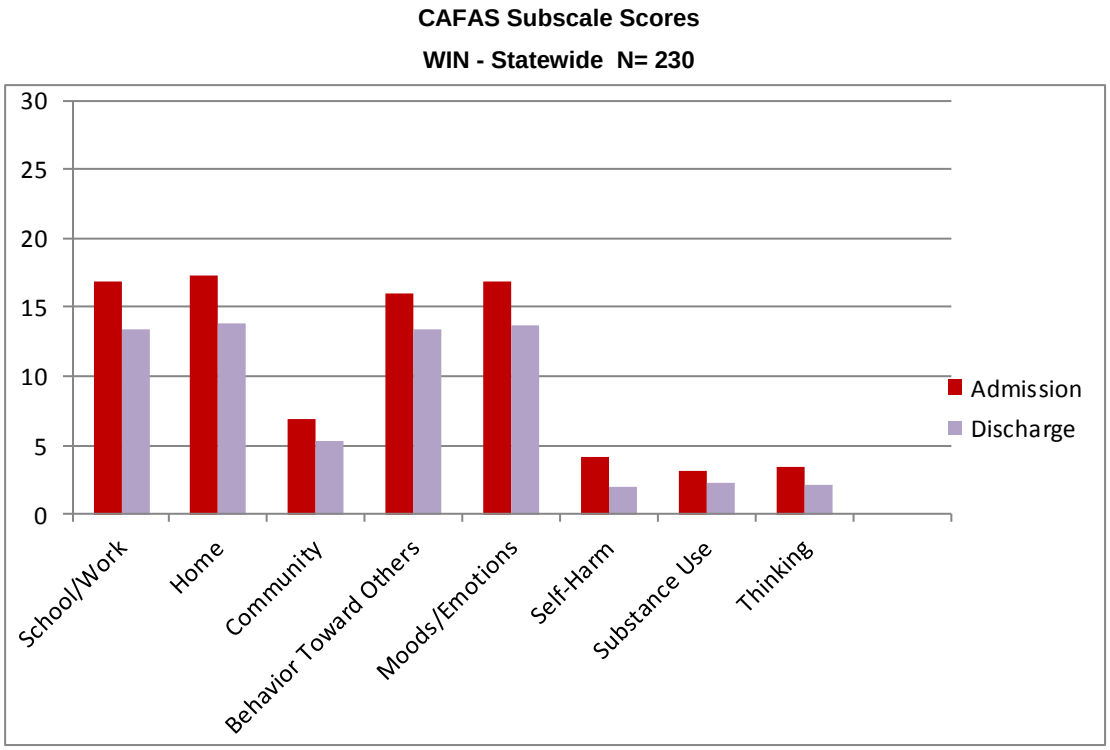
The following illustrates the admission and discharge CAFAS subscale scores for Children's Clinical Services (CCS).



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

WIN

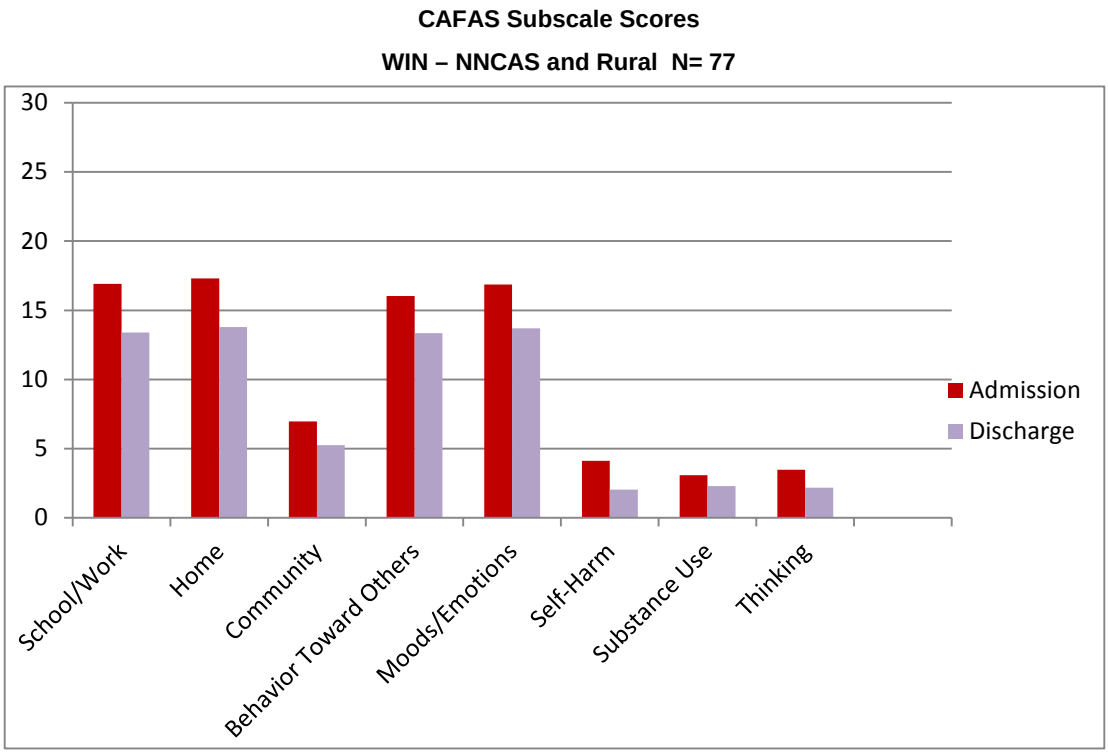
The graph below shows the admission and discharge CAFAS subscale scores for WIN statewide.



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

WIN-NNCAS and Rural

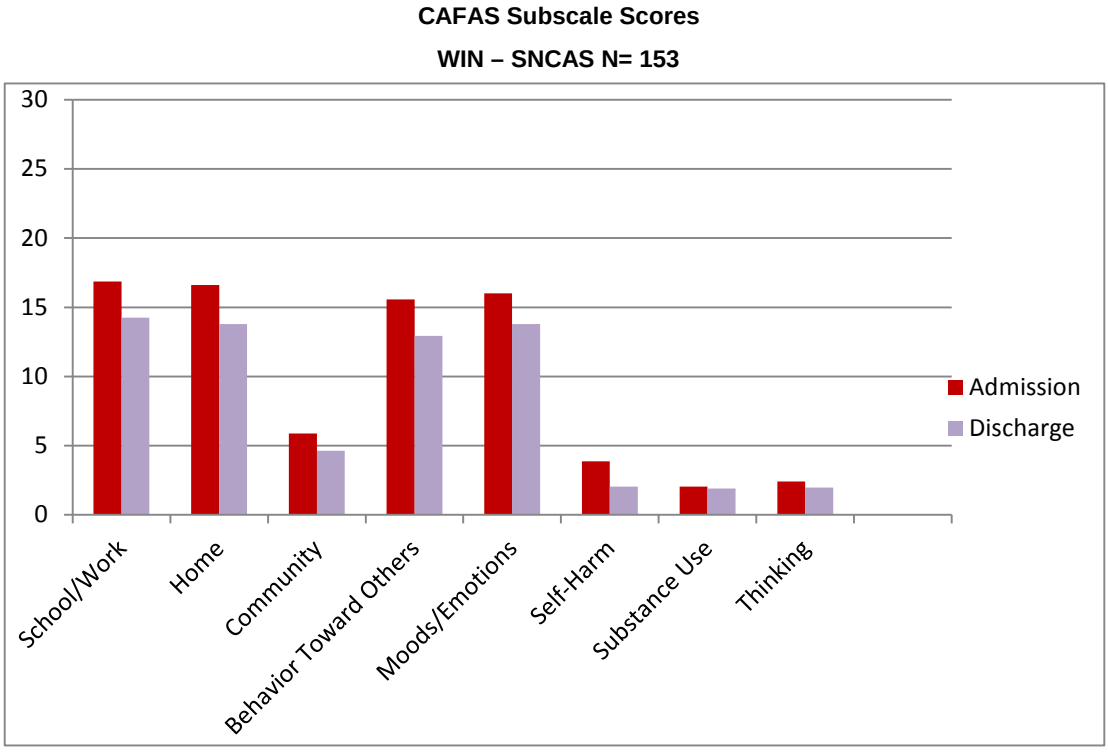
The following graph shows the admission and discharge CAFAS subscale scores for WIN at NNCAS and Rural.



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

WIN-SNCAS

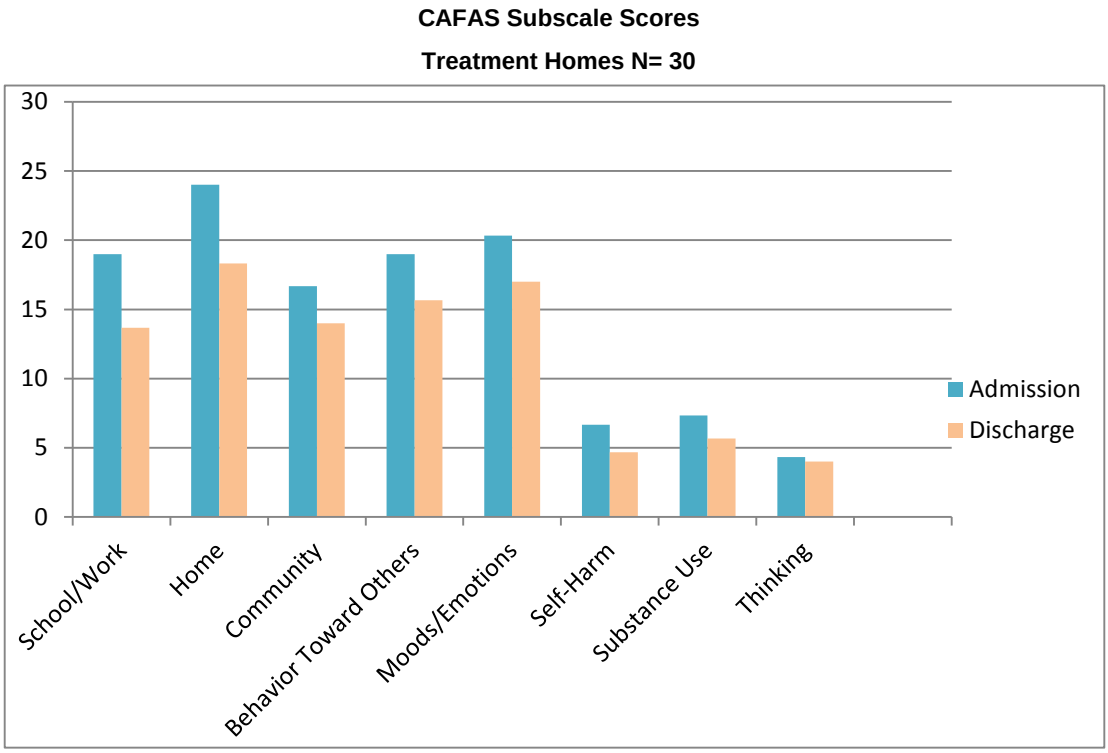
The admission and discharge CAFAS subscale scores for WIN at SNCAS are depicted below.



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

Treatment Homes

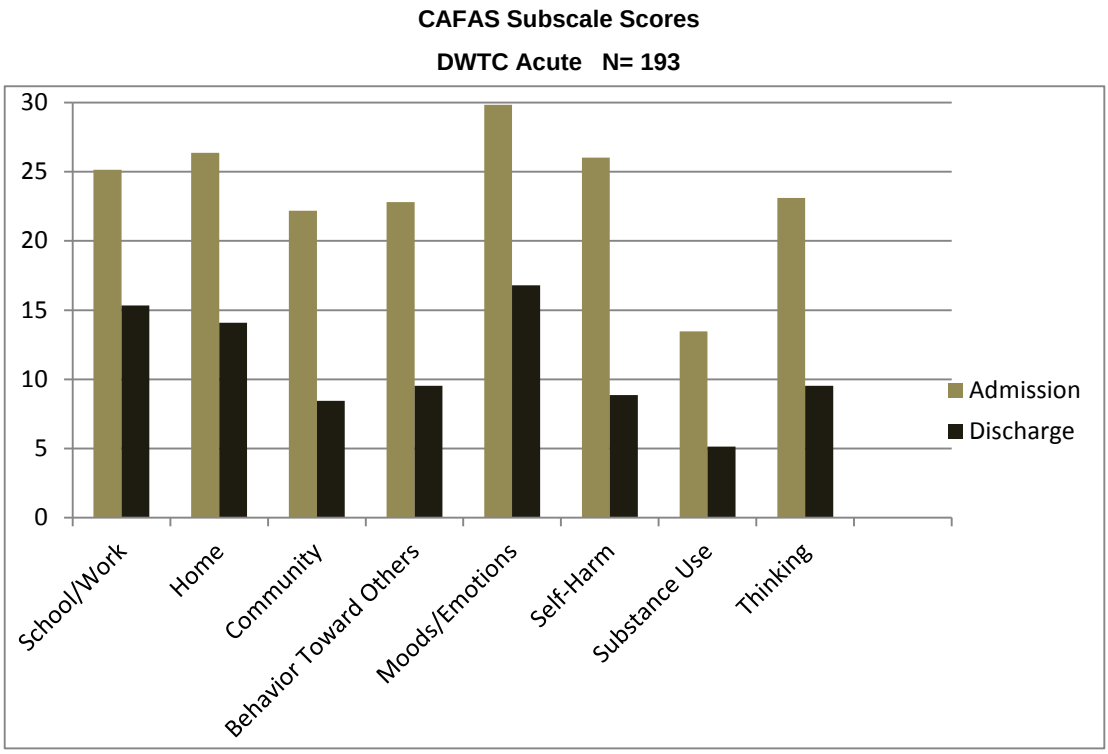
The graph below shows the admission and discharge CAFAS subscale scores for Treatment Homes Statewide.



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

Desert Willow Treatment Center Acute Hospital

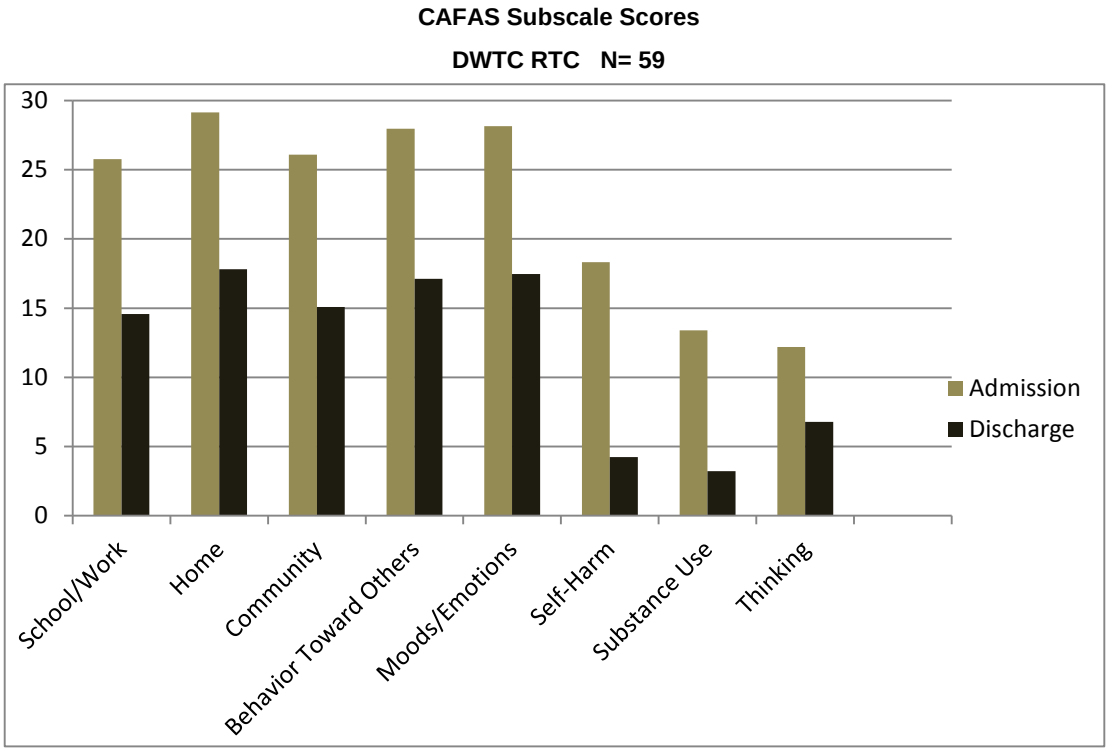
The admissions to discharge CAFAS subscale scores for Desert Willow Treatment Center Acute Hospital are depicted below.



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

Desert Willow Treatment Center RTC

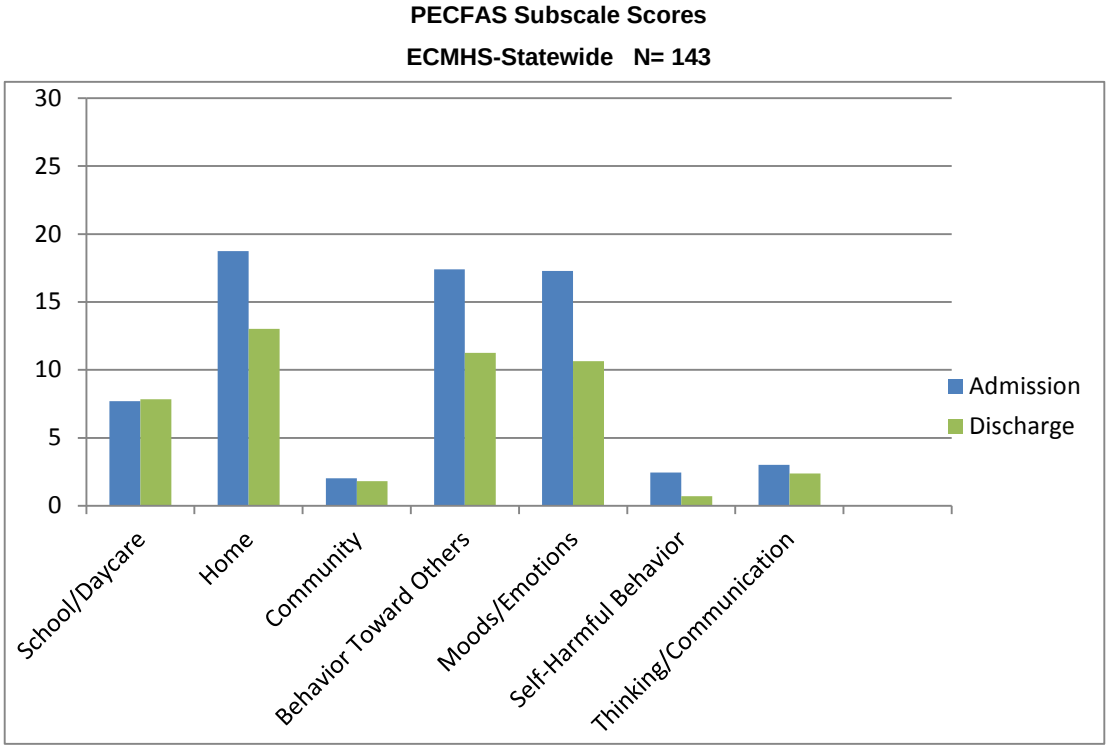
The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Residential Treatment Center.



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

Early Childhood Mental Health Services

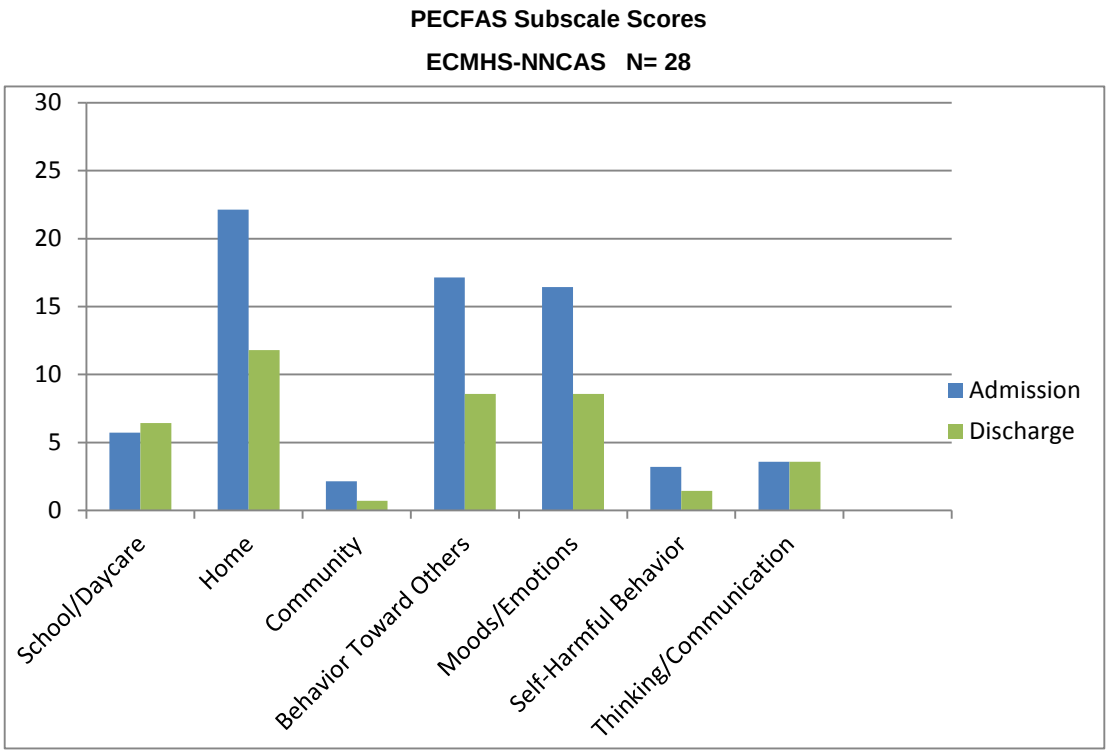
The graph below shows the admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services statewide.



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

Early Childhood Mental Health Services- NNCAS

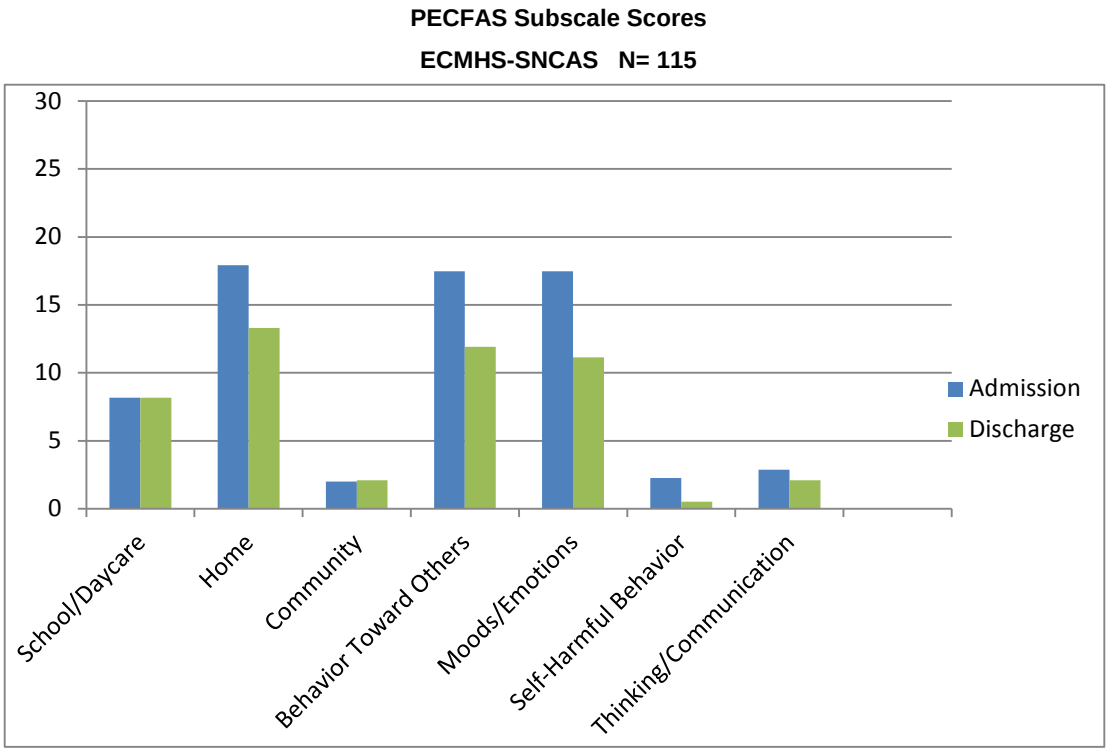
The graph below shows the admission to discharge for PECFAS subscale scores for Early Childhood Mental Health Services at NNCAS.



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

Early Childhood Mental Health Services- SNCAS

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



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

Education and Juvenile Justice Outcomes

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

Performance was classified into three categories:

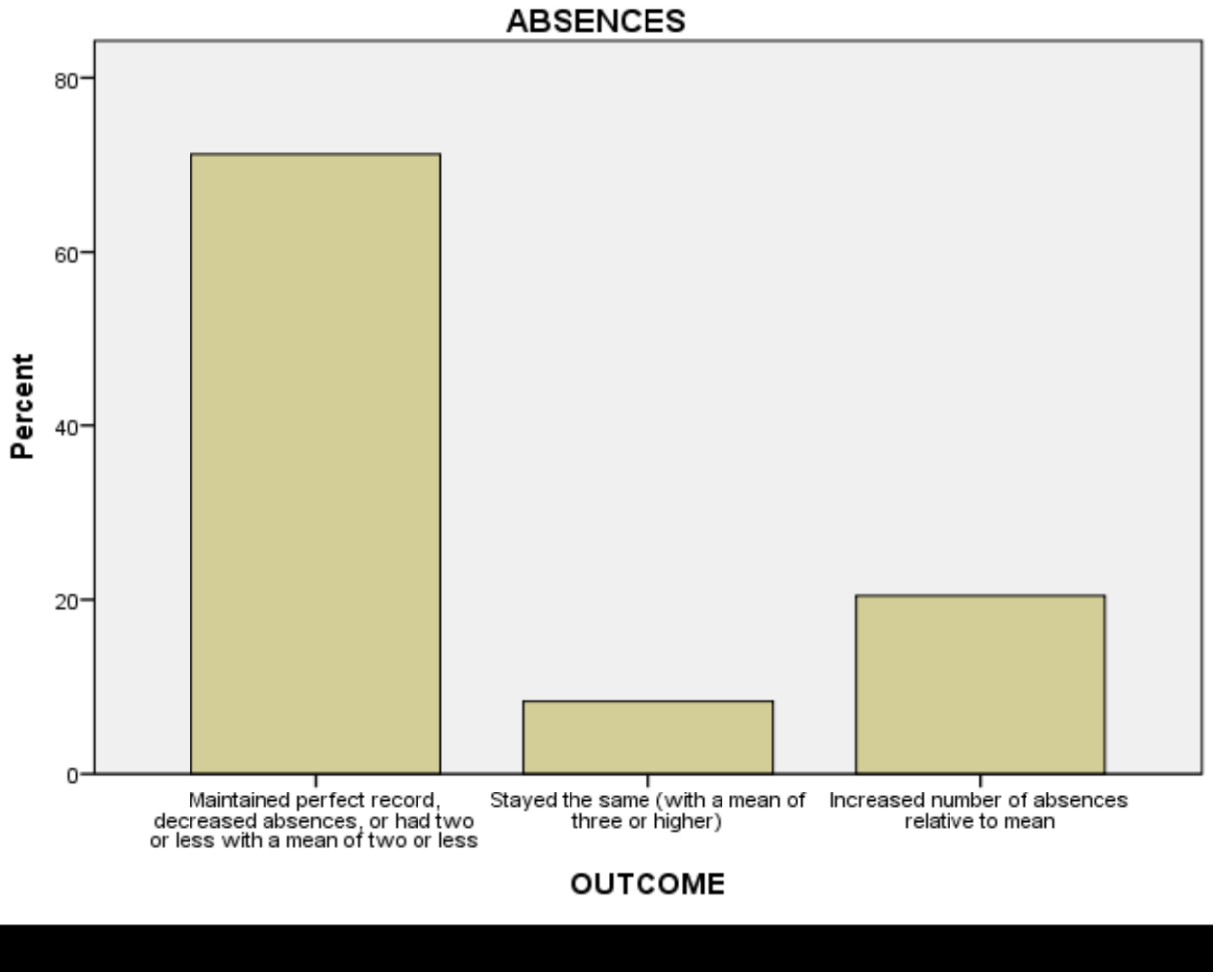
1. A client was considered to be maintaining an excellent performance or showing improvement if he or she met any one of three criteria:
   - The client had a perfect record historically and in the most recent period;
   - The client had a history of averaging no more than two absences per grade period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

2. A client was considered to have stayed the same at a level that could be improved if he or she had:
   - Three or more absences per period historically and had the same number as his or her average in the most recent period (absences only), or

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

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

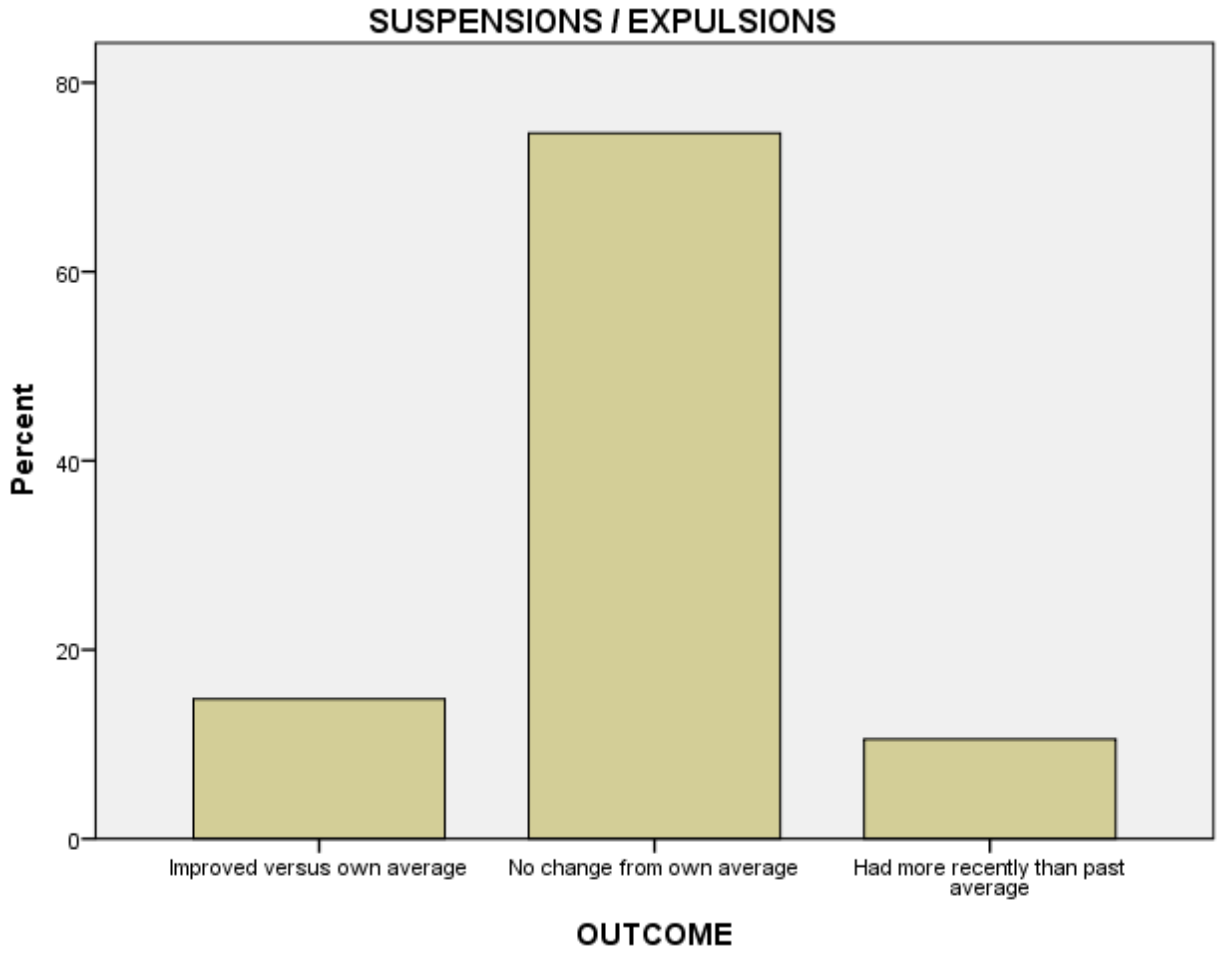
Absences: Statewide/All Programs



In FY2014, 827 clients had absences data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 589 (71.2%) of the clients.

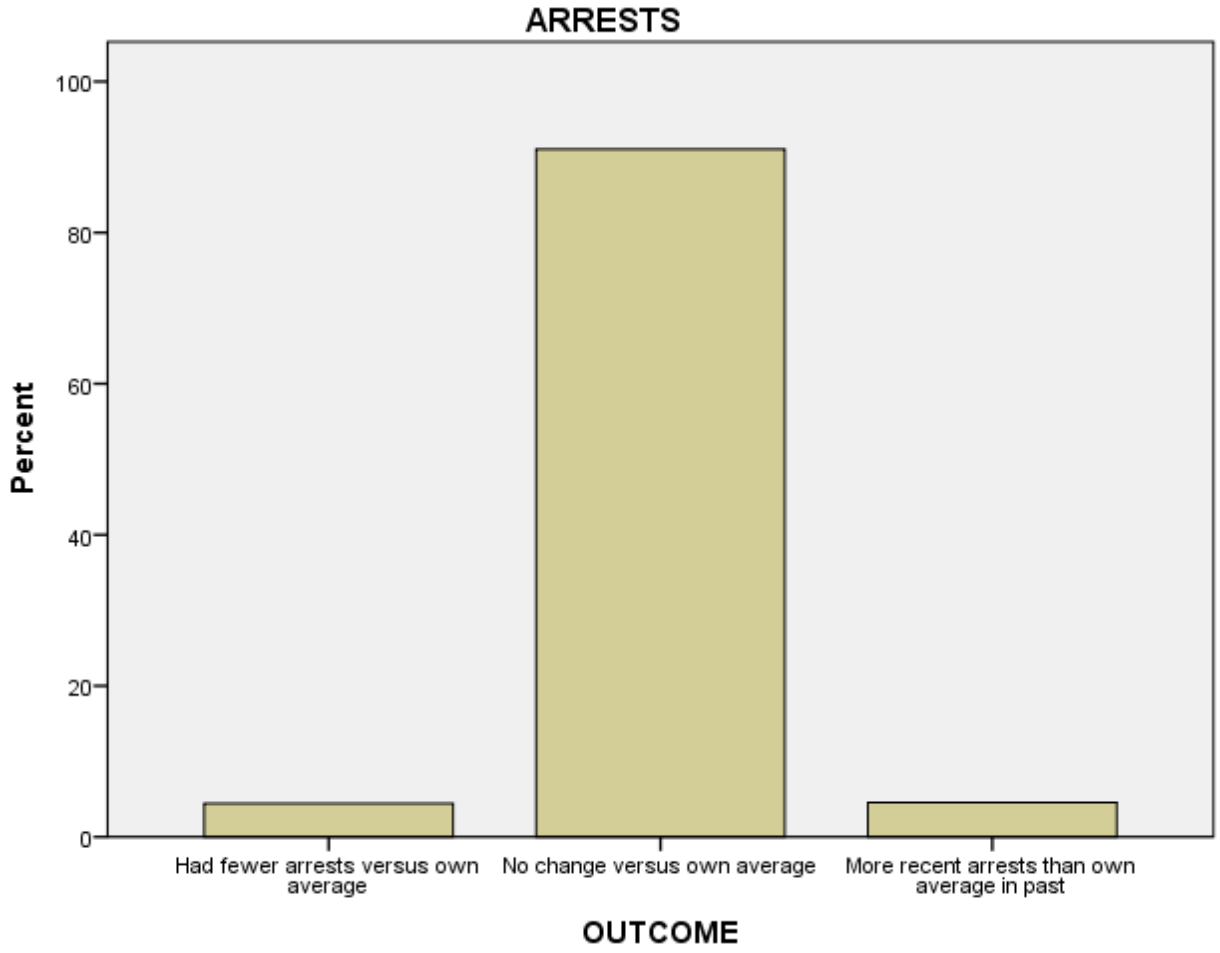
Absences remained the same at three or more compared with a mean of three or more for 69 (8.3%) clients. Absences increased to three or more and the client average was greater than two days for 169 (20.4%) of the clients.

Suspensions and Expulsions: Statewide/All Programs



In FY2014, 825 clients had suspensions and expulsions data for at least two grade periods from which an average could be constructed. Suspensions and expulsions decreased versus the client's own average for 122 (14.8%) of the clients. For 616 (74.7%) of the clients, there was no change in suspensions and expulsions versus his or her own average. Suspensions and expulsions increased versus the client's own average for 87 (10.5%) of the clients.

Arrests: Statewide/All Programs



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

CONSUMER SURVEY RESULTS

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

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

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

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

Community Based Services Survey – Spring 2014	Youth % positive	Parent % positive	National Benchmark for Parent Response[1]
Services are seen as accessible and convenient regarding location and scheduling	88	92.89	85.7%
Services are seen as satisfactory and helpful	81	93.84	86.1%
Clients get along better with family and friends and are functioning better in their daily life	78	76.92	66.3%
Clients feel they have a role in directing the course of their treatment	77	95.56	87.6%
Staff are respectful of client religion, culture and ethnicity	94	99.39	92.8%
Clients feel supported in their program and in their community	82	95.48	86.9%
Clients are better able to cope and are doing better in work or school	80	77.71	66.3%

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

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

MOBILE CRISIS RESPONSE TEAM ACTIVITIES

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

Comments from satisfied parents and guardians of MCRT clients:

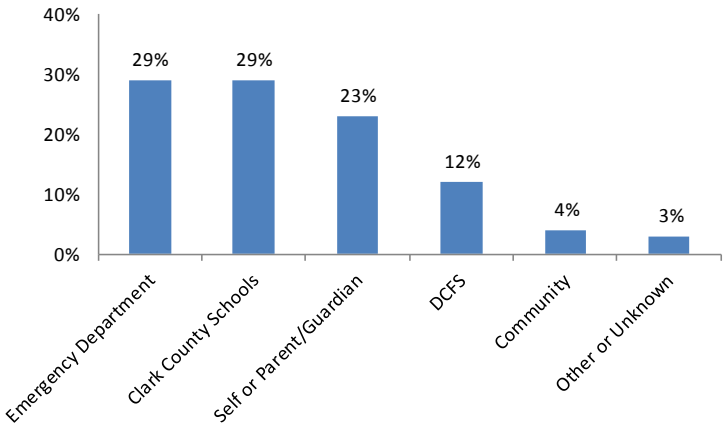
"The team was very professional. I appreciate all the help and support that has been given to my son."

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

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

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

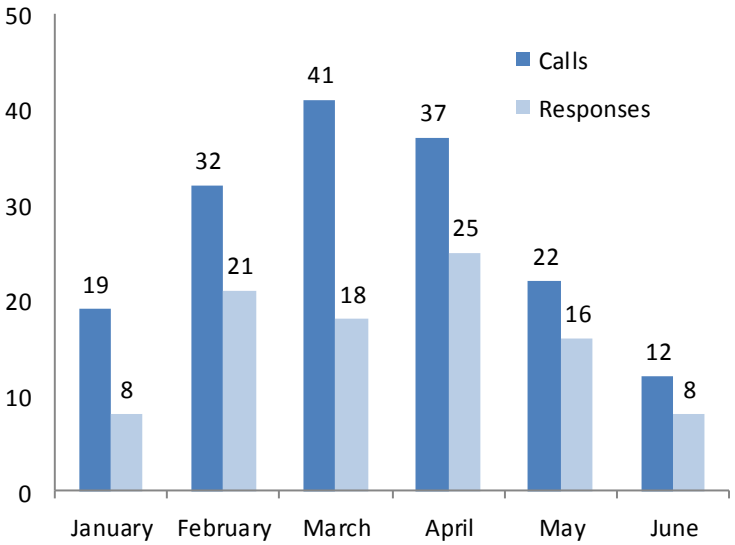
Referral Sources: UMC & Schools Refer Most



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

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

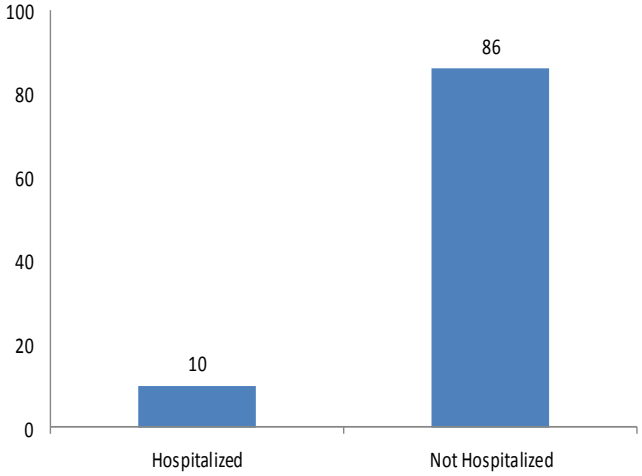
April Was Busiest Month



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

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

Hospital Diversion Rate = 90%



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

Parents and Guardians Provided High Consumer Satisfaction Ratings

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

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

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

MCRT in FY2015

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

ATTACHMENT C

DCFS Community Based Services Parent/Caregiver –
Youth Survey Results Statewide
Spring 2014 report

DCFS Community-Based Services
Parent / Caregiver – Youth Survey Results
Statewide Spring 2014

From March 31 to May 9, 2014, 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 where 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 358 parent/caregivers and 189 youth in program services. Of the 358 parent/caregiver surveys, 25 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	77	418	18%	68
WIN	39	181	22%	36
Early Childhood Mental Health Services	83	346	24%	N/A
SNCAS Total	199	945	21%	104
NNCAS				
Outpatient Services	74	222	33%	40
WIN–Reno/Rural	48	160	30%	45
Early Childhood Mental Health Services	37	175	21%	N/A
NNCAS Total	159	557	29%	85
Statewide Total	358	1502	24%	189

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 2014

SNCAS

Children's Clinical Services Results

Parent/Caregiver N=77; Youth N=68 Total Served = 418 Sample = 18%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	90	84
Services were scheduled at times that were right for us.	91	79
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	85
The people helping my child and family stuck with us no matter what.	89	74
I felt my child and family had someone to talk to when he/she was troubled.	93	72
The services my child and family received were right for us.	93	75
I received the help I wanted for my child.	87	79
My family got as much help as we needed for my child.	83	78
POSITIVE OUTCOMES		
My child is better at handling daily life.	67	68
My child gets along better with family members.	76	63
My child gets along better with friends and other people.	77	76
My child is doing better in school and/or work.	61	63
My child is better able to cope when things go wrong	51	72
I am satisfied with our family life right now.	62	51
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	80	59
I helped to choose my child and/or family's treatment goals.	89	83
I participated in my child's and family's treatment.	96	77
CULTURAL SENSITIVITY		
Staff treated our family with respect.	97	96
Staff respected our family's religious/spiritual beliefs.	97	95
Staff spoke with me in a way that I understood.	95	94
Staff was sensitive to my family's cultural and ethnic background.	94	79
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.	89	N/A
In a crisis, I would have the support I need from family or friends.	84	79
I have people with whom I can do enjoyable things.	91	84
I am happy with the friendships I have.	N/A	81
I feel I belong in my community.	N/A	55
FUNCTIONING		
My child is better at handling daily life.	67	68
My child gets along better with family members.	76	63
My child gets along better with friends and other people.	77	76
My child is able to do the things he/she wants to do.	82	76
My child is doing better in school and/or work.	61	63
My child is better able to cope when things go wrong.	51	72

SNCAS

Children's Clinical Services Results

INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	84	75
Staff explained my child and my family's rights and confidentiality issues.	94	81
I receive support and advocacy from my Nevada PEP Family Specialist.	79	65
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	74	73
Our family is aware of people and services in the community that support us.	82	70
I am better able to handle our family issues.	77	63
I am learning helpful parenting skills while in services.	74	78
I have information about my child's developmental expectations and needs.	84	66
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	91	81
My child's Psychiatrist/MD answered my questions.	89	82
My child's Psychiatrist/MD spends enough time with him/her.	82	75
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	83	77
My child's Psychiatrist/MD understood his/her problems and feelings.	83	74
My child's meetings with his/her Psychiatrist/MD were helpful.	78	70
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	83	73
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	85	79

Parent/Caregiver comments

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

- The support and guidance I get from the counselor. The support he received from the counselor and the direct and honest opinions the counselor gave him in many small situations we've been thru.
- He is learning to overcome the fear of talking to people.
- Therapy
- getting issues resolved
- He has someone to talk to
- Our therapist has always shown concern and never made my son feel worthless or embarrassed of his actions.
- Teaching my daughter to explore options on handling everyday life.
- Therapy with our therapist along with medication
- the emotional and personal issues
- The positive relationship he has developed with his therapist, the encouragement, the continuous support, and his therapist makes himself available anytime in an emergency.
- Being able to talk with someone other than Mom or Dad.
- Meds; Psychiatrist
- She can express her emotions and talk out her fears and anxiety.
- Providing our family and son with appropriate viable ways of communicating effectively and enjoyably too.
- Therapist knowing background on her. Treating her before along with birth mother. Knows when to be 'tough' in order to get through to her.
- The patience and kindness of our therapist and the medicine from his psychiatrist MD gives. Also, there is a progress from our son.
- He can learn to cope with his feelings rather than act out of anger.
- Coping skills, learning skills, parenting skills, listening skills.
- Talking with our therapist has helped. Meds have helped.

Youth comments

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

- Therapy and my case workers have been respectful and understanding. They talk to me in a way me and my family understand.
- Lots of toys for Christmas
- Learning how to deal with my Dad's death and not to let it upset me as much.
- Therapy to help me with friendships
- I am able to say all the things I want
- Relief, knowledge
- My therapist
- I understand myself a little better
- the therapy sessions
- The most helpful thing has been the help I've received.
- the things that has been helpful about the services is that when I have problems I always fix them.
- Talking out my problems and not being judged.
- Being able to verbally say what's going on to someone.
- I got prescribed medication that helps me with my depression.
- I have a more understanding in why I'm in a facility.
- Helped me realize what my illness is.
- They made me want to change (which I still am) enough to never have to come back.
- Learning how to understand and cope with my feelings.
- the most helpful thing is how to get my anger in control.
- I am able to see her on a weekly basis and it helps because I am able to use my techniques in school and at home, and I can come back to tell her.
- I get help with daily life.
- The tremendous amount of support from everyone has been really helpful!
- I learned coping skills
- Controlling my anger
- Being able to talk
- The medicine somewhat helps me control myself

Parent/Caregiver comments	Youth comments
♦ Therapy and psychiatrist ♦ For about 2 years he received treatment and changed for the better but when he didn't go to therapy, he began to behave very badly and then he went to another therapist, but he got worse and now we are not going again. ♦ To know that we are not alone and that there are people who can help us to be better people and can understand us and help us contend with these emotional situations. They believe me that it isn't easy, the people understand that it isn't easy, both for the sick person and for the family ♦ Therapist support toward both me and my daughter ♦ Very important because they taught him how to control his agitation and how he can come out of it, he can dissipate it instead of staying in it. Thanks for this. His state of health is much better. ♦ Helping him deal with things better ♦ emotional support ♦ able to deal with problems and peer pressure ♦ Helping family dynamics ♦ She looks forward to having someone to talk to that she feels is nonjudgmental. ♦ My daughter is able to cope better with issues and is no longer suicidal. ♦ Receiving the medication needed to improve behavioral problems and attention deficit ♦ Helping with school, help with behavior ♦ All the different exercises ♦ The opportunity for him to express his true feelings and emotions and seek help. ♦ Resource finder ♦ He has been opening up a lot more about how he feels about certain situations. He is less explosive and much calmer when things happen. We have an overall better relationship. We hope to continue growing as a family and for him to become a productive adult in the future. ♦ That you feel confident in expressing your feelings and problems. And that they help you recover quickly when you have moments when you feel depressed. ♦ Being able to speak a little more. Also getting help with child's medication. ♦ The worker is great for help when I ask for it from her. ♦ Coping skills for cutting; compassion ♦ Learning to cope with not being with her mom. ♦ Learning to control his emotions. Explaining his feelings without judgment. ♦ The medications and interest that the therapist has shown in helping him. ♦ She has learned to control her emotions, not completely but much better. ♦ That I have learned to get along better with the family. Overall we communicate more. ♦ Being able to have someone to talk to. ♦ We're getting the guidance we need to cope with life. ♦ I understand better in spite of not knowing what happened and he is expressing words. Thanks. God Bless them. ♦ They have helped her a little in controlling her appearance. ♦ My child is learning to obey. ♦ The support and resources we received. ♦ Trying to deal with her listening skills and behavior skills - still working on how to interact with her 17 month old sister. ♦ General therapy ♦ She is, after only 5 sessions, better at articulating her needs which has led to fewer outbursts and a more peaceful home life. ♦ Thank you for all the help to my daughter. ♦ Our therapist has built a good rapport with us and this helps us feel supported	♦ I learned coping methods. ♦ It's helping me with my life which is opening up a lot about how I feel, my anger, and the rest of the problems that's been fixed. ♦ Just knowing someone doesn't want me to commit suicide. ♦ the most helpful thing was when they give me advice. ♦ Someone to talk to. ♦ I've been able to think more before acting. I have been able to act, and ask for help when I need it. ♦ coping tools ♦ Talking to my therapist. Making my own goals. ♦ That I get to tell them my emotions at how I am feeling or if I'm upset or depressed. ♦ the most helpful thing is that I can talk to guys and I know you guys won't say anything and also the projects we do help me get over things. ♦ They've helped me get through so much. Thanks to these services I been doing better. ♦ the mini goals I was able to set to accomplish even bigger ones. ♦ They help me with behavioral problems. ♦ having someone to talk to ♦ The advice that I am getting, helps me to maintain a positive attitude. ♦ I've been able to talk about my feelings. I usually don't open up. ♦ They help me with my anger issues. ♦ Getting the help I need ♦ They turned my life around ♦ Learning how to cope with anxiety and depression. Everyone's been very helpful and supporting. ♦ Somebody to talk to ♦ It helps me to make progress. ♦ I feel better about myself ♦ Talking and letting my feelings out. ♦ I learned to cope with any problems I face.

Parent/Caregiver comments	Youth comments
♦ WIN supporting and helping us through all of the trials and tribulations we are going through. ♦ Understanding communication activities with kids ♦ The doctor and social worker listening to our concerns. ♦ My son is able to open up "partially" to a stranger about how he feels. ♦ Being able to talk to someone about concerns. ♦ having someone she can talk to	
2. What would improve services your child and the family received? ♦ greater effort to receive an accurate diagnosis, which we never got, maybe due to lack of insurance?? ♦ Talk. Listen. ♦ that more staff actually care ♦ Family therapy ♦ Perhaps an after school appointment ♦ The availability of psychiatric services - having great difficulties finding one, or one with appointment openings sooner than 6 mos. Or they do a switch and bait and try to get you to go with their services / therapists /BST /PSR package deal. No thanks! ♦ To have counselor be firmer with our child. Let him know he is out of line. ♦ Some family sessions ♦ So far what she has been receiving has been very helpful. ♦ Not sure since the services are quite good. Perhaps doubling up on sessions per week (but not sure). ♦ Information trickles down to us, (esp. when we were fostering). Would have liked more info on background to be more prepared for behaviors. ♦ Continued treatment will be a great help for the betterment of our child and for him to become normal. ♦ Everything has been satisfactory until now!! ♦ I am happy with all the services I'm receiving. ♦ So far everything is going well. ♦ That they give us more time because the time is very short. ♦ Nothing other than coffee out front. ♦ Much improved, he behaves like a normal child. They taught him to control his states and so realize his goals. ♦ her manner of confronting situations ♦ magic wand ♦ I don't feel I have received information on tools to deal with my daughter. ♦ So far so good. ♦ Continuous medication treatment ♦ right now It's good ♦ I feel that the services are good, however I would like to be able to have more info on the future of fresh assessments. ♦ if he [client] would listen ♦ If we could have some activity with them of relaxation and meditation. ♦ Unknown at the moment, but the social worker is great and I appreciate her. ♦ After hour appointments. After 5:30 pm. ♦ I like that the therapist includes the family and it would be more personal if they spoke Spanish. ♦ I am in agreement with the services. We now have the necessary time with the therapist. ♦ That sometimes they calm him ♦ My son is sufficiently better, now he doesn't think negatively, he acts differently in conversations. I realize that his thoughts have matured. Sometimes things bother him and he reacts badly toward me and his sisters. ♦ Many things could be improved. For example, the girl requires more attention when we sit down to talk to her, something we can't do right now. Otherwise we are satisfied. ♦ We felt you have already helped us improve on things with the services we get now.	2. What would improve services you received? ♦ There is nothing to improve; everyone here is really good and respectful. ♦ everything except my therapist ♦ A Break ♦ I would not improve the services I've received so far ♦ The services that would improve is that I would like to have some time alone with my therapist. ♦ more time with therapist ♦ If the psychiatrist didn't assume they knew me well like my therapist ♦ Less services, more time to figure things out myself. ♦ My anger would get better as the services continues. ♦ Nothing. This is very helpful and convenient for me and my family. ♦ maybe give your patients a little more time with your doctors. ♦ I haven't been receiving services that long, but there hasn't been anything I would change. ♦ Nothing really, it's cool now. ♦ It's fine ♦ If therapist would see patients as someone who needs help, not just another patient that helps them earn their paycheck. ♦ Nothing needs improvement ♦ If there was less waiting time to go in. ♦ Nah it's fine brab! ♦ I think I received what I need. Maybe I would ask for more time but overall I feel like I am good with what I got. ♦ nothing ♦ I think everything given here is good and nothing more needed. ♦ More family meetings. ♦ This services are already great. ♦ Maybe a closer location, But this place isn't too far. ♦ I do not know. But yes I would. ♦ You need to have more people like my therapist ♦ I don't know. I don't think I've been in long enough to answer; everything is good with the services I receive. ♦ Trying my best ♦ Nothing; they're perfect ♦ This is the best it will / can be! ♦ nothing, everything is fine the way it is ♦ I receive exactly what I need ♦ Better communication skills on my part.

Parent/Caregiver comments	Youth comments
♦ First, thanks. He is already consenting and we are united like before what happened. ♦ If there was more frequent contact. ♦ The services are good but I would like there to be more days per week. ♦ to always get the support ♦ later appointment times or Saturday appointments having the psychiatrist in the same location. ♦ Everything is okay. ♦ consistency	
3. Additional Comments? ♦ I am grateful for the services I've received here, in the past 8-9 yrs, I have been advised by 3 very knowledgeable and caring people, and a few others that weren't so helpful. Without these services we may have had much deeper, more serious issues to deal with. ♦ I would like if we talk or focus more on my daughters depression. ♦ We are terrorized by a 8 yr old. ♦ You guys have helped us in ways I can't explain. I thank you from the bottom of my heart. I don't know where we would be if it wasn't for the help we received from you. Thank you. ♦ I want to say thank you to our therapist for being the wonderful therapist she is. She has taught my daughter coping skills and more things about herself and understanding herself. ♦ Just keep goign with what you guys doing, thanks ♦ My son does very well with the services he already has in place and should not have to switch to see the Psychiatrist, that's wrong. Kids have enough emotional issues and their stability is essential for success. No switching up of services. Please offer Psychiatric Services too, on site / in Ctr., this would greatly alleviate a lot of difficulties in obtaining these services (Psychiatric Services) even for patients who have Medicaid this is imperative to their treatment. ♦ Our therapist has been a great therapeutic fit for our family. He has really helped us (mom, dad and teenage son) communicate more vulnerably and has provided our son with new (to him) ways of forging and/or developing relationships with his teacher ♦ Overall good experience. We were new to whole process and once we asked things were explained to us. ♦ The people that work at this facility Las Vegas West neighborhood are all courteous, helpful and kind. Excellent job. Thanks. ♦ Only to say that I wish my son would change his way of behaving and being a little bit, because he has some bad thoughts. ♦ Yes: "Thanks" and I congratulate you for your interest in knowing what we think of your services. I think we can always try harder and be better. This shows your interest in the people. "Thanks" again. ♦ I give thanks for the services we have received and to tell you that the staff have the skills to achieve the goals of the patients. ♦ It's great working with our therapist ♦ Overall very pleased that these services are available for our little girl. ♦ That I am very grateful for all the support and understanding and patience that we have had for him and me. ♦ I believe your services that you provide are great and helpful to families that can get help from anywhere else. ♦ Thank you for your program. I appreciate you all. ♦ My child's therapist is very compassionate and understanding, I'm very grateful. ♦ Only to thank you for providing this assistance and services for our youth. Thanks!! ♦ I'm grateful for our therapist, she is a great person because she helped us sufficiently, especially my son.	3. Any additional comments? ♦ Thank you for supporting me and listening to my problems. ♦ I love my house in Bldg 13 and I love my therapist ♦ I enjoy coming here. ♦ I enjoy therapy here! ♦ Therapist shouldn't treat patients as just another person to treat, but as a patient, a human that needs help. ♦ I think I'm happy with everything as of right now. ♦ I am happy with the help that I received. ♦ I am thankful for the services given in this place, it's really helped me a lot improve my coping skills. ♦ Thank you for giving me all the help I needed to change. ♦ Thank you guys for helping me get through this all and being there when needed. ♦ very nice staff members. Keep it up. ♦ this too hard to do I do not like this. ♦ My therapist is a nice, kind man. ♦ The services help me ♦ This place is very helpful for me and the people around me.

Parent/Caregiver comments	Youth comments
♦ In the first place I like the help the treatments have given us and I am very grateful for all that they have done for us. Many thanks. ♦ Make this available to more children. ♦ They're a pleasure to depend on when we need to talk or for any other reason. ♦ I would like to know if we are really going to get a normal life and his therapy not needed anymore. Thanks. ♦ Thanks to our therapist for helping us improve the behavior of our child. ♦ I'm happy with everyone ♦ I'm very happy that as an adoptive parent I'm getting help and support for my child issues. ♦ I have found a great deal of difficulty locating and tapping into any form of community outreach programs. Providing clients with a list of resources and a calendar of events would be hugely beneficial and each client could individually decide which resources they need, i.e. food pantry - interview clothing - holiday outreach - medical - dental etc. It's a shame that it took an act of violence to open the doors of "community" resources . Imagine how many incidents could be prevented if that type of information was disseminated through all schools, religious institutions, libraries or the post office and DMV. ♦ This place is very good and our therapist is the best. Thanks. ♦ thank you for services you provide ♦ kids have opened up a lot. Thank You ♦ Our therapist is wonderful	

SNCAS WIN Results		
Parent/Caregiver N=39; Youth N=36 Total Served = 181 Sample = 22%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	81	73
Services were scheduled at times that were right for us.	95	82
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	92	83
The people helping my child and family stuck with us no matter what.	92	83
I felt my child and family had someone to talk to when he/she was troubled.	92	78
The services my child and family received were right for us.	90	77
I received the help I wanted for my child.	90	81
My family got as much help as we needed for my child.	85	75
POSITIVE OUTCOMES		
My child is better at handling daily life.	79	83
My child gets along better with family members.	84	77
My child gets along better with friends and other people.	84	78
My child is doing better in school and/or work.	78	74
My child is better able to cope when things go wrong	67	83
I am satisfied with our family life right now.	83	83
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	92	61
I helped to choose my child and/or family's treatment goals.	89	86
I participated in my child's and family's treatment.	95	94

SNCAS

WIN Results

Parent/Caregiver N=39; Youth N=36 Total Served = 181 Sample = 22%	Parent/Caregiver Positive Response %	Youth Positive Response %
CULTURAL SENSITIVITY		
Staff treated our family with respect.	97	82
Staff respected our family's religious/spiritual beliefs.	92	85
Staff spoke with me in a way that I understood.	95	89
Staff was sensitive to my family's cultural and ethnic background.	91	82
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	95	N/A
I have people that I am comfortable talking with about my child's problems.	95	N/A
In a crisis, I would have the support I need from family or friends.	92	79
I have people with whom I can do enjoyable things.	95	89
I am happy with the friendships I have.	N/A	89
I feel I belong in my community.	N/A	89
FUNCTIONING		
My child is better at handling daily life.	79	83
My child gets along better with family members.	84	77
My child gets along better with friends and other people.	84	78
My child is able to do the things he/she wants to do.	79	83
My child is doing better in school and/or work.	78	74
My child is better able to cope when things go wrong.	67	83
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	87	91
Staff explained my child and my family's rights and confidentiality issues.	90	83
I receive support and advocacy from my Nevada PEP Family Specialist.	87	78
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	83	74
Our family is aware of people/ services in the community that support us.	92	81
I am better able to handle our family issues.	86	74
I am learning helpful parenting skills while in services.	94	86
I have information about my child's developmental expectations and needs.	92	79
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	90	73
My child's Psychiatrist/MD answered my questions.	94	80
My child's Psychiatrist/MD spends enough time with him/her.	87	77
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	87	77
My child's Psychiatrist/MD understood his/her problems and feelings.	77	67
My child's meetings with his/her Psychiatrist/MD were helpful.	87	73
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	93	68
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	81	73

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ more PSR ♦ They are coordinated and supported ♦ The support I get from my WIN worker ♦ The support I get from my WIN worker ♦ My WIN worker has been a great resource for our family mainly for the child and the issues at hand. ♦ Therapy ♦ My WIN worker have been a great support for my child and me. ♦ PSR and therapy ♦ Team work, everyone on the same page ♦ My WIN worker has been a great resource for our family and the child placed in our home. She is a great help with dealing with the individual child's needs. ♦ Helping us with parenting skills for the individual child. ♦ Our child has stopped being aggressive and he is more expressive but not enough. ♦ constant communication and support ♦ wrap around services ♦ counseling and anger management have been very helpful ♦ Teaching and learning how to cope as a foster mom to help the kids. ♦ Everyone working as a team to help our children, especially our WIN worker ♦ The child will be able to deal with his feelings regarding family separation. ♦ Being able to learn how to express his feelings and cope with not being with his bio Mother. ♦ the behaviors are more positive and she no longer self harms. ♦ I can talk to the staff when the child is troubled. She is very helpful. Always answers my questions and returns my calls right away. I'm very happy with her services. ♦ communication with team ♦ PSR Work ♦ having CFT meetings - weekly visit from worker - excellent communication ♦ Contact with the team. ♦ Another person to talk to. ♦ Supports us and helps us a lot ♦ The workers really try to get the help the child needs and making sure the child is doing well in the home. ♦ the coordinating services provided by the WIN workers ♦ The child has not received any service from WIN yet. I've asked the WIN worker and she stated there isn't any funding available. The psychiatry appointment was canceled because the state nurse referral was never sent.	1. What has been the most helpful thing about the services you received? ♦ I've done a lot better than when I started ♦ They would help me with my education ♦ My WIN worker has talked with me and it really helps. ♦ Not giving up on me ♦ Getting the help I need and skills ♦ Some of the adults I've been placed with have been very helpful to me. ♦ That I got help from my WIN worker ♦ New coping things ♦ The plans I get to help me ♦ The keeping check on what I've been doing these weeks. ♦ Everything, Love It! ♦ Yes, because they wait and listen to what I am feeling, and they help me do better. ♦ The most helpful thing is of course the support I have received. I do not feel so alone anymore and I know I have people who care about me, who are cheering on my success. It keeps me motivated. ♦ I get help ♦ My therapist ♦ Learning to cope with bad situations ♦ Getting my therapist cause she is real cool and she make my day. ♦ DFS ♦ I have gotten better ♦ I get help. Bonding with workers. ♦ Being able to cope with my problems and find new solutions. ♦ How kind everyone is to me ♦ Everybody has been great and helps me get through my problem
2. What would improve services your child and the family received? • Educational Advocate would have helped her if started last September. • More after school programs for the kids to get involved with. • more activities for them, and after school programs for the kids • I wish DCFS-C.W. had better lines of communications with our WIN worker, so she could be better informed, and help us make better educated decisions for the child. • everything was satisfactory • same keep therapy, PSR, BST Psychiatry M.D. • It would improve the cases in my opinion if Child Welfare would have better open lines of communication with our WIN worker, I feel that way she could help us make better educated decisions for the child. • The services are very professional and productive, we are satisfied with everything. • more accessibility • The addition of more resources to engage teenagers in productive and fun activities.	2. What would improve services you received? • Too soon to end services • That they were a day I agreed on. • Nothing, my services are fine. • Nothing else to do for me • Being trusted more by my Case Worker and being able to go out. • I wouldn't improve anything • Once every two weeks. On a Wednesday. • Nothing, fine as is • I enjoy the services I have just the way they are. • Less services • communication • Change psychiatrist and more activities.

• 100% support she is giving her. The child always asked me to call to her when she's in trouble. • for our family they are the best WIN workers • Keep doing what they do • I've notified the WIN worker, the county worker and tried calling the state nurse. The referral was never put in for the psychiatrist to the state nurse. Also, he needs a program in the summer to help with his behaviors. I asked for one spring break and WIN said it would be in place but nothing was in place.	
3. Additional Comments? ♦ I would like to see her and her brother adopted ASAP. ♦ Our WIN worker has been wonderful to explain all steps that she does. ♦ This has been the best thing that happened to us since our foster kids have been in our house. ♦ We are extremely happy with our WIN caseworker. She goes out of her way to please us. Our daughter has thrived from the activities that our WIN worker presented her with. ♦ When I asked her about what my F.D. needs I can always get an answer right away (financial help for what my child wants to do). ♦ Keep up the good work and "Thank You" ♦ Thanks to WIN-workers and supervisors for trying to find out ways to help the child and what services would be helpful. ♦ Most WIN workers that I have worked with are great. This one hasn't done anything for the children yet.	3. Additional Comments? ♦ Thank you for your support in my life. ♦ Thank you ♦ I want less time in this placement. And get adopted. ♦ My WIN worker does a very great job with me. ♦ In need to talk to my case worker. ♦ pleasure working with my WIN workers! ♦ Baseball trainer ♦ you guys are good at your job

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=83; Youth = NA Total Served = 346 Sample = 24%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	90	N/A
Services were scheduled at times that were right for us.	98	N/A
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	95	N/A
The people helping my child and family stuck with us no matter what.	94	N/A
I felt my child and family had someone to talk to when he/she was troubled.	98	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.	92	N/A
My family got as much help as we needed for my child.	92	N/A
POSITIVE OUTCOMES		
My child is better at handling daily life.	79	N/A
My child gets along better with family members.	83	N/A
My child gets along better with friends and other people.	85	N/A
My child is doing better in school and/or work.	77	N/A
My child is better able to cope when things go wrong	66	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.	87	N/A
I helped to choose my child and/or family's treatment goals.	97	N/A
I participated in my child's and family's treatment.	99	N/A

SNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=83; Youth = NA Total Served = 346 Sample = 24%	Parent/Caregiver Positive Response %	Youth Positive Response %
CULTURAL SENSITIVITY		
Staff treated our family with respect.	99	N/A
Staff respected our family's religious/spiritual beliefs.	100	N/A
Staff spoke with me in a way that I understood.	99	N/A
Staff was sensitive to my family's cultural and ethnic background.	99	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.	95	N/A
In a crisis, I would have the support I need from family or friends.	95	N/A
I have people with whom I can do enjoyable things.	99	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.	79	N/A
My child gets along better with family members.	83	N/A
My child gets along better with friends and other people.	85	N/A
My child is able to do the things he/she wants to do.	84	N/A
My child is doing better in school and/or work.	77	N/A
My child is better able to cope when things go wrong.	66	N/A
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	97	N/A
Staff explained my child and my family's rights and confidentiality issues.	96	N/A
I receive support and advocacy from my Nevada PEP Family Specialist.	84	N/A
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	90	N/A
Our family is aware of people/ services in the community that support us.	93	N/A
I am better able to handle our family issues.	86	N/A
I am learning helpful parenting skills while in services.	93	N/A
I have information about my child's developmental expectations and needs.	93	N/A
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	90	N/A
My child's Psychiatrist/MD answered my questions.	89	N/A
My child's Psychiatrist/MD spends enough time with him/her.	91	N/A
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	91	N/A
My child's Psychiatrist/MD understood his/her problems and feelings.	90	N/A
My child's meetings with his/her Psychiatrist/MD were helpful.	86	N/A
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	78	N/A
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	82	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ not sure, just started. But so far so good. ♦ Understanding his needs to provide better support to him and watching him grow and learn. ♦ the hands on techniques. Learning different skills. ♦ it has been helpful knowing that I can get help whenever I need it and they listen to what I have to say. ♦ Being able to communicate with her thoroughly and her talking about her feelings openly. ♦ She gets along better with peers and coping is getting better. ♦ putting me in contact with the right people to have him tested. ♦ The counseling ♦ Teaching me different things to do with my baby ♦ Knowing why she does what she does and how to handle it. ♦ Trying to help them understand how to cope with problems and process the emotions. ♦ Helping me focus on positive redirection and positive reinforcement; helping me learn ways to focus on how to get the children to focus and respond and listen better. ♦ Learning how to handle tantrums and help them control their emotional responses. ♦ Better understanding of child needs and coping with his problems. ♦ Helping learn his feelings and how to deal with them. ♦ Helping me better handle my kids. ♦ My son's vocabulary and speech and overall verbal skills have improved remarkably. Thank You! ♦ My therapist's availability very helpful! ♦ Therapy once a week ♦ Therapy (once a week) ♦ How to manage his anger ♦ The time of appointments is good for us; our therapist adjusted her schedule to best meet ours. ♦ His behaviors have decreased a great deal. He shares his feelings now. ♦ Our therapist explains things to our grandson so he can understand, he listens more often. ♦ His behaviors are more stable now, his tantrums have decreased. ♦ This has helped with the transition from another foster home to ours. ♦ That my son really enjoys the time he gets to spend with her. ♦ He is new to our home and he has adjusted well with the help of the therapist who knew him before. ♦ My granddaughter is calmer, has confidence and is happy. Our therapist has been on this journey with us and has always been supportive and an advocate. ♦ She is able to use words to explain what is wrong or how she is feeling. ♦ Our therapist comes to me and consistently answers calls or texts messages. ♦ Handling daily life ♦ The whole family has someone to talk to and feels comfortable with the therapist. ♦ I enjoy seeing my son and being with him ♦ I have someone to talk to and can give me ideas that I can use with her. ♦ He has someone to talk to and who will listen. ♦ We have someone who listens and will help us navigate. ♦ Coping skills ♦ having him learn how to share with others ♦ everything ♦ the service has helped my kids overcome some very large obstacles and helped prepare them for the adoption service. ♦ the support and encouragement have been key to both child and family.	1. What has been the most helpful thing about the services you received? ♦ NA

♦ Advice on how to handle our foster child's anger. ♦ Trying to make the little one be the best he can be. ♦ Speaking ♦ The most helpful thing was being there for the children when they need someone to talk to and listen to them as well. ♦ Child is learning how to show her feelings ♦ Therapy and resource ♦ The care and concern of the staff . The kids look forward to their time. ♦ To take baby steps ♦ Encouragement to keep with what we are doing even though the improvement has been slow. ♦ The most helpful thing about the services this child received was the therapy services because said services helped the client to attain progress in his behavior. ♦ The caregiver support we receive from our therapist. He has given us tips, books, videos and other information on how to be better caregivers to our child. ♦ Helps him to open up and discuss what is bothering him. Also helps so that he trusts me and is comfortable with me. ♦ some parenting skills ♦ Opportunities for his developmental growth ♦ A platform to start further research. The therapist seems to be comfortable with all of our approaches and pushes us in further attachment and stronger parent roles. I always feel supported. ♦ They have learned to express themselves. ♦ The individual attention ♦ I am aware of how to talk and give simple directions to him. ♦ Services have helped the child make sense of feelings and increased our ability to communicate in healthy manner ♦ for my child to have someone in his life that he looks forward to seeing. ♦ Learning what the child needs to behave better. Knowing what I can do to help the child. ♦ Learning how to calm her down and deal with stuff. ♦ Medicare, there is more, I can't single them out.	
2. What would improve services your child and the family received? ♦ We are making great strides in his development and we are satisfied at this time. ♦ Everything is adequate. ♦ Keeping the staff more consistent. ♦ More individual with the child. ♦ More routine visits for outside source - example O.T. and speech therapy. ♦ She is amazing and I learn a lot from her as does my child. ♦ Helping my son get over his mood at times. ♦ If I was included rather than the foster mom. I was told I'd join services after 2 weeks and haven't yet been invited. ♦ Parent with treatment plan in beginning of services. Speech - O.T. ♦ group sessions especially if one member of the family is not getting along ♦ Daycare for other children in the home. ♦ location is not convenient at all ♦ Nothing I can think of because I am pleased with the services. ♦ We are doing much better with what his therapist has taught him. ♦ everything is very good and complete ♦ better climate control. Always real hot or too cold. ♦ Watching child's behavior at Day Treatment to better understand behavior and emotions. ♦ More services locally located for children, instead of running all over town. ♦ Very happy with the services ♦ To participate and do the right things in life. ♦ Knowing more about the child's family history and background. ♦ We need more Psychiatrists for children. Their offices are usually far, very booked, and limited. More of a County issue. Also - would have preferred a separate appointment for my child's	2. What would improve services you received? ♦ NA

history as some information is inappropriate for him to hear. ♦ to give me custody of my son and let us be a family and be happy. Stay outta my life. ♦ happy with the services at this time ♦ actually spending time, to see how she really is ♦ thanks, but everything is great ♦ more time together ♦ If the children could have treatment together. ♦ We are satisfied with the services. ♦ I'm satisfied ♦ Better location, like having an office in the Southwest Area of Las Vegas. ♦ I feel very good about the treatment she is receiving. ♦ having spousal help that I would have had, had she not passed away.	
3. Additional Comments ♦ Our therapist is awesome. ♦ The service they provided is great. Keep up the good work. ♦ Thank you for helping our children / family. ♦ This program has definitely improved my family's happiness and well-being. ♦ Our therapist is both knowledgeable and friendly. She's been awesome! ♦ All's well. Your services are right on track. ♦ So far I feel that this child is getting the help needed. ♦ This program has helped my family very much and I am very grateful. ♦ Helpful hints and my child has learned a lot. ♦ Our therapist did a great job answering questions. ♦ Great job! ♦ Our therapist was consistent and willing to answer questions. ♦ Our therapist does a good job making us feel a part of the treatment. ♦ It has been very helpful for my son and his behavior. ♦ The therapist has been great with making him comfortable in our home. ♦ Thank you for the support and being a constant in my granddaughter's life. ♦ just started receiving services but so far we like services. ♦ It's a blessing to have the support from this service. ♦ I enjoy seeing my son. ♦ I enjoy working with my therapist, she always listens and encourages. ♦ He has a great therapist here and he's always happy when we say we are coming. ♦ Thank You ♦ Our therapist has been very helpful and we are happy with her services. ♦ I am very pleased with the care my son receives from both the doctor and his staff and the therapist. Very professional and compassionate providers. ♦ The therapist has been very helpful to me and the child. He offers advice for situations we are going through. ♦ CPS should look at serious cases; everything was fine before they came in the picture ♦ I would prefer treatment to be in my home. It would be more convenient for my children. ♦ As pre-adoptive parents, we truly appreciate knowing we have support needed to heal the hurts as best as we can and it means the world to be able to ask questions about problems freely, without judgment. ♦ I enjoyed our visits, someone that I could talk to about my child and be able to talk about change and how to deal with things, about child differently. ♦ the staff helping my foster child is very professional and very helpful. ♦ She is improving a lot but still needs a lot of help. ♦ We're in the process of permanent adoption to me.	3. Any additional comments? ♦ NA

NNCAS

Outpatient Services Results

Parent/Caregiver N=74; Youth N=40 Total Served = 222 Sample = 33%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	86	69
Services were scheduled at times that were right for us.	93	90
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	93	80
The people helping my child and family stuck with us no matter what.	88	78
I felt my child and family had someone to talk to when he/she was troubled.	82	73
The services my child and family received were right for us.	82	79
I received the help I wanted for my child.	88	73
My family got as much help as we needed for my child.	85	73
POSITIVE OUTCOMES		
My child is better at handling daily life.	75	73
My child gets along better with family members.	73	60
My child gets along better with friends and other people.	68	72
My child is doing better in school and/or work.	69	59
My child is better able to cope when things go wrong	64	63
I am satisfied with our family life right now.	69	58
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	53
I helped to choose my child and/or family's treatment goals.	94	78
I participated in my child's and family's treatment.	100	83
CULTURAL SENSITIVITY		
Staff treated our family with respect.	99	90
Staff respected our family's religious/spiritual beliefs.	98	76
Staff spoke with me in a way that I understood.	99	85
Staff was sensitive to my family's cultural and ethnic background.	100	74
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	83	N/A
I have people that I am comfortable talking with about my child's problems.	88	N/A
In a crisis, I would have the support I need from family or friends.	85	83
I have people with whom I can do enjoyable things.	96	80
I am happy with the friendships I have.	N/A	74
I feel I belong in my community.	N/A	59
FUNCTIONING		
My child is better at handling daily life.	75	73
My child gets along better with family members.	73	60
My child gets along better with friends and other people.	68	72
My child is able to do the things he/she wants to do.	68	70
My child is doing better in school and/or work.	69	59
My child is better able to cope when things go wrong.	64	63
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	92	87
Staff explained my child and my family's rights and confidentiality issues.	96	80
I receive support and advocacy from my Nevada PEP Family Specialist.	71	50
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	78	61

Our family is aware of people/ services in the community that support us.	77	78
I am better able to handle our family issues.	79	63
I am learning helpful parenting skills while in services.	81	85
I have information about my child's developmental expectations and needs.	82	73
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	95	85
My child's Psychiatrist/MD answered my questions.	97	88
My child's Psychiatrist/MD spends enough time with him/her.	89	73
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	92	79
My child's Psychiatrist/MD understood his/her problems and feelings.	94	85
My child's meetings with his/her Psychiatrist/MD were helpful.	89	85
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	93	89
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	95	88

Parent/Caregiver comments	**Youth comments**
1. What has been the most helpful thing about the services your child received? ♦ meds to help him in school ♦ she has been given several tools to use ♦ counseling and anger management have been very helpful ♦ This is our first visit ♦ my child has someone with whom she can feel comfortable talking to and this makes it easier to let her grow up ♦ she learned to control herself ♦ it's been too early to tell ♦ being able to talk to someone about how she's feeling ♦ he is coping better in school ♦ medications and providing excellent services ♦ Continued genuine care and support for my child and family ♦ help with coping skills ♦ the communication with his Dr. and the Dr.'s willingness to help ♦ He is able to talk to others about what he is feeling and his mental stability ♦ the kids have someone to talk to while their parents are in jail ♦ Talk out her feeling about her mother that she angry with ♦ finally getting a diagnosis and medication ♦ I finally have a team who listens and helps our family ♦ Being able to e-mail back and forth to document her issues as they arise and how quickly we are seen when things are bad. ♦ helping to understand behaviors attached to PTSD ♦ It helped her cope from her past, is out more ♦ giving me tools to deal with the child ♦ The understanding of not only child's concerns but parents' concerns also, and a plan to meet all concerns ♦ Handouts, parent counseling in addition to child's, ease of access to psychologist via phone and email ♦ I am learning things that can help me too. As I learn I am able to help her cope better with things that she struggles with. ♦ The child has the understanding of communication with others. Being able to work on the disability. ♦ Our therapist was fabulous and I think she has done wonders with my foster daughter. ♦ her therapist is helpful ♦ they were helpful to help with her skills ♦ he has been using the tools he learned ♦ He learning to control his anger ♦ She has found a place that she can go ahead and talk to someone who will help her to try and understand her feelings and hope to deal with them.	1. What has been the most helpful thing about the services you received? ♦ I am generally in a better mood ♦ My therapist advises ♦ suggestions / guidance ♦ good therapy sessions ♦ CFTs have helped me stay informed about my discharge progress ♦ The ways of handling things ♦ The most helpful thing for me is that there are very helpful people here to help me. ♦ How my psychiatrist helped me and understood me very well. ♦ FLH-#4 ♦ When things don't get to worst. ♦ opening my eyes a little bit more ♦ They're helping me clean up my act and get better. ♦ Learning coping skills ♦ My meds and the help I'm getting ♦ having guidance to help me through a time of trouble and knowing that I'm not defective. ♦ That I have someone to talk to that won't worry too much and is able to help me through things that I don't want to tell my parents. ♦ My therapist is helping me. She understands where I'm coming from. ♦ I really like my counselor and I like coming here because I feel safe and I like talking to my counselor. ♦ The most helpful thing about the service I received was learning how to cope with problems. ♦ I'm able to try and think about right and wrong not both and thinking about what I can do to work on. ♦ being able to talk to someone ♦ I am able to understand what's going on and that everything doesn't need to worry me. ♦ Just being able to talk when I meet with her. I feel safe here. ♦ The guidance that I received from my psychiatrist and all the help that came with it. ♦ My psych is very understanding ♦ Learning how to stop thinking about bad things ♦ I was able to speak with my therapist when I needed it. ♦ being able to talk about anything ♦ Learning about my problems ♦ talk to someone ♦ My counselor helps me a lot, ♦ they have helped me a lot with the things I have been through.

♦ Meds to help focus and stay on track ♦ Having someone outside the family to listen to him and help him with coping skills. ♦ Understanding how our children need a little extra talking time. So very happy they have an outlet that will help them and not be judged, helping us as parents to better ourselves for our children. ♦ Our therapist has help greatly in helping our family to bond with each other. Because of this the family is able to have a calmer and more balanced home. ♦ Our therapist's family therapy. She has helped our family tremendously! We are now bonded and the children are more attached to us than we ever thought possible because we implemented her suggestions and are always open and willing to try her ideas. She has great ideas! ♦ Access to psych care not financially restrictive; Dr. responds to emergencies. Dr. open relates / connects beautifully with our 16 yr old son ♦ My child wanted someone who could help without trying medications first. Therapist very respectful of this. ♦ Mostly socializing, guidance to encourage and learn appropriate behavior, positive behavior as opposed to negative behavior. ♦ It got him into the right kind of class at school, and received necessary medication. ♦ Therapy ♦ She has been able to control herself better and she has someone to talk to when we have an appointment here. ♦ We understand better why he reacts the way he does. ♦ How to help my son understand my rules and follow my directions. ♦ It helps him cope with daily life at school. ♦ So far it has been mostly teaching me how to better help him through his difficulties. I don't think we have had enough time yet to "help" him. ♦ Our therapist is very kind and understanding of the needs of my child. We could not pick a better person for our child to see. ♦ medications ♦ the weekly counseling sessions ♦ knowing we have someone there for us ♦ Knowing that there is support for both me and my child. ♦ I am very satisfied with the services he receives. ♦ That he feels much better. ♦ She is less angry with my family and her grades improved and she talks more with me. ♦ The appointments with the Psychiatrist.	
2. What would improve services your child and the family received? ♦ everything is good ♦ nothing - she needs to use tools given ♦ Understanding the next steps ♦ Just continue what we're doing for right now ♦ more visits, maybe doing family counseling ♦ not sure - great staff ♦ Not sure, great staff ♦ all service providers working together. Being in one room all at the same time. ♦ more counseling ♦ nothing, keep up the good job! ♦ she has to talk more ♦ If there were a magic pill to make her all better ♦ Not sure at this point, still fairly new to the services. ♦ Being able to do anything together and that I, the parent, not being scared of child. ♦ More appointment times ♦ participation more on the other parents involvement hopefully someday for both of our kids. ♦ If the services were located in a more convenient location.	2. What would improve services you received? ♦ No, I like my services. ♦ It's already good ♦ find new subjects to talk about ♦ Getting a new therapist ♦ There seems to be no problems. ♦ Being able to understand how to talk to someone that loves me. ♦ I am perfectly content with my services. ♦ nothing, everything is perfect. ♦ They are good the way they are now. ♦ I don't really know but I know it needs something else. ♦ what improve services is that the thinking about what I can't do and what I do which helps ♦ nothing, it was very helpful ♦ services are ok ♦ more time

♦ If the services were more conveniently located (closer to our home). ♦ Better communication / organization with referrals to external medical / educational entities (messages and paperwork lost; accountability) When front office transfers calls, advise caller vs "just a minute please." ♦ more available interaction with sports and other - more interaction with family and Pt. ♦ more / better communication ♦ need a little more communication between staff and parents ♦ Nothing, keep up the good work ♦ Front desk at times is very hard to communicate what you may need from them. ♦ talk more about issues with child to parent ♦ Everything is very good. The therapists help us a lot. ♦ All the thoughts of the whole family. ♦ If they could give me appointments more quickly the first time. ♦ That they wouldn't stop services for not having health insurance, that it wouldn't be an obstacle to getting better treatment.	
3. Additional Comments? ♦ Great now ♦ My other daughter is doing well and enjoys her meetings ♦ Thank you for all your help so far, and into the future ♦ thank you guys for your help ♦ I would recommend this service to anyone ♦ everyone has been very helpful and understanding. ♦ This started four years ago, but only recently got services due to his diagnosis only got to the point of suicide. Sad that my child did not help earlier. ♦ Everything's great ♦ thank you for helping our children and helping us learn how to help them and us better. Being there for them always. ♦ Without the services CBS provides, our child would have not come as far as he has in the time he has received services. ♦ Without CBS's staff and services, we probably would not have felt comfortable adopting our children as quickly as we did - if at all. Prior to starting our family therapy, we were not bonding effectively. Thank You! ♦ My grandson has come a long way from the acute autistic child - to presently high functioning autistic child. Sports, other interaction will benefit him greatly, where energy can be utilized under guidance. Thanks ♦ the "Staff" questions on page 2 are a little bit? ♦ This place is great. My daughter is getting the help / support that she needs. ♦ Our therapist does a good job handling our family needs ♦ Just a simple Thank You from my family. ♦ The staff that work with my child are very understanding and patient with my child. ♦ Yes, Thank You. ♦ Many thanks for your help and support!!! Thank You. ♦ No, we are very grateful for our therapist. ♦ Mental Illness is very dangerous, for those who have it and those around them. He can't control his actions, negative thoughts. He puts the whole community at risk. He needs to have more support, more places open to the public without the inconvenience of not having health insurance or that some insurance doesn't cover residential facilities, to receive the treatment most needed for each patient, that insurance works.	3. Any additional comments? ♦ I am very happy that my Psychiatrist helped me on a lot of things. ♦ I need a new therapist please. ♦ Staff is amazing ♦ the staff is amazing and is very helpful and respectful

NNCAS WIN Results		
Parent/Caregiver N=48; Youth N=45 Total Served = 160 Sample = 30%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
The location of services was convenient for us.	96	80
Services were scheduled at times that were right for us.	96	86
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	94	87
The people helping my child and family stuck with us no matter what.	94	84
I felt my child and family had someone to talk to when he/she was troubled.	98	87
The services my child and family received were right for us.	96	73
I received the help I wanted for my child.	96	78
My family got as much help as we needed for my child.	92	89
POSITIVE OUTCOMES		
My child is better at handling daily life.	79	73
My child gets along better with family members.	83	84
My child gets along better with friends and other people.	85	77
My child is doing better in school and/or work.	85	82
My child is better able to cope when things go wrong	76	82
I am satisfied with our family life right now.	79	79
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	88	68
I helped to choose my child and/or family's treatment goals.	94	88
I participated in my child's and family's treatment.	100	82
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	89
Staff respected our family's religious/spiritual beliefs.	100	84
Staff spoke with me in a way that I understood.	100	96
Staff was sensitive to my family's cultural and ethnic background.	100	80
SOCIAL CONNECTEDNESS		
I know people who will listen and understand me when I need to talk.	96	N/A
I have people that I am comfortable talking with about my child's problems.	96	N/A
In a crisis, I would have the support I need from family or friends.	96	91
I have people with whom I can do enjoyable things.	91	98
I am happy with the friendships I have.	N/A	87
I feel I belong in my community.	N/A	84
FUNCTIONING		
My child is better at handling daily life.	79	73
My child gets along better with family members.	83	84
My child gets along better with friends and other people.	85	77
My child is able to do the things he/she wants to do.	91	82
My child is doing better in school and/or work.	85	82
My child is better able to cope when things go wrong.	76	82
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	98	75
Staff explained my child and my family's rights and confidentiality issues.	100	87
I receive support and advocacy from my Nevada PEP Family Specialist.	83	92

NNCAS

WIN Results

Parent/Caregiver N=48; Youth N=45 Total Served = 160 Sample = 30%	Parent/Caregiver Positive Response %	Youth Positive Response %
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	81	88
Our family is aware of people/ services in the community that support us.	98	98
I am better able to handle our family issues.	100	77
I am learning helpful parenting skills while in services.	96	96
I have information about my child's developmental expectations and needs.	98	72
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	97	86
My child's Psychiatrist/MD answered my questions.	97	100
My child's Psychiatrist/MD spends enough time with him/her.	94	86
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	97	83
My child's Psychiatrist/MD understood his/her problems and feelings.	94	83
My child's meetings with his/her Psychiatrist/MD were helpful.	97	90
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	97	70
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	91	97

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ everyone is good, treated our family awesome ♦ She is using the skills they taught her ♦ Being able to talk to our WIN worker and knowing my words won't be twisted around ♦ Caring and support team, very impressed ♦ Helpful with resources for clothing and behavior problems ♦ He's using the skills they taught him ♦ It is helpful they are teaching him new skills ♦ help him with his anger issues with his teacher, and understanding his medical conditions ♦ Social Skills, proper behavior at school and home, PSR, assistance with IEP ♦ Social skills, proper behavior at school and home, manners, PSR ♦ Immediacy ♦ Being included in meetings and decision making, helping my daughter advocate for her needs and pick services she's invested in. ♦ All ♦ CTF Meeting our WIN worker helped resolve issues. ♦ The support of WIN worker in keeping group home accountable for my child and us (her adoptive parents). ♦ meetings ♦ Our WIN worker and Wraparound Services. Communication with our WIN worker - she helps support him as well as advocates what we need. ♦ He is now able to cope with anger and is doing well in school. He is learning. ♦ All of the great resources that have been offered to us ♦ the resources and the attention given. ♦ Being able to converse with the WIN worker and case worker to solve problems	1. What has been the most helpful thing about the services you received? ♦ Whenever I need something I get the help I need right away. ♦ I am learning how to accept no and how to be more accountable. ♦ the CFTs have helped me understand where I am in the discharge planning and have helped me complete goals. ♦ coming home ♦ I am learning to look after myself. I have independent living to help me with that. ♦ I don't know, the home I'm in I guess ♦ Learning skills ♦ they help me with my problems ♦ Everyone being told the same things and being kept on the same page. ♦ I can be a kid with my team and they try their best to keep happy ♦ They helped me deal with some of the questions that I had ♦ she's nice and takes me to eat. She does the things I want to do. I think my WIN worker should get a raise. ♦ breaks from the house and meeting are helpful with a sign in sheet and connect to family ♦ they listen and help find ways to get my needs met ♦ show me how to stand up for myself ♦ coping skills, and different ♦ Better behaved ♦ The most helpful thing about my services is the workers, they understand me and my problems. ♦ Social Worker, CASA, Grandma, pizza party. ♦ I'm happy with all the people who have helped me and my family. ♦ anger treatment ♦ Being able to stay in school and communicate better with friends and family

Parent/Caregiver comments	Youth comments
♦ getting questions answered ♦ the support that all members of the family have received to re-unite the family has been the most important thing for this child. WIN has been helping to put her world back together. ♦ The understanding of the workers knowing the issues and the support from them. ♦ I think the most helpful thing from WIN has been the facilitating of communication. I love that my foster child feels comfortable to talk to our WIN worker and that she supports him and my family. ♦ Dr. is not helpful ♦ Always giving them the help he needs to guide him in the right direction ♦ That they are always willing to help in any way they can. Also they have great advice. ♦ Obtaining tons of new approaches in helping my daughter with issues not being adequately handled by her school. ♦ Monthly meetings setting goals and discussing progress. ♦ the most helpful has been when he was in the Maple Star.	♦ I have received a watch to tell time in school. ♦ I would say helping me with my personality and finding who I am ♦ my behavior in school and with my family members ♦ CFT ♦ They listen! ♦ The fact that I have received all my wishes ♦ I have someone to call or talk to. My WIN worker is very supportive and nice to me. ♦ They kept me from bad people ♦ that they pay for my school stuff so that parents don't have to. ♦ people helping me with all the things that I need help with ♦ Went by quick ♦ I like them coming out once a month ♦ counsel ♦ Willow Springs ♦
2. What would improve services your child and the family received? ♦ more hours with PSR ♦ Everyone has been great. They are on top of all the problems in her life ♦ I like how everything is. ♦ Respite Care ♦ Available Respite Care ♦ I don't think I could do this without our WIN worker to help me through difficult times. ♦ A lot of people I have worked with had a title position but never followed through with their tasks. ♦ I really don't know what WIN is doing or why they are involved. ♦ I am very happy with the services that you have given us. You have helped us in many ways and we are very satisfied. ♦ The child needs to be more active in the program, understanding different options and participating more - the workers on his case have been working towards this. ♦ daycare and extra activities ♦ Better communication ♦ All that can be done is being done. ♦ A clear explanation of roles in the pilot program. Boundaries and responsibilities made more clear. ♦ community needs help. ♦ to get diagnosis for Autism ♦ Nothing for me, I received great service	2. What would improve services you received? ♦ Faster services (when I need help, they should work on it ASAP not three weeks later.) ♦ I need to be accountable and to accept no. ♦ Less interference between my probation / WIN / therapy / psychiatry needs and my school / home life. ♦ less people ♦ I have had three WIN workers in 3 years. More consistency. ♦ Idle ♦ getting a lot of work done and trying to get home ♦ more visits with mom ♦ it's been helpful with the services ♦ Nothing the services I'm getting is great. ♦ I like everything ♦ Helpfulness from the other staff of WIN. ♦ NO NO NO ♦ more time at home ♦ really nothing I like what I'm getting ♦ More resources! ♦ nothing, I like the way it's going ♦ If they can find my mom without questioning. ♦ people giving me more help that I need to get , like anger ♦ more communication with DCFS social worker, also if they were more cooperative
3. Additional Comments? ♦ Again, wanted to thank everyone that has helped my granddaughter with all her problems in life. I will miss everyone! ♦ Our WIN worker is amazing. She genuinely cares about our child and our family. Thank You. ♦ Thank You ♦ This question (#26) and several others suggest that the caregiver is not trained, or less intelligent than staff. ♦ I feel very blessed to have had the chance to work with all of you. ♦ This child is not ready to be taking care of himself within the IL program at this time. There are still concerns. ♦ WIN has helped so much - F.I.S.H. ♦ Need help with Dr. and School ♦ Thanks to all that helped reunify my son's with me. You all are awesome! ♦ Thanks to all the workers that helped with my boys. You guys are awesome! ♦ Thank you.	3. Any additional comments? ♦ I love all my WIN workers as if they were family to me. ♦ I want to go home. ♦ I need to be with family if I am to be successful. ♦ My WIN worker's awesome ♦ Social worker; to final a home as soon as possible. ♦ thank you for being there with me. ♦ you guys were awesome

NNCAS

Early Childhood Mental Health Services Results

Parent/Caregiver N=37; Youth N=NA Total Served = 175 Sample = 21%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
The location of services was convenient for us.	76	NA
Services were scheduled at times that were right for us.	92	NA
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	NA
The people helping my child and family stuck with us no matter what.	92	NA
I felt my child and family had someone to talk to when he/she was troubled.	97	NA
The services my child and family received were right for us.	89	NA
I received the help I wanted for my child.	92	NA
My family got as much help as we needed for my child.	92	NA
POSITIVE OUTCOMES		
My child is better at handling daily life.	84	NA
My child gets along better with family members.	76	NA
My child gets along better with friends and other people.	78	NA
My child is doing better in school and/or work.	77	NA
My child is better able to cope when things go wrong	68	NA
I am satisfied with our family life right now.	81	NA
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	68	NA
I helped to choose my child and/or family's treatment goals.	92	NA
I participated in my child's and family's treatment.	97	NA
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	NA
Staff respected our family's religious/spiritual beliefs.	88	NA
Staff spoke with me in a way that I understood.	100	NA
Staff was sensitive to my family's cultural and ethnic background.	88	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.	92	NA
In a crisis, I would have the support I need from family or friends.	95	NA
I have people with whom I can do enjoyable things.	97	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.	84	NA
My child gets along better with family members.	76	NA
My child gets along better with friends and other people.	78	NA
My child is able to do the things he/she wants to do.	81	NA
My child is doing better in school and/or work.	77	NA
My child is better able to cope when things go wrong.	68	NA
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	94	NA
Staff explained my child and my family's rights and confidentiality issues.	97	NA
I receive support and advocacy from my Nevada PEP Family Specialist.	63	NA
My Nevada PEP Family Specialist supports me in leading my child's treatment planning or Child and Family Team meetings.	71	NA
Our family is aware of people/ services in the community that support us.	78	NA
I am better able to handle our family issues.	81	NA

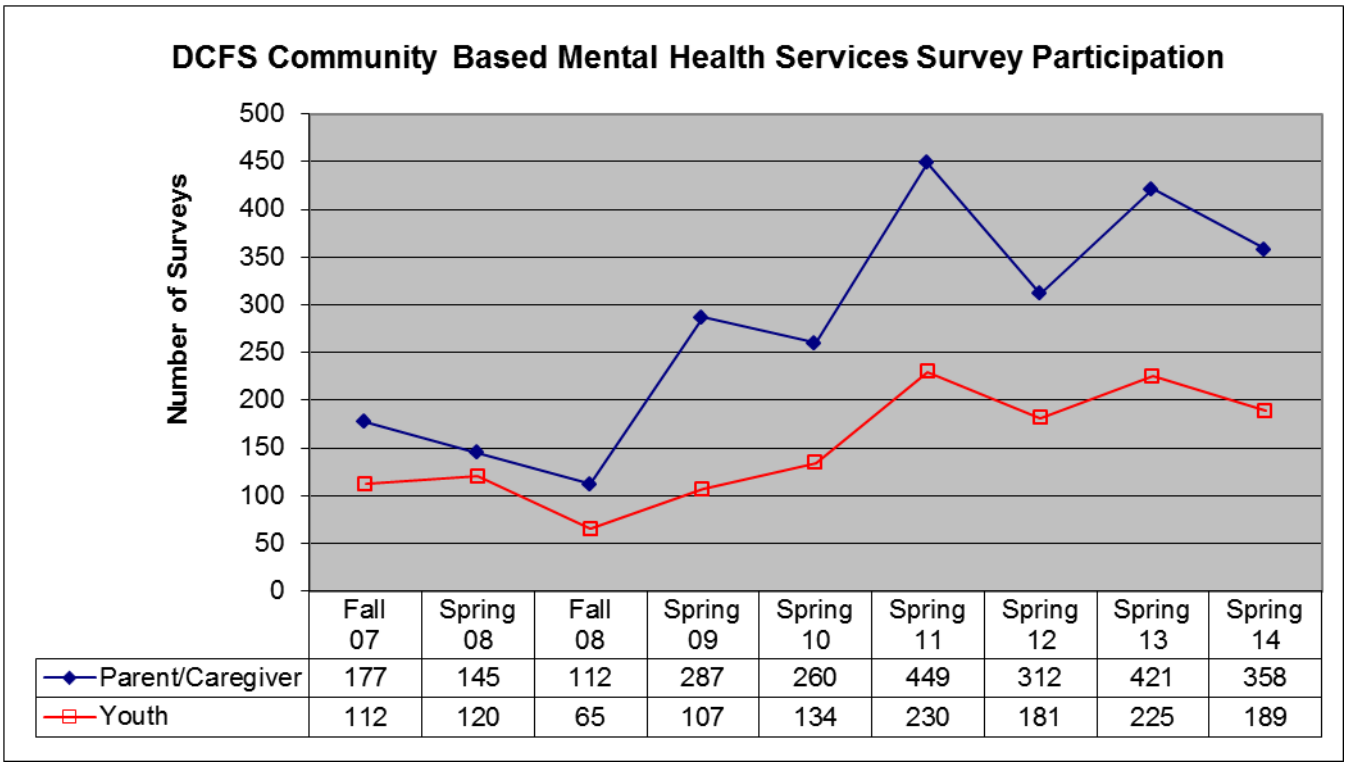
Parent/Caregiver comments	Youth comments	
I am learning helpful parenting skills while in services.	89	NA
I have information about my child's developmental expectations and needs.	92	NA
PSYCHIATRIST/MD		
My child's Psychiatrist/MD was respectful and helpful.	100	NA
My child's Psychiatrist/MD answered my questions.	100	NA
My child's Psychiatrist/MD spends enough time with him/her.	100	NA
My child's Psychiatrist/MD provides guidance and support to his/her treatment.	97	NA
My child's Psychiatrist/MD understood his/her problems and feelings.	97	NA
My child's meetings with his/her Psychiatrist/MD were helpful.	100	NA
The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her.	94	NA
Overall-I am pleased with the services my child has received from his/her Psychiatrist MD.	97	NA

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? ♦ having one on one with his psychiatrist and working with school ♦ We have some tools to help the child adopt to his own challenges ♦ She has been helped by the day treatment program ♦ The school is happy with his behavior and services have helped me understand his behavior ♦ Therapy and meds ♦ I believe that most everything here and everyone are helpful ♦ Most help to us is sexual behavior problems ♦ Someone to talk to! ♦ Someone that understands what they are going thru ♦ communication ♦ Learning how to deal with overwhelming feelings ♦ Our counselor really works well with us. Always helping me and child to learn new ways to deal with his situations. ♦ Learning new methods of interacting with my child, and learning new ways to engage him based on his interests ♦ behavioral medication needs ♦ Experience and time to grow emotionally ♦ I tried for a long time to get my son help and no one was able to help him due to him being "too young!" CBS stepped up and started treating him which has greatly improved quality of life for him and our family. ♦ She has someone to talk to besides family ♦ Consistency... Out therapist never gave up... ♦ Better communication with my daughter and a closer bond as father and daughter ♦ thus far her being able to be here has been helpful, now looking forward to the work to help her ♦ Learning to focus better and cope with anger problems ♦ understanding his issues he's going through ♦ Our family feels safe and secure with our therapist. She is always encouraging and reassuring to help our family's needs. Her professional demeanor is pleasant and fits in with family dynamic as well. ♦ psychiatrist ♦ It gives them someone that they can talk with. ♦ It gives them someone that they can talk with. ♦ Communication - this child is using his voice instead of negative behaviors. He is also more able to admit some of is wrong behavioral choices. ♦ Being able to verbalize his thoughts and feelings and becoming empathetic to others ♦ Someone who listens without judgment, and seems to care	1. What has been the most helpful thing about the services you received? ♦ NA

♦ the help he need to go through life beginning as a child ♦ teaching the parents better ways to help the child and informing the parents of helpful services in the community ♦ understanding my child's problems ♦ Dealing with his problems	
2. What would improve services your child and the family received? ♦ No, you do everything good to me. ♦ I'm in a crises with the child, we get as much help as we need for this child ♦ better access to Dr. only available on Thursdays ♦ practice, routine and consistency ♦ If I could magically move your office closer to my house ♦ hoping to reach her a little more and see more improvement on her emotions ♦ I'm satisfied with services provided thus far ♦ A report of how she's viewed and a list of to do's till her next visit that addresses current issues and corrective behaviors. ♦ they are fine just how they are ♦ Still waiting for WC School District to give him a psychologist referral. ♦ A problem beyond Day Treatment ♦ What he is receiving is helping ♦ cannot think of any improvements, the services received have been very helpful and timely	2. What would improve services you received? ♦ NA
3. Additional Comments? ♦ I appreciate having someone who can help us. I'm just not sure if we are actually succeeding. ♦ She still feels she needs to lie to me as to not get any consequences. Although she's getting somewhat better at telling the truth to me. ♦ Great job ♦ Good job, thanks ♦ Our therapist has been very helpful to our family. The behavior has been changing for the better since we have started coming here. ♦ If your services were not available to us, I don't think that we would have as much success with our child. Everything that we receive here is outstanding and very much needed from our family. Thank you. ♦ Our therapist has been very helpful and understanding. Even if parents are separate it might be helpful to get them both in the meeting at SAME time. ♦ The staff here is great and my child is comfortable communicating with them. ♦ Thanks for saving my family ♦ Super sad Dr. is leaving! ♦ Would love to have option of having our therapist observe in our home for a day or more to see his different behaviors outside of his appointments. ♦ very pleased with this agency and staff	3. Any additional comments? ♦ NA

Survey participation

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



	Fall 07	Spring 08	Fall 08	Spring 09	Spring 10	Spring 11	Spring 12	Spring 13	Spring 14
Parent/Caregiver	177	145	112	287	260	449	312	421	358
Youth	112	120	65	107	134	230	181	225	189

The current survey shows a statewide decrease (15%) in parent/caregiver participation and a corresponding decrease (16%) in youth participation when compared to the same survey conducted in the spring of last year. Statewide there were a combined total of 547 agency parent/caregiver and youth survey participants. There was an overall statewide participation decrease of (16%) from the Spring 13 survey.

A Hispanic version of the parent/caregiver survey instrument was again available for this project. Of the 358 parent/caregiver surveys returned statewide, 25 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 – SNCAS
YOUTH SURVEY (11 years and older)

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

Today's Date: _____

Where do you receive services? (Mark one box only)	**Outpatient Services**	**Wraparound In Nevada (WIN)**
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 ☐ Transgender ☐ Female ☐ Other
5. Your Race: **(Mark all that apply)**	☐ African American ☐ Am. Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White (Caucasian) ☐ 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 ☐ With Another Family Member ☐ Foster Home ☐ Therapeutic Foster Home ☐ Homeless Shelter ☐ Group Home ☐ Residential Treatment Center ☐ Crisis Shelter ☐ State Correctional Facility ☐ Runaway / Homeless / On the Streets ☐ Hospital ☐ Local Jail or Detention Facility ☐ Other:_____
9. Is anyone in your immediate family currently serving in the United States military?	☐ Yes ☐ No

DCFS COMMUNITY-BASED SERVICES – SNCAS
YOUTH SURVEY (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. If a statement does not apply to you, you may mark the Does Not Apply box.

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

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

As a result of the services I receive:

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Does Not Apply
29.	I am better at handling daily life.						
30.	I get along better with family members.						
31.	I get along better with friends and other people.						
32.	I am better able to do the things I want to do.						
33.	I am doing better in school or work.						
34.	I am better able to cope when things go wrong.						
35.	I am satisfied with my family life right now.						
36.	I am aware of people and services in the community that support me.						
37.	I am better able to handle family issues.						
38.	I am learning helpful skills while receiving services.						
39.	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
40.	In a crisis, I would have the support I need from family or friends.						
41.	I have people with whom I can do enjoyable things.						
42.	I am happy with the friendships I have.						
43.	I feel I belong in my community.						

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

Psychiatrist/MD:

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

52. 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)**	☐ Yes, in a clinic or office ☐ Yes, but only in a hospital emergency room ☐ No ☐ Do not remember
53. Are you on medication for emotional/behavioral problems?	☐ Yes ☐ No
53a. If yes, did the doctor or nurse tell you what side effects to watch for?	☐ Yes ☐ No

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

_____

_____

_____

55. What would improve services you received?

_____

_____

_____

Please provide any additional comments you would like to share with us.

_____

_____

_____

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 775-688-1707 extension 24 if you have any questions or comments regarding this survey.

ATTACHMENT E

DCFS Residential Discharge Survey Report Parent/Caregiver –
Youth Survey Results Statewide
FY 2014

DCFS Residential Discharge Survey Report
Parent / Caregiver – Youth Survey Results
Statewide FY 2014

From July 1, 2013 to June 30, 2014, 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 317 parent/caregivers and 361 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	279	356	78%	321
Oasis On Campus Treatment Homes	7	22	32%	7
SNCAS Total	286	378	76%	328
NNCAS				
Adolescent Treatment Center	14	42	33%	13
Family Learning Homes	17	45	38%	20
NNCAS Total	31	87	36%	33
Statewide Total	317	465	68%	361

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 2014

SNCAS
Desert Willow Treatment Center (DWTC)

Parent/Caregiver N=279; Youth N=321 Total Discharged = 356 Sample = 78%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Buildings in which services were provided are safe.	95	93
Buildings in which services were provided are comfortable.	95	90
Buildings in which services were provided are well cared for.	95	93
Staff members were available to discuss treatment services.	95	93
Staff made efforts to work with the scheduling needs of parents and/or significant others (i.e., meetings, medications reviews, IEPs, phone contacts).	96	95
GENERAL SATISFACTION		
DWTC met the needs stated during the course of treatment.	97	97
DWTC met my expectations.	91	92
I am satisfied with the care and treatment provided by DWTC.	96	91
POSITIVE OUTCOMES		
Youth's school needs were addressed.	96	97
Progress was made on treatment issues.	97	97
I would recommend DWTC services to others in need of treatment.	95	90
PARTICIPATION IN TREATMENT		
I am satisfied with my opportunity to have input into treatment.	93	90
CULTURAL SENSITIVITY		
Treatment provided was sensitive to my cultural and spiritual needs.	96	96
STAFF		
Staff that provided treatment services were caring and professional.	95	92
Staff protected personal privacy.	97	93
Staff protected confidentiality.	97	94
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=7; Youth N=7 Total Discharged = 22 Sample = 32%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	100
Visitation rooms were comfortable and provided privacy with my child.	100	100
Services were scheduled at times that were right for us.	100	83
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	100

SNCAS

Oasis On Campus Treatment Homes

Parent/Caregiver N=7; Youth N=7 Total Discharged = 22 Sample = 32%	Parent/Caregiver Positive Response %	Youth Positive Response %
The people helping my child and family stuck with us no matter what.	100	71
I felt my child and family had someone to talk to when troubled.	86	86
The services my child and family received were right for us.	100	86
My family got the help we wanted for my child.	100	86
My family got as much help as we needed for my child.	100	83
POSITIVE OUTCOMES		
My child's educational needs were met during residential services.	100	71
My child is better at handling daily life.	100	86
My child gets along better with family members.	100	83
My child gets along better with friends and other people.	100	67
My child is doing better in school and/or work.	100	71
My child is better able to cope when things go wrong	100	86
I am satisfied with our family life right now.	100	86
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	83	100
I helped to choose my child and/or family's treatment goals.	100	86
I participated in my child's and family's treatment.	100	83
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	50
Staff respected our family's religious/spiritual beliefs.	100	100
Staff spoke with me in a way that I understood.	100	71
Staff was sensitive to my family's cultural and ethnic background.	100	83
FUNCTIONING		
My child is better at handling daily life.	100	86
My child gets along better with family members.	100	83
My child gets along better with friends and other people.	100	67
My child is doing better in school.	100	71
My child is better able to cope when things go wrong.	100	86
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	71
Our family is aware of people and services in the community that support us.	100	86
I am better able to handle our family issues.	100	N/A
I am learning helpful parenting skills while in services.	100	N/A
I have information about my child's developmental expectations and needs.	100	N/A

Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? • Worked on my son with his anger to help him learn self-control so at home or school he can calm down. He has also learned respect of people and property. There was certain staff who I feel went above and beyond. • On how to be respectful and have respect. • That the child is better able to handle crises situations and cope. • The communication and skills of staff to listen to concerns	1. What has been the most helpful thing about the services you received? • I learned how to cope and ignore my peers when they are making me angry. • Accepting feedback and expressing my feelings in the right way. • All of the role plays that we do. They don't just give you negatives right away. • Staff telling me when I get angry sometimes they will say I'm stuck and try to tell me calm down, take a time out instead of acting out.

helped a lot. I am comfortable speaking with staff about any issues and confident they are fixed. • It has helped him a lot and structured him a lot. • Support and advice to me as far as my son's behavior.	• I learned a lot of coping skills and self-control. • The talking am learning. • Me realizing that me getting help was for me to have a better future.
2. What would improve services your child and the family received? • More communication. Overall everything was good. There was a couple times when I felt as if I couldn't communicate except with select staff. • None. It was same stuff I learned somewhere in another state through parenting. • I believe the staff did an excellent job. I honestly can't think of anything at this time for this unit. • In the way how he's able to talk and opinionate to voice out what he feels. • Nothing.	2. What would improve services you received? • TVs in our rooms, more attention, more outings. • TIME STUDY! • The only thing is how we have to do the staff's every moves (like a dog). • Talk to me when I'm angry, try to put me in my room and let me take my anger out inside my room and give me a better choice. • More time for Rec. • The amount of space and freedom. • My actual opinion is to understand diagnosis of the kids and their struggles.
3. What would improve client safety? • More aware of "contraband" or items parent not wanted. My son had stolen certain items a few times and I was not informed or questioned. Also, when brought up concerns to staff they said ok, but nothing was done to fix/change. • There is none. • I believe the staff did an excellent job. I honestly can't think of anything at this time for this unit. • I think they did a very good job • Nothing	3. What would improve client safety? • Not having weapons in the house. • Lock windows! • There is no way (well at least I think) if someone was going to do it they will. • Check back when I'm coming out of my room so they know where I'm at. I can't get outside with staff and it's only when I'm at level 2 or 3. • I think there should be cameras in front of the rooms. • Discuss it more and point out what's wrong.
4. Additional Comments • I am grateful for my son's treatment. He did really well and I felt comfortable discussing any issues/concerns with select staff. • I am grateful that Oasis was here for my child. • Thank you for everything! • The staff were great and very helpful. They listened to concerns and fixed any arising issues. I am thankful for this service. They helped my son a lot.	4. Any additional comments? • I loved my staff and supervisor, keep up the good work. • I don't think not one thing needs to change - Well maybe some. • To have staff give me all the contraband that I had and my head phones that I got taken away and hope you guys have a Merry Christmas. • Nope. Merry Christmas. • It was extremely fun but not fair with the stuff because my brother received stuff from places I go and he doesn't even know what it is!!!!! • The program taught me to notice the struggles I had and how to cope with it.

NNCAS

Adolescent Treatment Center

Parent/Caregiver N=14; Youth N=13 Total Discharged = 42 Sample = 33%	**Parent/Caregiver Positive Response %**	**Youth Positive Response %**
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	75
Visitation rooms were comfortable and provided privacy with my child.	77	83
Services were scheduled at times that were right for us.	100	100
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	86	85
The people helping my child and family stuck with us no matter what.	86	77
I felt my child and family had someone to talk to when troubled.	93	67
The services my child and family received were right for us.	86	69

NNCAS

Adolescent Treatment Center

Parent/Caregiver N=14; Youth N=13 Total Discharged = 42 Sample = 33%	Parent/Caregiver Positive Response %	Youth Positive Response %
My family got the help we wanted for my child.	86	77
My family got as much help as we needed for my child.	71	77
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	93	69
My child is better at handling daily life.	79	77
My child gets along better with family members.	79	83
My child gets along better with friends and other people.	64	83
My child is doing better in school and/or work.	92	77
My child is better able to cope when things go wrong	79	92
I am satisfied with our family life right now.	71	77
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	92	69
I helped to choose my child and/or family's treatment goals.	92	77
I participated in my child's and family's treatment.	100	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	100	45
Staff respected our family's religious/spiritual beliefs.	89	63
Staff spoke with me in a way that I understood.	100	85
Staff was sensitive to my family's cultural and ethnic background.	100	75
FUNCTIONING		
My child is better at handling daily life.	79	77
My child gets along better with family members.	79	83
My child gets along better with friends and other people.	64	83
My child is doing better in school.	92	77
My child is better able to cope when things go wrong.	79	92
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	100	85
Staff explained my child and family's rights, safety and confidentiality issues.	93	77
Our family is aware of people and services in the community that support us.	92	77
I am better able to handle our family issues.	93	N/A
I am learning helpful parenting skills while in services.	86	N/A
I have information about my child's developmental expectations and needs.	86	N/A

Parent/Caregiver comments

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

- Help her on self-control and eating disorders.
- She got to make adjustments for coming home.
- Therapy.
- Family therapy sessions.
- Discipline and structure for CLIENT and candid open counseling meetings with therapist were very effective.
- She has learned more coping skills, how to treat people better and finished 11th grade. She's learned how to do better for herself.
- Supportive staff, a safe and friendly environment. I loved that everyone was kind and respectful toward me and my family.
- Staff being understanding with relatives' needs.

Youth comments

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

- Fun basketball, staff, also peers.
- Having support and learning resources/skills for when I'm 18.
- The thing that has helped me the most during my stay would be the strictness/unlenient staff.
- People caring about me and my problems.
- Learning to think of consequences and not feel angry.
- A.R.T. Group working skills.
- The therapy helped me get along more with my family.
- To not take me for granted.
- Help and my grandparents.
- The most helpful thing was the therapy.

• He has learned life skills that he needs to succeed. • My son was given a reality check here. I also learned some valuable parenting skills. • She and my other family were safe. • Our child has learned to be more self-confident in some situations and feels he can communicate with family in all situations not just at home. • He has learned boundaries and respect for others.	• The time that I was here. The time helped me appreciate things. • I think the way the staff were consistent on teaching social skills. • Therapy, outings to relieve stress.
2. What would improve services your child and the family received? • I was happy with services and can't think of anything that would change. I enjoyed working with all of you and felt well supported during my sons stay here. • Everything is perfectly good. • Work on common goals not ATC goals. Do not give written information re: policies that are not followed due to "informal" policies and be consistent. • No improvement needed. • I feel that the program is generalized in a way that the children are taught the same skills regardless of why they are here. More individualized treatment, I feel, would have helped and more family sessions or parent-support groups. • Not sure/was excellent. • N/A It was very helpful.	2. What would improve services you received? • No more yelling. • Nothing. • I truthfully think there is nothing that needs improvement. • Less annoying children. • Nothing, get more food. • More skills to practice. • Common Staff not being so disrespectful. • If my family was more involved. • I'm not sure. • To use my coping skills . • A couple of staff respects me more. • Allowing me to talk to people I feel safe with. Providing less stressful situations.
3. What would improve client safety? • My son at one point was put with a gay roommate - that concerned me because I knew there were times when they were locked in a room unsupervised at night. I feel it could be dangerous with a child who might have a past of sexual abuse - or - with a child who wouldn't speak up. • Monitoring cameras on the place. • No improvement needed. • I did not feel at any time that my son was unsafe.	3. What would improve client safety? • I was safe for my entire stay here. • Stop having kids that fight. • Have extra single bed rooms so you don't have to have a roommate if you don't get along. • Allowing more privileges. • Don't take what our charts say so seriously. • It's good. • Roommate requests. Keep dodgeball out of P.E.
4. Additional Comments • I will be meeting with Division of Health and Human Services on June 28 and Bureau of Health Care Licensing to address some of the issues that remain unresolved, including treatment. • We see great improvement in his attitude and behavior. • This program has been the best thing for her and all of the family. The therapist has been so wonderful and accommodating for our needs (scheduling etc.) A few staff members have been so good to us. I feel this program has saved my daughter's life - has redirected her toward positive living. I'm grateful to you all. • I know my son has taken skills from the program that he can use in everyday life. • Thank you for all your help and concern. • Thank you all so much for the caring and productive things you've all put into my son and my family. [happy face] • Thank you for all your help. • I would like to thank the entire staff for caring and tolerating and always encouraging her to do better for herself, and also for taking the time to communicate with me.	4. Any additional comments? • I want to thank my therapist for being effective and helpful and understanding during my time here in ATC. • The staff have changed my life. Also special thanks to my therapist. • Give the kids more food. • Staff at ATC were helpful and respectful and did not give up on me when I gave up on myself! • Staff should listen and understand kids better instead of not caring.

NNCAS

Family Learning Homes

Parent/Caregiver N=17; Youth N=20 Total Discharged = 45 Sample = 38%	Parent/Caregiver Positive Response %	Youth Positive Response %
ACCESS TO SERVICES		
Services were provided in a safe, comfortable, well-cared-for environment.	100	95
Visitation rooms were comfortable and provided privacy with my child.	87	83
Services were scheduled at times that were right for us.	100	90
GENERAL SATISFACTION		
Overall, I am pleased with the services my child and/or family received.	100	80
The people helping my child and family stuck with us no matter what.	100	90
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.	94	85
My family got the help we wanted for my child.	94	68
My family got as much help as we needed for my child.	65	90
POSITIVE OUTCOMES		
My child's educational needs were met during his/her stay.	100	80
My child is better at handling daily life.	69	89
My child gets along better with family members.	88	75
My child gets along better with friends and other people.	88	75
My child is doing better in school and/or work.	81	72
My child is better able to cope when things go wrong	63	90
I am satisfied with our family life right now.	75	75
PARTICIPATION IN TREATMENT		
I helped to choose my child and family's services.	87	85
I helped to choose my child and/or family's treatment goals.	100	95
I participated in my child's and family's treatment.	94	85
CULTURAL SENSITIVITY		
Staff treated our family with respect.	94	95
Staff respected our family's religious/spiritual beliefs.	100	84
Staff spoke with me in a way that I understood.	100	95
Staff was sensitive to my family's cultural and ethnic background.	100	68
FUNCTIONING		
My child is better at handling daily life.	69	89
My child gets along better with family members.	88	75
My child gets along better with friends and other people.	88	75
My child is doing better in school.	81	72
My child is better able to cope when things go wrong.	63	90
INTEREST ITEMS		
Staff explained my child's diagnosis, medication and treatment options.	94	85
Staff explained my child and family's rights, safety and confidentiality issues.	100	95
Our family is aware of people and services in the community that support us.	87	80
I am better able to handle our family issues.	87	N/A
I am learning helpful parenting skills while in services.	93	N/A
I have information about my child's developmental expectations and needs.	100	N/A

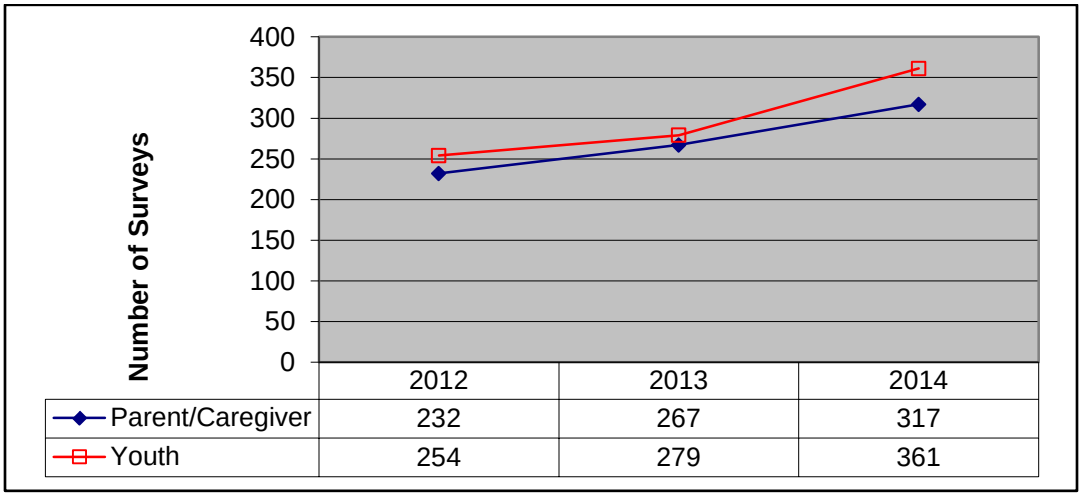
Parent/Caregiver comments	Youth comments
1. What has been the most helpful thing about the services your child received? • The Parent Training. • We received skill with managing our child's behaviors especially with her violence issues. • The structure and consistency he received. The break the family received - the peace. • Learning about different resources in the community. • We learned new skills to use as a family. • Talking. • Parent Training and CFTs. • The staff person truly goes out of her way for the best for my child and she has the best relationship with the whole family - she steadily kept me informed. • Wanting and willing to get everyone involved, being there whenever we had questions. • The case manager was very helpful and gave us a lot of insight. • Supervision from staff and cameras, the discipline of sending him to go to sleep early and getting him up early. Watching the sneaky ways of my son. • The way my daughter has used her coping skills, her improving her grades. • Learning respect, how to get along better with his sisters, how to control his temper. • Transition help. • The staff was great, always explained everything - it was very enlightening as to how the system works. • Our therapist is amazing. So is the staff in Home 4. They all helped us so much! They deserve much praise!	1. What has been the most helpful thing about the services you received? • The helpful thing about the services is the staff and the peers because they're the ones who helped me with a lot of stuff. • Learning how to respect people more. • Comments throughout my service with peers also staffs to me plus conversations. • Help getting along with my mom. • The most helpful thing was being supported by the staff and team members. • Learning how to control my temper. • Anger control. • I know better now and I know what is right or wrong. • To use anger management. • I am able to control my temper so I don't blow up as fast. • Having a safe place to stay to accomplish my goals. • Coping skills. • Art group. • Getting along with mom. • The restitution and reunification with family. • It helped me know right from wrong now. • Guidance.
2. What would improve services your child and the family received? • Nothing, services were great. • Nothing, services were great. • To find a compromise with visitation when a child is on loss. • More staff with Autistic knowledge (everyone was great but more staff would be helpful for you guys). • A more secure environment. • Case manager that is available during more weekday hours. • The staff has some wonderful ideas that I agree should be implemented in the homes. More exercising and better nutrition plans are needed. • Making sure all persons involved are on the same page. • More understanding about other children involved. • The staff is too soft and coherent or non-drillant when it came to supervise my son, he was the person I felt was very lenient when it came to my family. • I cannot think of anything. The staff did a great job. • They need more help.	2. What would improve services you received? • Less rules, more time with staff. • Not giving up on passing through the learning center. • Seeing family more. • I think everything was great, except for being talked to while mad. • Nothing. • Social worker letting me have more time with my family. • Arguing needs more improvement. • My anger. • There were times that I was treated like a child and got left out of important details. • Going to therapy. • More time in the day for activities.
3. What would improve client safety? • I don't think there is anything. • Safety was never a concern. • My child was safe here and I never felt like you guys didn't have control. • Door alarms. • I have never has to worry about my child while in your care. • You all already do a great job. I'm very pleased. • Cameras in children's bedrooms so they are supervised at all times. We had issues with other kids stealing from my child. Also, don't just check pockets - kids are sneaking things in, search them better.	3. What would improve client safety? • Room search every day for weapons. • Two people in kitchen at a time. • I think that the services were great the way they were. • Sending to rooms. • Setting more alarms. • Nothing. • When a client is searched (search them) and don't just check their pockets.

4. Additional Comments	4. Any additional comments?
• The staff in Home 4 are outstanding, great to work with. • My child's needs were excessive and could not be fully met by the FLH. He required placement at a higher level of care. The deficits in treatment were predominantly at the fault of my child, NOT of the treatment home. • A big thanks to the staff for their efforts. • I thank you everyone, you are without a doubt the greatest, me and my family love you! Thanks from the bottom of my heart for everything. • Kids should do more studying time and chores as much as they play video games. I think it's great, my son unfortunately accomplished 30% changes by coming into this program, but I'm happy that it made that difference and my son improved some of his discipline skills. • This is an awesome program. Keep up all the support for the families that need it. You sure helped us. Thank You. • The staff was strict when need to be, but also very caring and understanding. • I really felt that the staff has a very negative outlook and imposes on the girls to feel negative about themselves. • Thank you for all your help! It is much appreciated!!	• Want to thank all of the help that the team gave me. • I will miss the staff and my friends. • Thank you guys for helping me. • Thank you. • Staff person is a great and another staff person was fun and great to hang out with. • Thank you.

Survey participation

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

DCFS Residential Based Mental Health Services
Desert Willow, Oasis, ATC & FLH Discharge Survey Participation



	2012	2013	2014
Parent/Caregiver	232	267	317
Youth	254	279	361

The current survey shows a statewide increase (19%) in parent/caregiver participation and a corresponding increase (29%) in youth participation when compared to the same survey conducted last year. Statewide there were a combined total of 678 agency parent/caregiver and youth survey participants. There was an overall statewide participation increase of (24%) from the 2013 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
2014 Oasis On Campus Treatment Homes (Oasis) 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 2014 report is the seventh year of data collection for risk measures and departure conditions; only the current year and the previous four years of data will be presented in this report. This report is an analysis of risk measures and departureconditions collected from January 2014 through December 2014. Oasis submitted a timely and complete data set in 2014. 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 2014 through December 2014. 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	
2014	28.75 Range: 28 to 29	2014	14.75 Range: 12 to 18
2013	27.17 Range: 26 to 28	2013	14.83 Range: 10 to 17
2012	25.83 Range: 22 to 27	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: 27 to 35

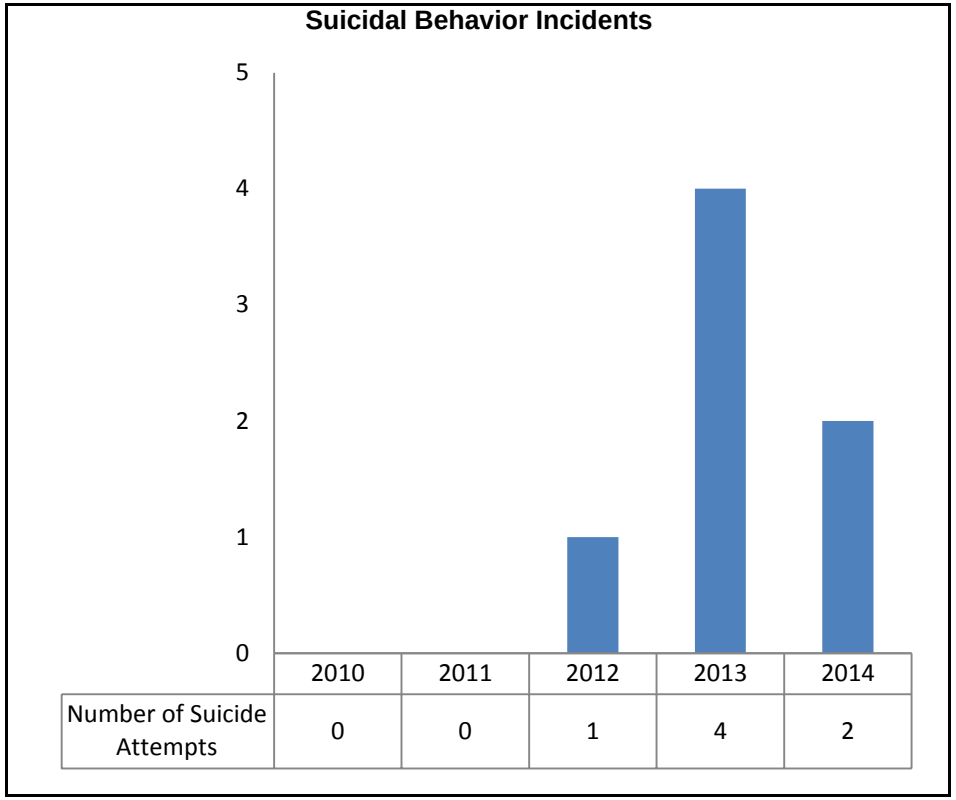
Suicidal Behavior

Descriptive Information:

- 1 was female and 1 was male.
- Average age was 15 (range: 13 - 17 years)
- Race
  Both youth were Caucasian
- Custody Status
  1 of the youth was in Child Welfare Custody
  1 of the youth was in Parental Custody on Probation
- 1 of the youth is Hispanic

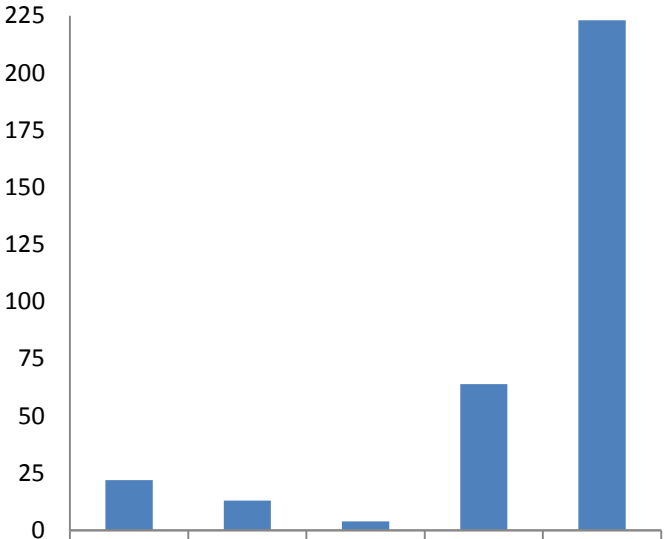
Clinical and Suicide Attempt Information:

- Bipolar Disorder NOS and Mood Disorder NOS were the diagnoses for the youth.
- Both of the youth had a history of suicide attempt.
- Both of the youth were under psychiatric care.
- Both of the youth attempted suicide by other means.
  1 youth attempted to discharge a fire extinguisher in her mouth.
  1 youth wrapped a string around her neck and told staff that he might hurt himself.
- Suicide Interventions
  1 youth received 15 minute checks.
  1 youth received verbal reassurance, redirection, timeout, praise/empathy statements, 1:1 interactions with staff, coupling statements, limit setting, and rationale / reality statements
- Suicide Outcome
  1 youth was monitored and completed a self assessment
  1 youth was admitted to a psychiatric hospital



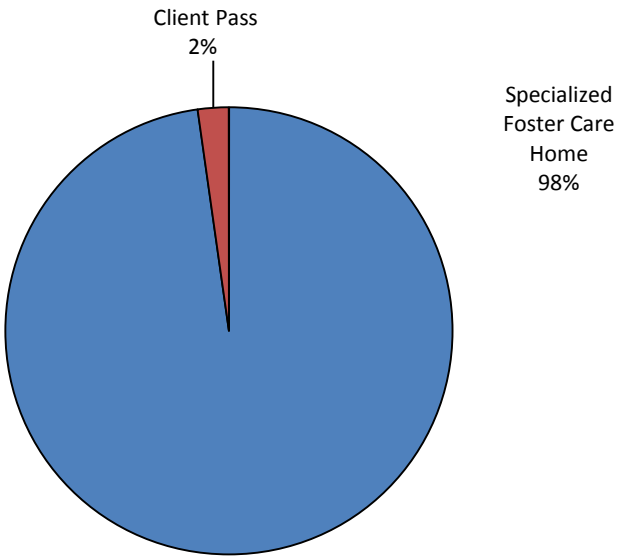
Medication Errors

Medication Error Incidents

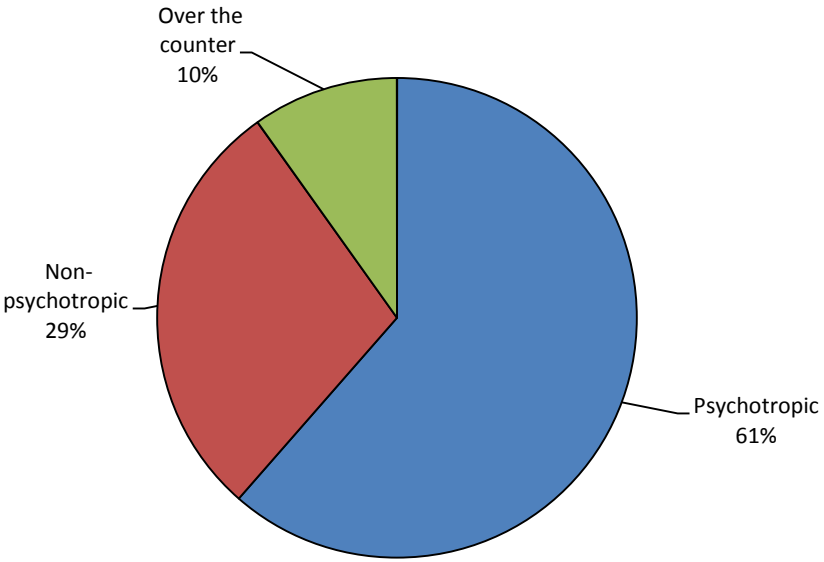


	2010	2011	2012	2013	2014
Number of Medication Errors	22	13	4	64	223

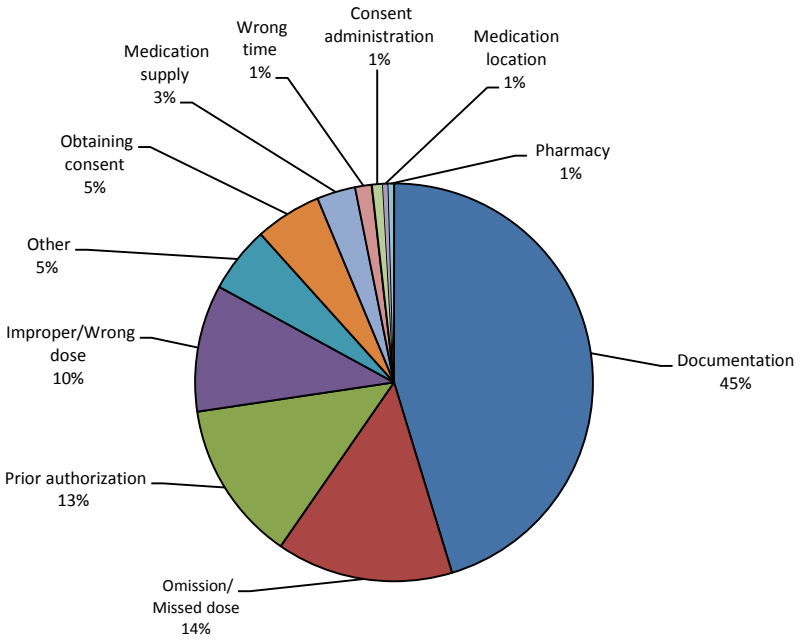
Location of Medication Error



Type of Medication

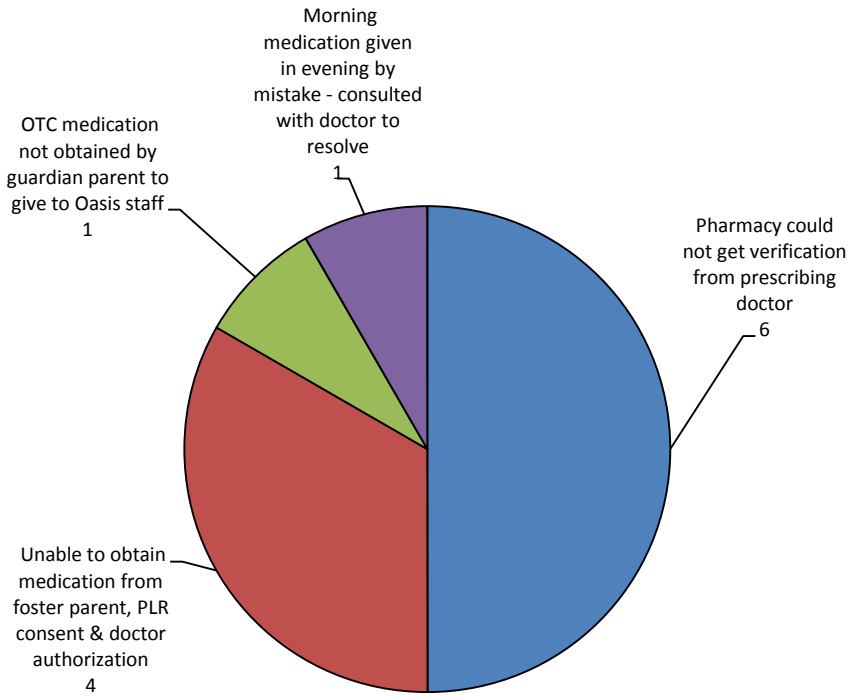


Type of Medication Error

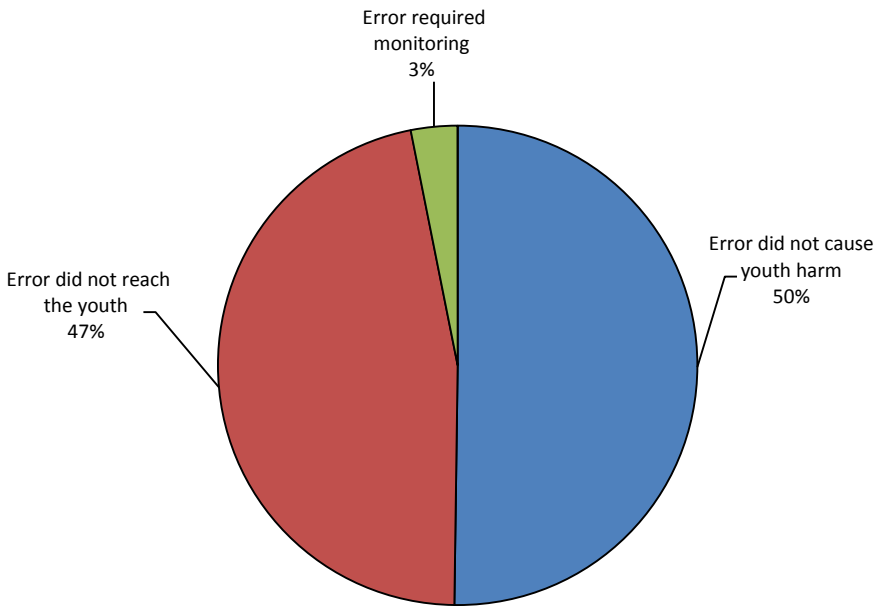


Medication Errors (Continued)

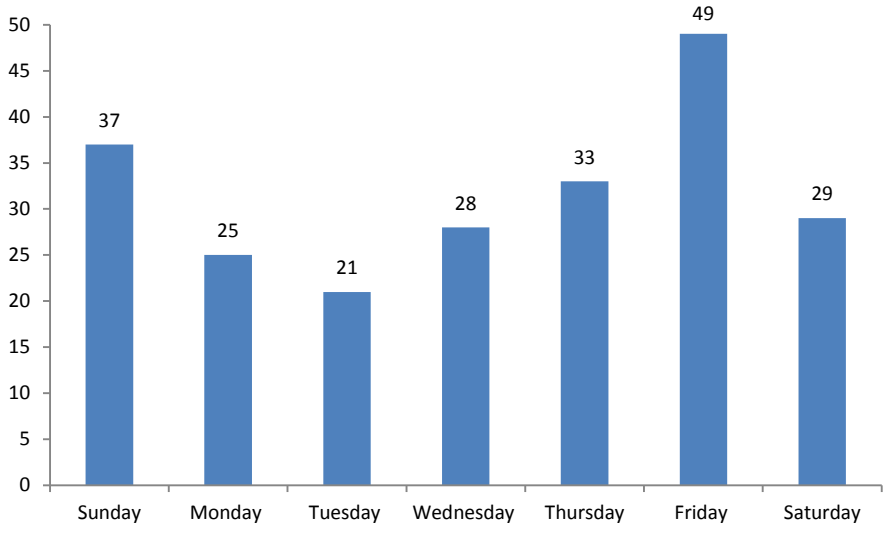
Type of Medication Error: "Other"



Medication Error Outcome



Medication Error by Day of Week



AWOL

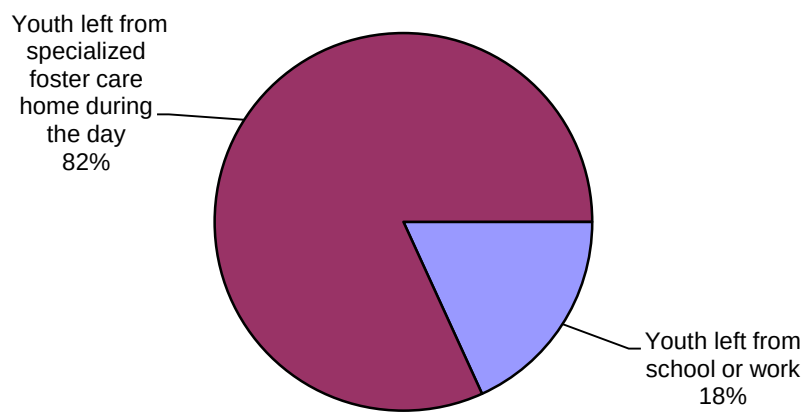
Descriptive Information:

- 6 (54.55%) were female and 5 (45.45%) were male.
- Average age was 15.64 (range: 14 - 17 years)
- Race
  6 (54.55%) Caucasian
  1 (9.09%) American Indian/Alaskan Native
  3 (27.27%) Asian
  1 (9.09%) Mixed
- 1 (9.09%) was Hispanic.
- Custody Status
  8 (72.73%) Child Welfare Custody
  2 (18.18%) Parental Custody on Probation
  1 (9.09%) DCFS Youth Parole Custody/Supervision

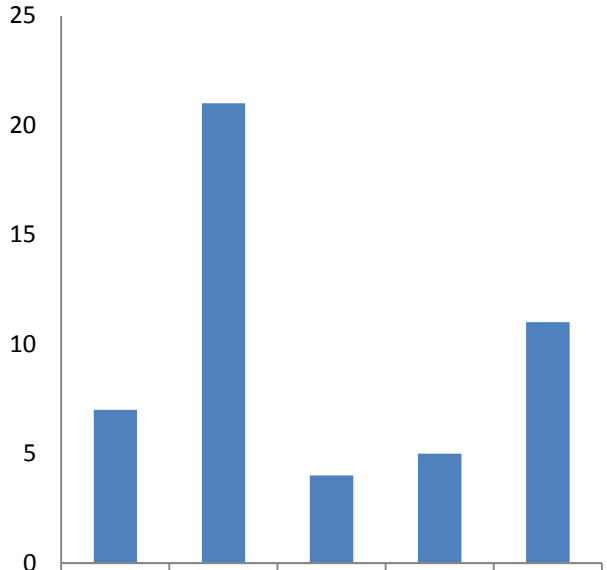
Clinical and AWOL Information:

- PTSD Disorder (5 or 45.45% of youth) was the most frequent diagnosis.
- 4.27 (range: 1 - 15) of days AWOL
- All 11 of the youth had a history of AWOL.

Type of Supervision at AWOL

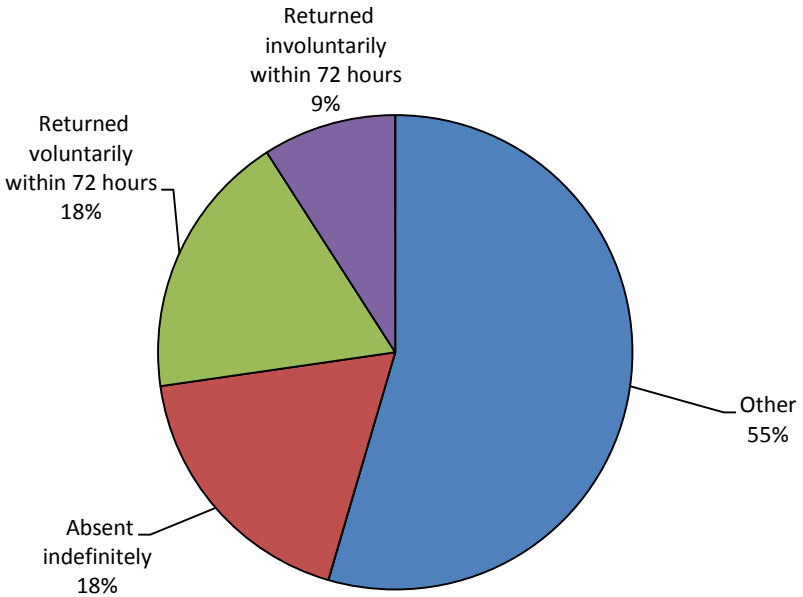


AWOL Incidents



	2010	2011	2012	2013	2014
Number of AWOL Incidents	7	21	4	5	11

Outcome of AWOL



Restraint and Manual Guidance

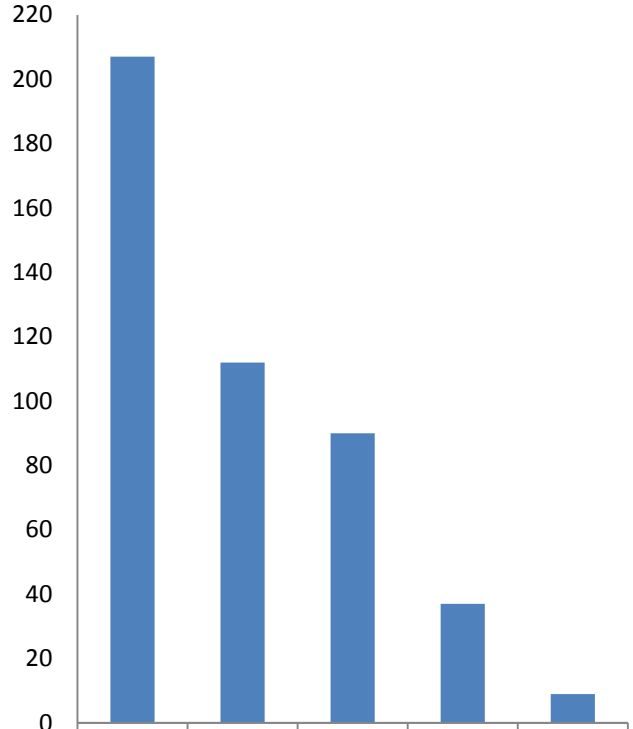
Descriptive Information:

- 5 were female and 4 were male.
- Average age was 10.22 (range: 6 - 17 years)
- Race
  6 were Caucasian
  3 were African American
- 3 were Hispanic.
- Custody Status
  6 Parental Custody and no Juvenile Probation involvement
  3 Parental Custody on Probation

Clinical and Restraint and Manual Guidance Information:

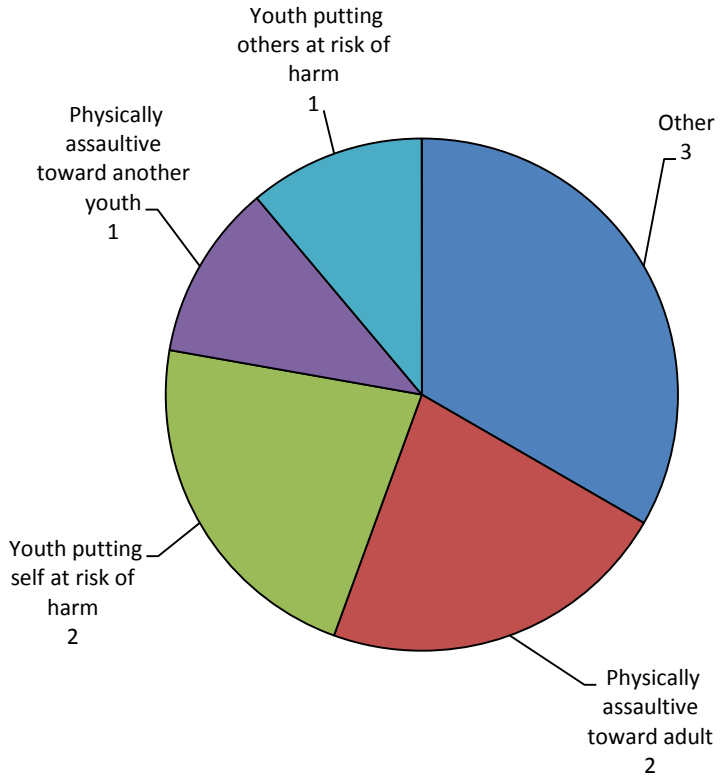
- Mood Disorder (4 youth) was the most frequent diagnosis.
- 5 of the youth had a history of restraint and manual guidance
- A manual guidance was used during each restraint.
- 1 was the average number of times a restraint used per incident
- 8.88 (range: 0 - 30) was average length of restraint in minutes
- 3 of the restraints had a debriefing held after the incident.
- The most common intervention used was verbal redirection.
- On average, 5.88 interventions were used in each incident.

Restraint and Manual Guidance Incidents



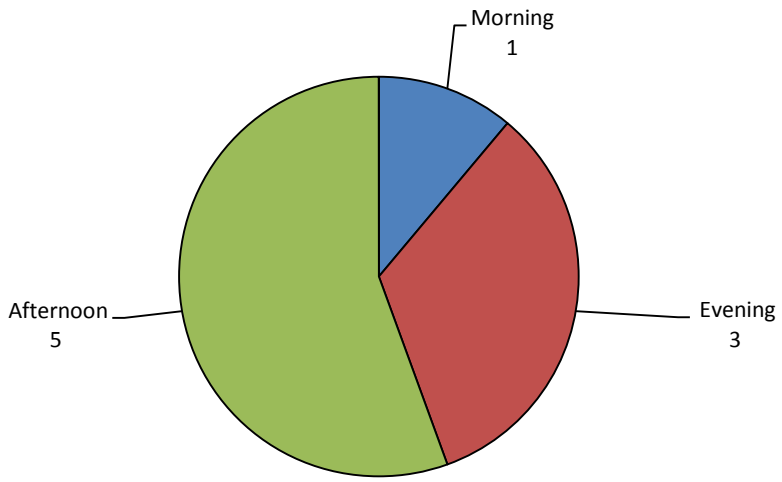
	2010	2011	2012	2013	2014
Number of restraint and manual guidance incidents	207	112	90	37	9

Restraint and Manual Guidance Event

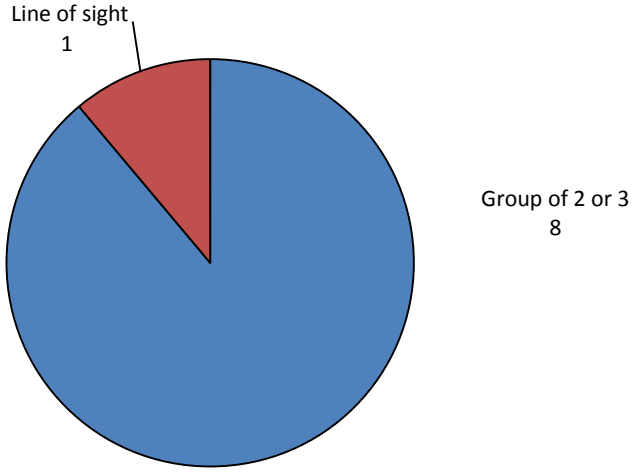


Restraint and Manual Guidance (Continued)

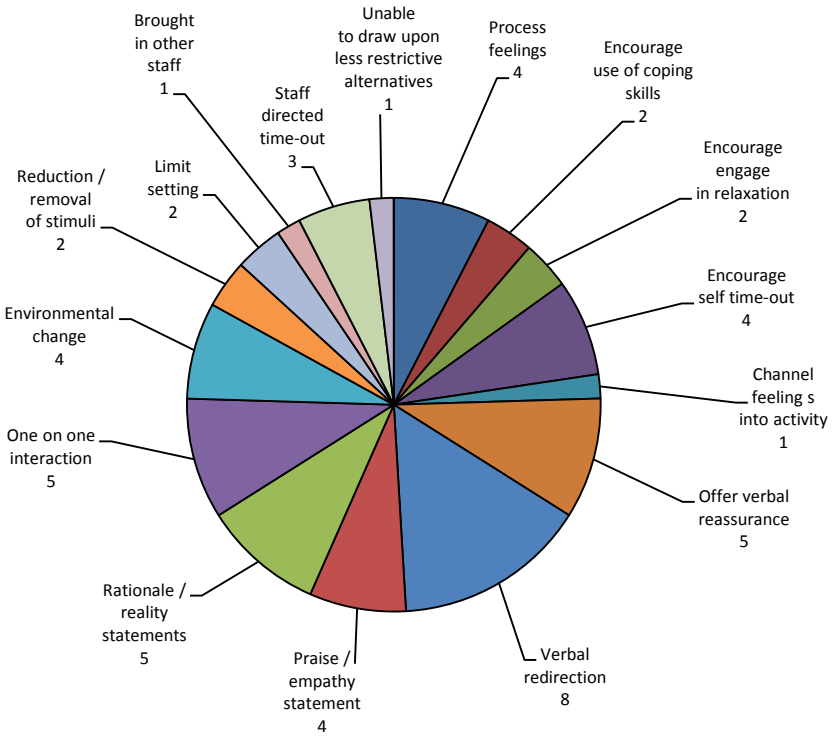
Incident Time of Day



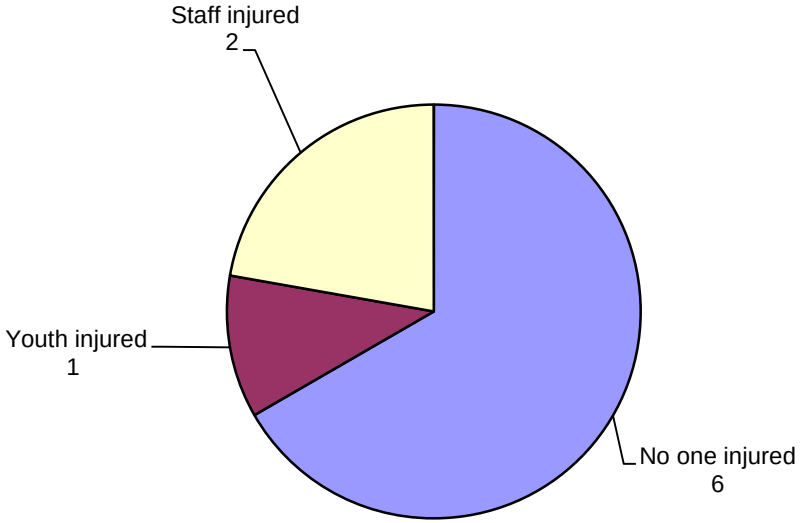
Type of Supervision for Restraint and Manual Guidance



Interventions Used Prior to Incident



Restraint and Manual Guidance Injury



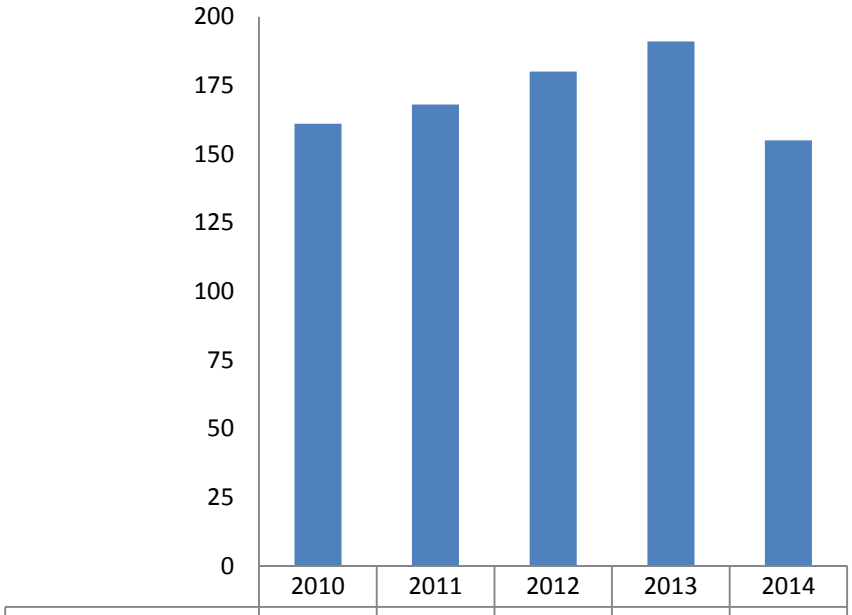
Departure Conditions

Oasis reported 30 discharges in the 2014 reporting period.

Descriptive Information:

- 21 (70%) were female and 9 (30%) were male.
- Average age was 14.73 (range: 7 - 18 years)
- Race
  19 (63.33%) Caucasian
  8 (26.67%) African American
  2 (6.67%) Asian
  2 (3.33%) Mixed
- 4 (13.33%) were Hispanic.
- Custody Status
  13 (43.33%) Child Welfare Custody
  6 (20%) Parental Custody on Probation
  2 (6.67%) DCFS Youth Parole Custody/Supervision
  9 (30%) Parental Custody and no Juvenile Probation involvement
- All of the youth were Medicaid recipients.
- The average length of stay at Oasis was 154.79 days, ranging from 3 days to 629 days (1.72 years).

AVERAGE LENGTH OF STAY



	2010	2011	2012	2013	2014
Average length of stay (days)	161	168	180	191	155

Clinical and Departure Information:

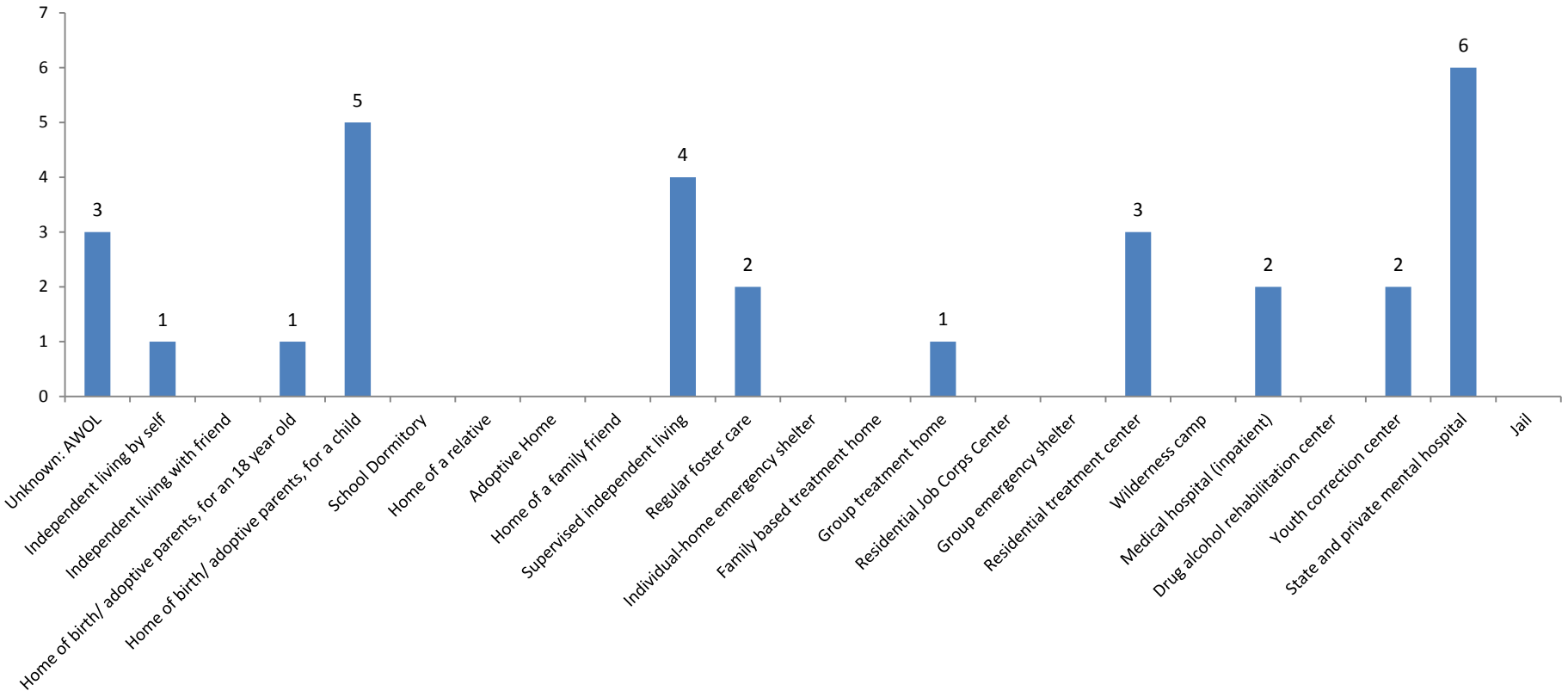
- PTSD (5 or 16.67% of youth) was the most frequent diagnosis at admission followed by Bipolar Disorder NOS (5 or 16.67% of youth).
- Mood Disorder (6 or 20% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (3 or 10% of youth).
- The average CASII composite score at admission was 23.86.
- The average CASII composite score at discharge was 23.44.
- 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
2014	14	Group treatment home
2013	13	Family based treatment home
2012	13	Family based treatment home
2011	11	Specialized foster care
2010	11	Specialized foster care

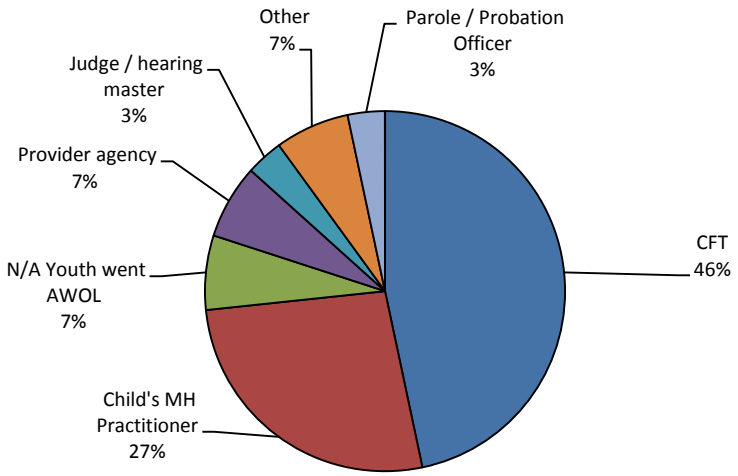
- In 2014, the ROLES score resulted in an average of 13.74, which equals the restrictiveness score of group treatment home.

Departure Conditions (Continued)

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



WHO RECOMMENDED DEPARTURE



Departure Conditions - Youth in Child Welfare Custody

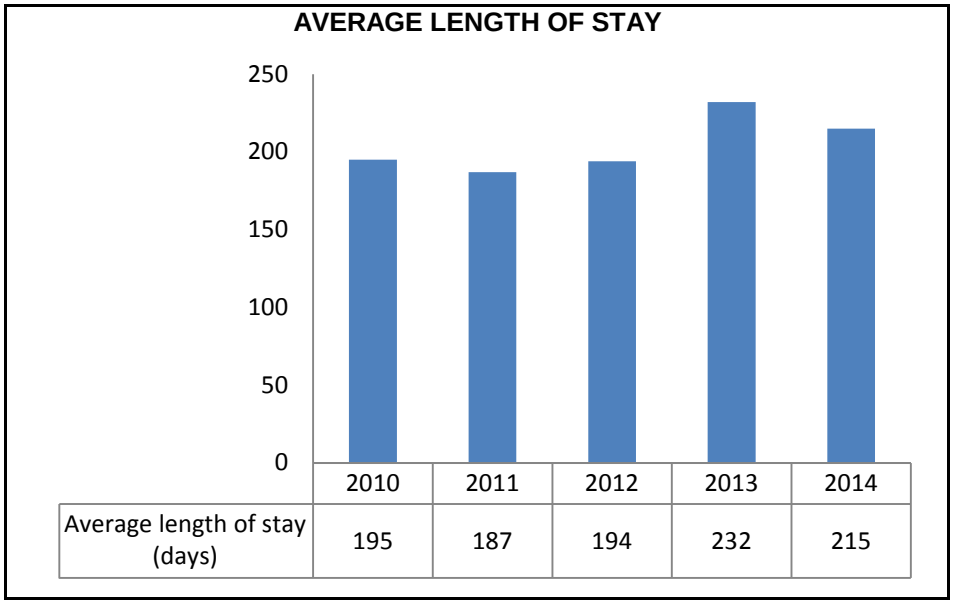
Of the 30 discharges reported by Oasis in the 2014 reporting period, 13 (43.33%) were in the custody of a public child welfare agency.

Descriptive Information:

- 7 (53.85%) were female and 6 (46.15%) were male.
- Average age was 14.69 (range: 10 - 18 years)
- Race
  9 (69.23%) Caucasian
  3 (23.08%) African American
  1 (7.69%) Asian
- 2 (15.38%) were Hispanic.
- The average length of stay at Oasis was 214.58 days, ranging from 43 days to 629 days (1.7 years).

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2014	15	Residential Job Corps Center
2013	12	Individual home emergency shelter
2012	13	Family based treatment home
2011	12	Individual home emergency shelter
2010	14	Group treatment home

- In 2014, the ROLES score resulted in an average of 14.83, which equals the restrictiveness score of residential job corps center.



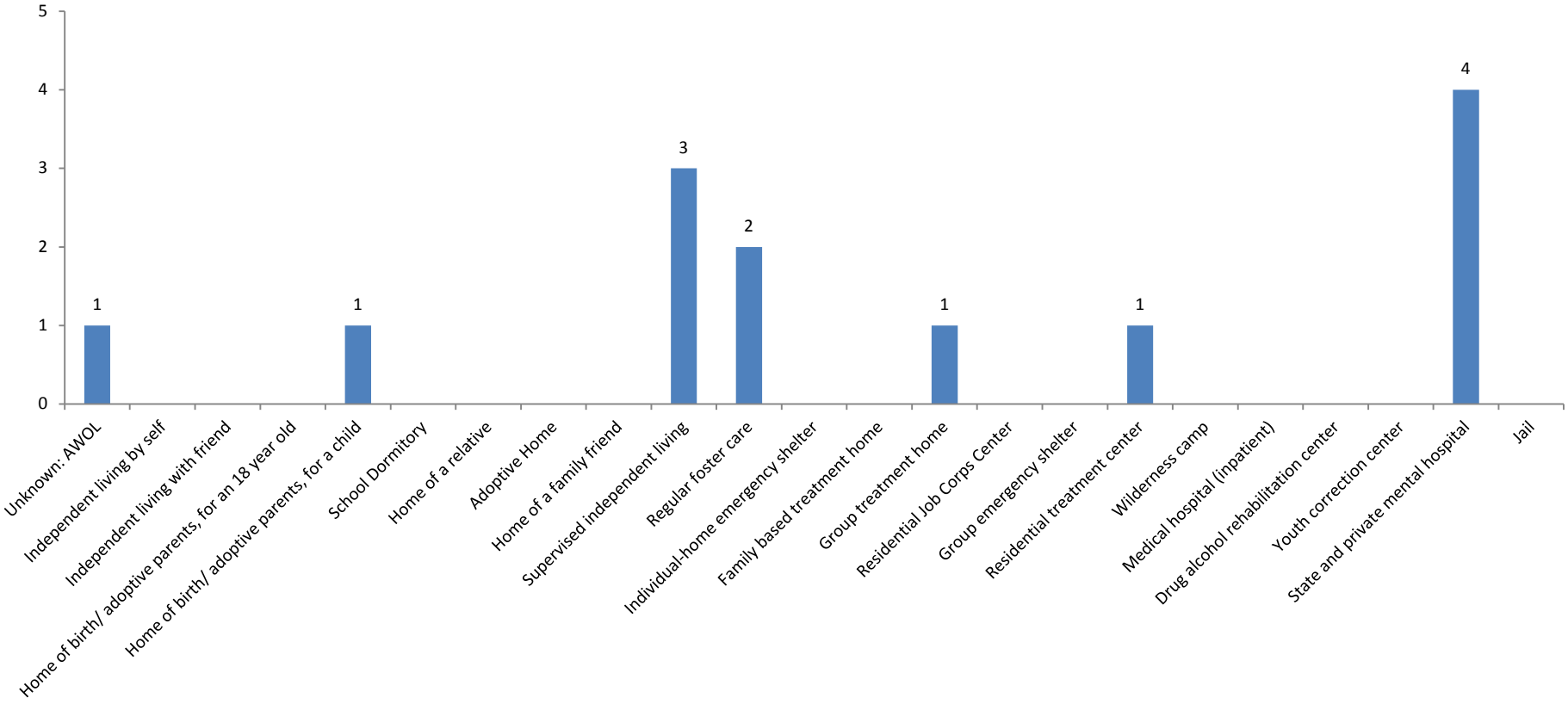
Clinical and Departure Information:

- Mood Disorder (4 or 30.76% of youth) was the most frequent diagnosis at adm admission followed by Oppositional Defiant Disorder (2 or 15.38% of youth).
- Mood Disorder (3 or 23.07% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (2 or 15.38% of youth).
- The average CASII composite score at admission was 24.42.
- The average CASII composite score at discharge was 23.22.

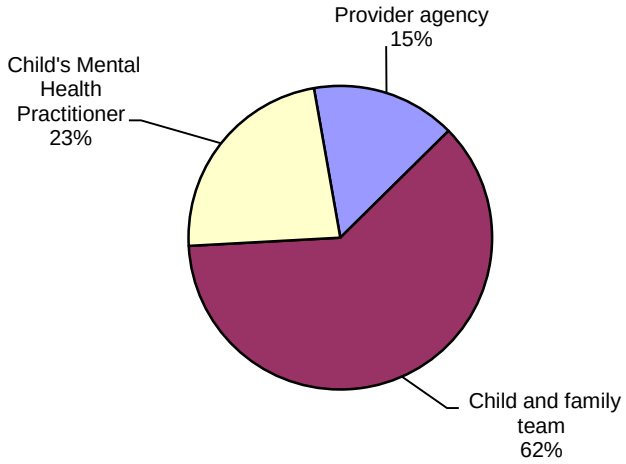
- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

Departure Conditions - Youth in Child Welfare Custody (Continued)

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)



WHO RECOMMENDED DEPARTURE



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:

- As compared to 2013, Oasis had a reduction in suicide attempts in 2014.
- Suicide interventions were identified and utilized in both incidents.

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:

- Errors are being documented and reported. When errors are consistently documented and reviewed, procedural improvements can be made to minimize future errors.
- In the Autumn of 2014, Oasis contracted for a part-time nurse to work with staff on Medication training, documentation, and reduction of medication 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:

- While AWOL incidents increased in 2014 as compared to 2013 and 2012, the number of occurances is still less than the number of AWOL incidents in 2011.

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:

- On average, 5.88 interventions were used for each restraint and manual guidance incident.
- Over the past five reporting periods, Oasis has shown a reduction in the use of restraint and manual guidance. In 2014 Oasis averaged 14.75 youth in the program each month with less than one restraint and manual guidance incident each month whereas in 2013, Oasis averaged 14.83 youth in the program each month with an average of 3.08 incidents of restraints and manual guidance per month.

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.

Restraint and Manual Guidance Practice Guidelines and Opportunities for Improvement (Continued):

- 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, 13 (43.33%) of the youth were placed in less restrictive settings.
- Upon discharge, 10 (33.33%) of the youth continued to receive services from the Division of Child and Family Services.

Children in Child Welfare Custody Highlights:

- Upon discharge, 6 (46.15%) of youth returned to a less restrictive environment.
- Upon discharge, 5 (38.46%) of the youth continued to receive services from the Division of Child and Family Services.

Practice Guidelines and Opportunities for Improvement:

- Only 14 (46%) of the departures for children in the custody of a child welfare agency was/were recommended by a CFT. In 2013, 10 (83%) of departures for children in the custody of a child welfare agency were recommended by a CFT. CFTs are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers
- 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 2014, Oasis had 3 support staff complete the Trauma Informed Care training.

Summary

Oasis submitted all of its 2014 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 2014 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of Medication errors, AWOLs, and Child and Famiy Team supported departures.

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 2014 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
2014 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 2014 report is the seventh year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2014 through December 2014. Adolescent Treatment Center (ATC) submitted a timely and complete data set in 2014. 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 2014 through December 2014. 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	
2014	16 Range: 16 to 16	2014	18.33 Range: 16 to 20
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

Suicidal Behavior

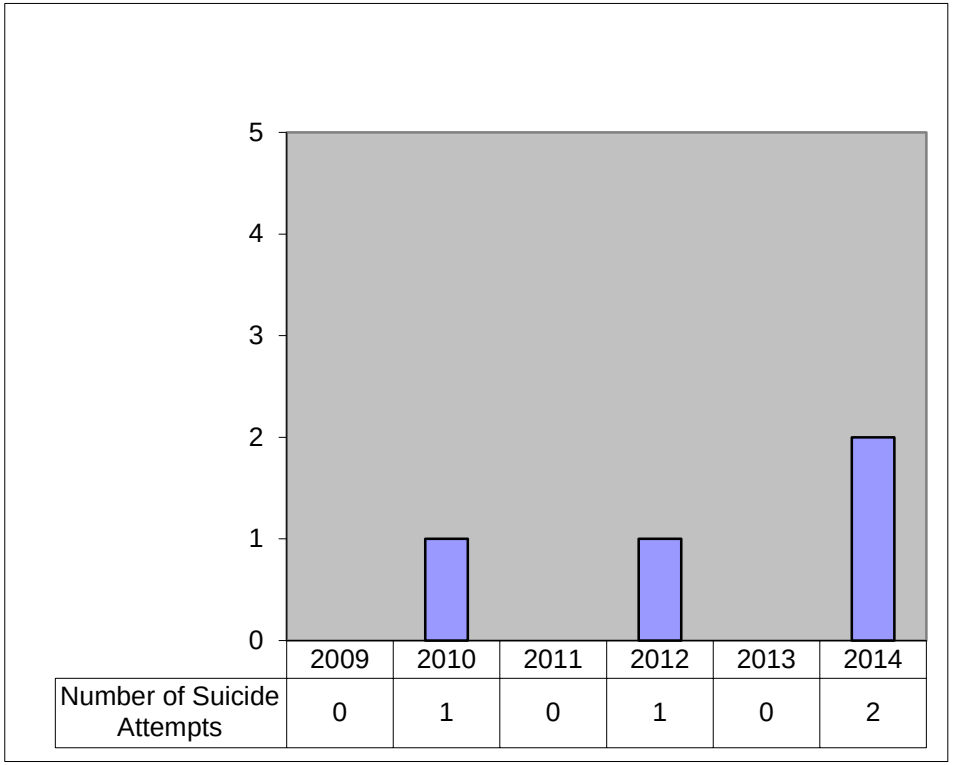
There were two attempted suicides during the 2014 reporting period.

Descriptive Information:

- 1 was female and 1 was male.
- Average age was 14.50 (range: 14 - 15 years)
- Race
  Both youth were Caucasian
- Custody Status
  1 of the youth was in Child Welfare Custody
  1 of the youth was in Parental Custody on Probation
- Neither youth was Hispanic

Clinical and Suicide Attempt Information:

- Bipolar Disorder NOS and Bipolar Disorder I were the diagnoses for the youth.
- One of the youth had a history of suicide attempt.
- Both of the youth were under psychiatric care.
- One of the youth attempted suicide by hanging and one by drowning.



	2009	2010	2011	2012	2013	2014
Number of Suicide Attempts	0	1	0	1	0	2

- Suicide Interventions
  1 youth was sent directly to West Hills.
  1 youth was on suicide safety precautions which include 24/7 15 minutes safety checks. Youth received group and individual counseling and was given one on one attention from the staff.
- Suicide Outcome
  Both of the youth were admitted to a psychiatric hospital

Medication Errors

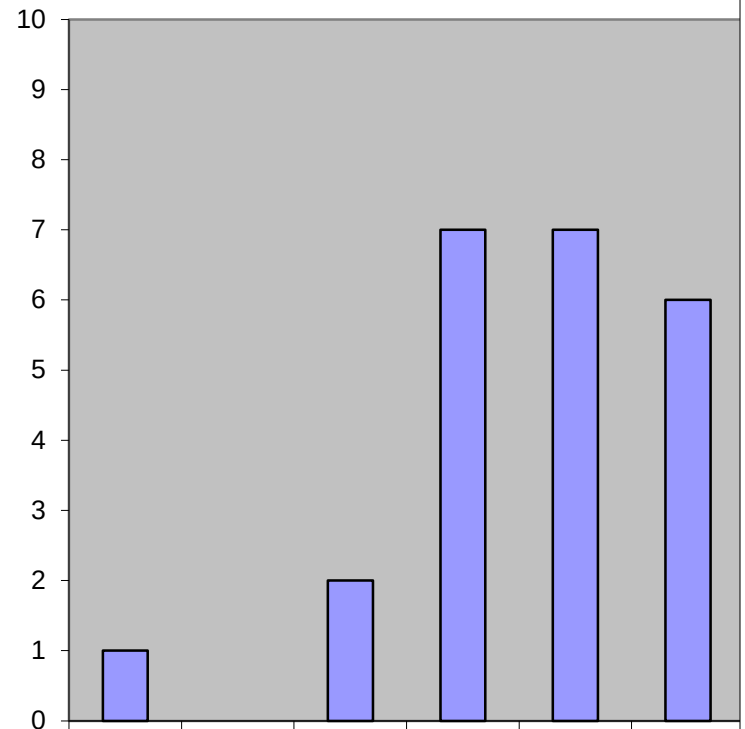
Medication Error Location

- 4 (66.67%) of the errors occurred in the home
- 2 (33.33%) of the errors occurred on a client pass

Medication Error Type Information:

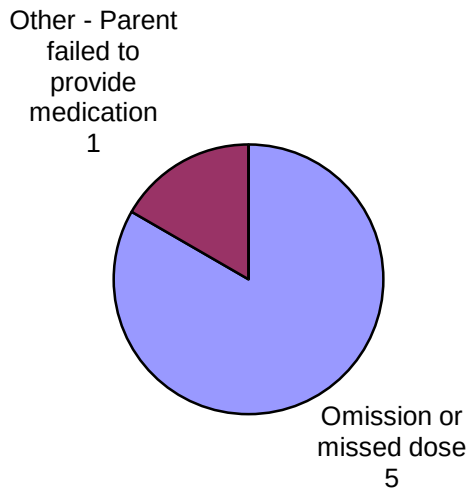
- 3 (50%) of the medication errors were psychotropic medication
- 2 (33.33%) of the medication errors were non-psychotropic medication
- 1 (16.67%) of the medication errors were over the counter medication

Medication Error Incidents



	2009	2010	2011	2012	2013	2014
Number of Medication Errors	1	0	2	7	7	6

Type of Medication Error



AWOL

Descriptive Information:

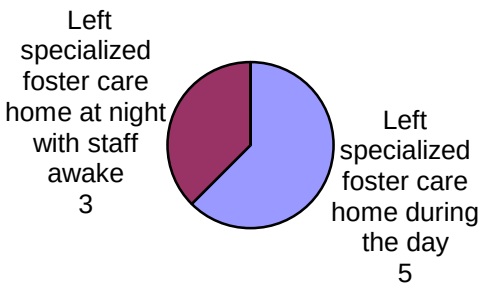
- 3 (37.5%) were female and 5 (62.5%) were male.
- Average age was 15.13 (range: 13 - 17 years)
- Race
  6 (75.0%) Caucasian
  2 (25.0%) African American

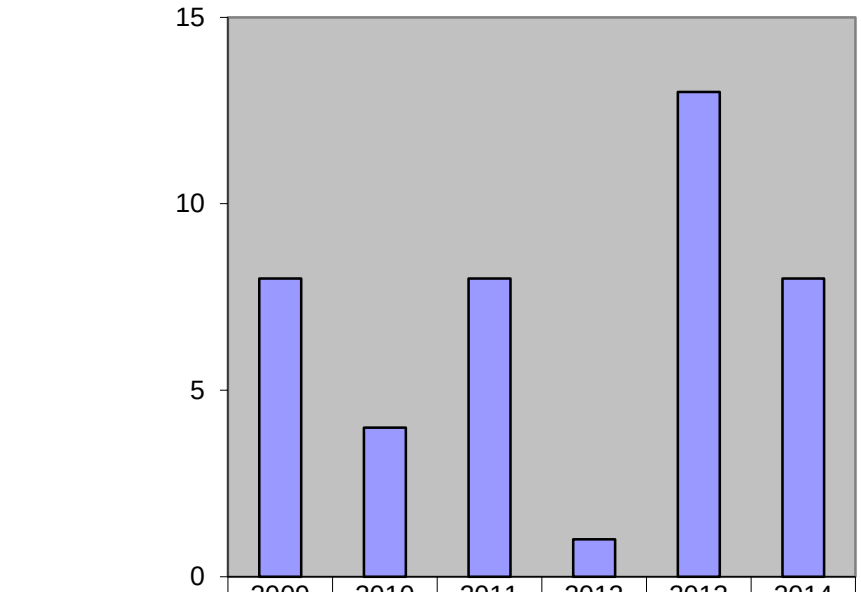
- Custody Status
  4 (50.0%) Child Welfare Custody
  5 (37.5%) Parental Custody on Probation
  1 (12.5%) DCFS Youth Parole

Clinical and AWOL Information:

- Oppositional Defiant and Bipolar Disorders (2 or 25.0% of youth each) were the most frequent diagnoses.
- 2.63 (range: 2 -5) was the average number of days AWOL
- All of the youth had a history of AWOL.

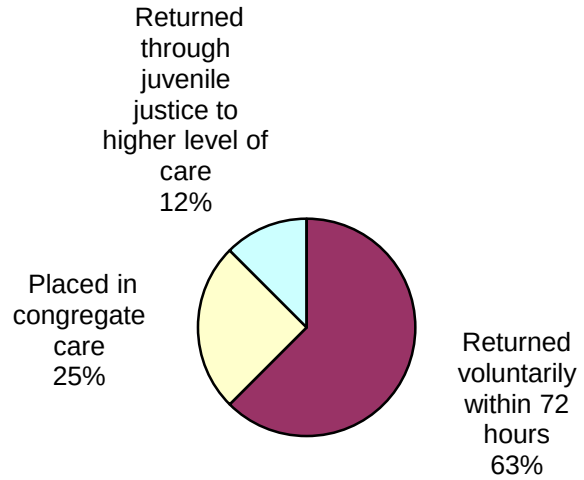
Type of Supervision at AWOL





	2009	2010	2011	2012	2013	2014
Number of AWOL Incidents	8	4	8	1	13	8

Outcome of AWOL



Restraint and Manual Guidance

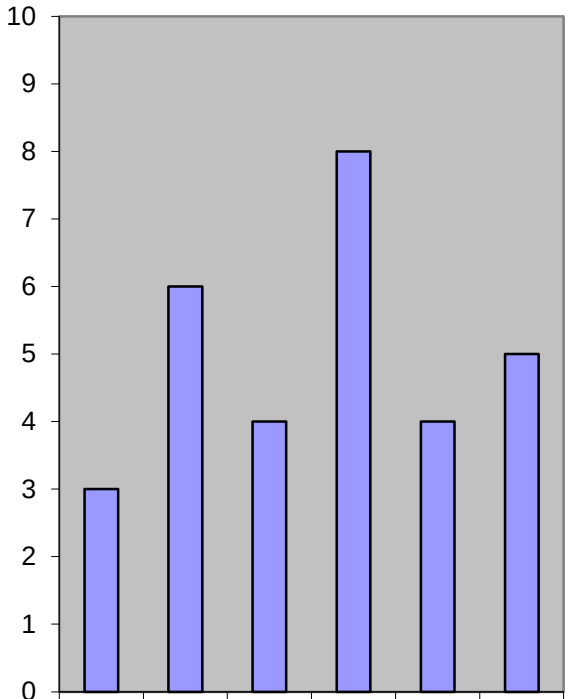
Descriptive Information:

- 3 female, 2 male.
- Average age was 13.2 (range: 12 -15 years)
- Race
  3 Caucasian
  2 African American
- Custody Status
  3 Child Welfare Custody
  2 Parental Custody on Probation

Clinical and Restraint and Manual Guidance Information:

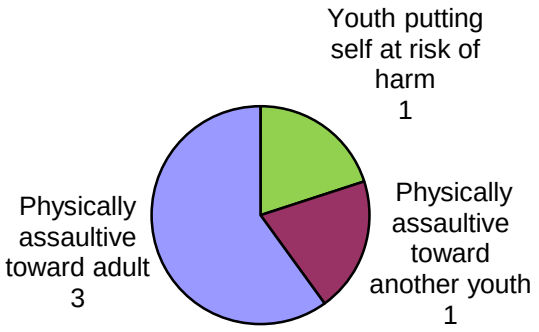
- Posttraumatic Stress Disorder (2 of youth) was the most frequent diagnosis.
- Only 1 of the 5 youth had a history of restraint and manual guidance
- 1 restraint was used per incident.
- No one was injured in any of the restraints.
- A manual guidance was used once during a restraint.
- 4.20 (range: 1 - 10) was average length of restraint in minutes
- All of the restraints had a debriefing held after the incident.
- The most common intervention used were verbal redirection and praise/empathy statements.
- On average, 5.6 interventions were used in each incident.

Restraint and Manual Guidance Incidents



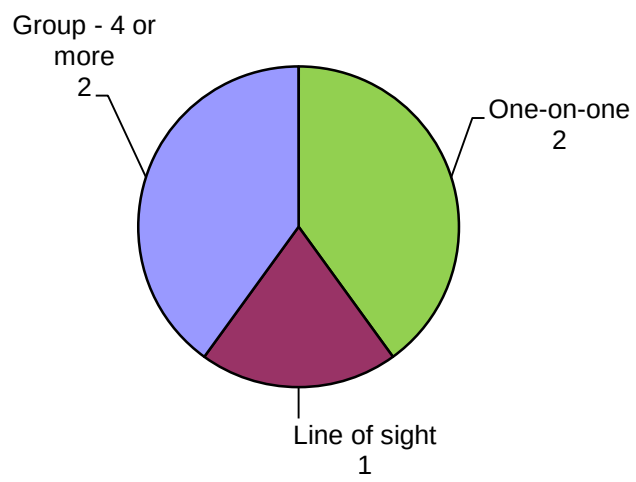
	2009	2010	2011	2012	2013	2014
Number of restraint and manual guidance incidents	3	6	4	8	4	5

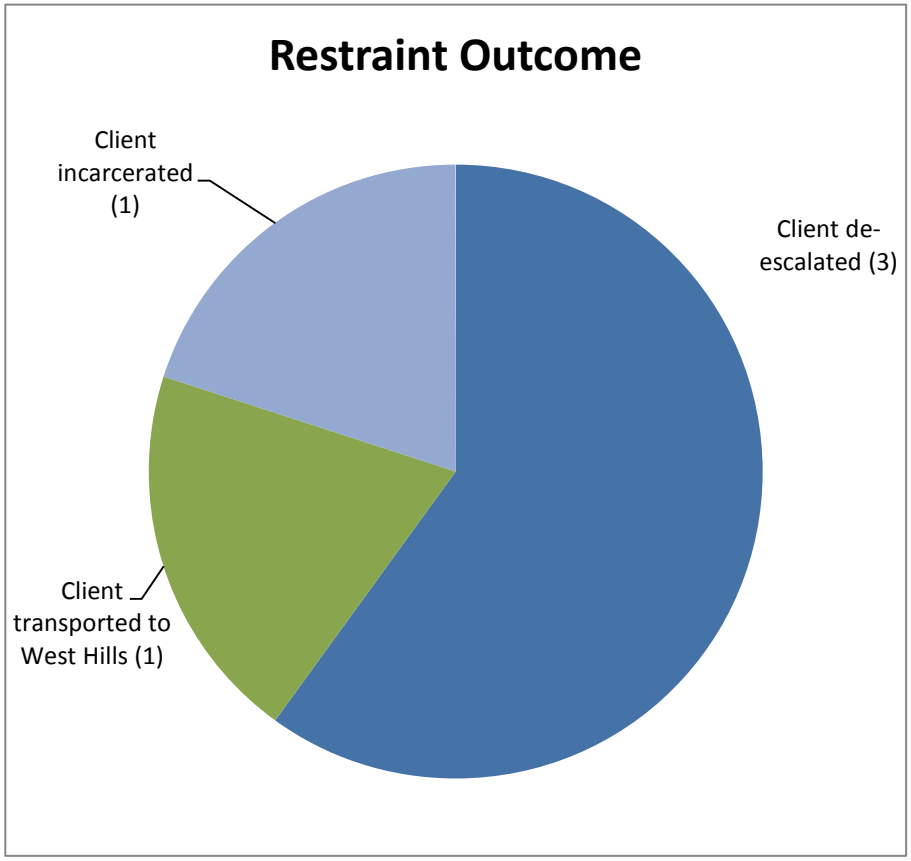
Restraint and Manual Guidance Event



Restraint and Manual Guidance (Continued)

Type of Supervision for Restraint and Manual Guidance





Departure Conditions

ATC reported 35 discharges in the 2014 reporting period.

Descriptive Information:

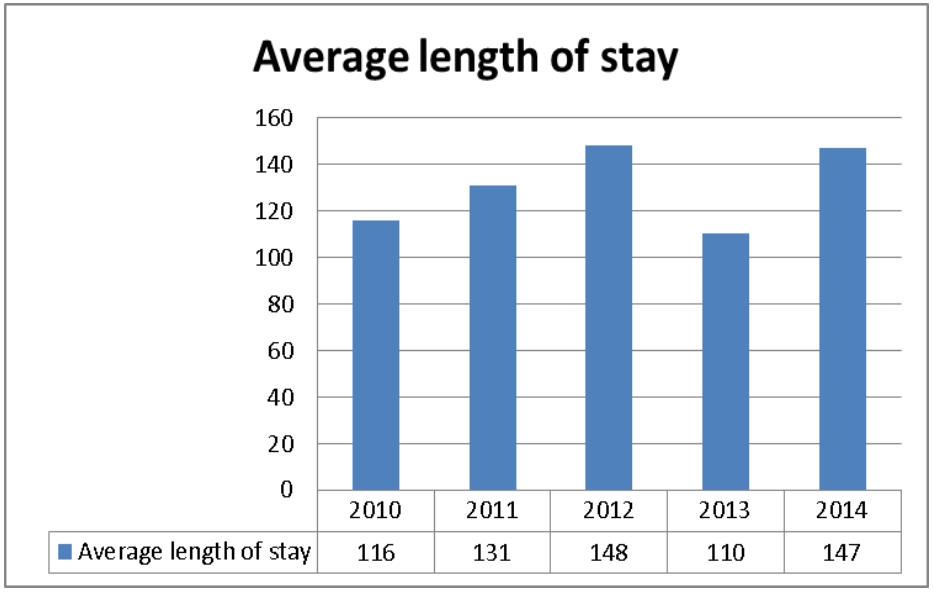
- 15 (42.86%) were female and 20 (57.14%) were male.
- Average age was 14.71 (range: 12 - 17 years)
- Race
  28 (80%) Caucasian 1 (2.86%) Asian
  4 (11.43%) African American
  2 (5.71%) Mixed
- 4 (11.43%) were Hispanic.
- Custody Status
  16 (45.71%) Parental Custody on Probation
  9 (25.71%) Child Welfare Custody
  5 (14.29%) DCFS Youth Parole Custody/Supervision
  5 (14.29%) Parental Custody and no Juvenile Probation involvement
- 32 (91.43%) were Medicaid recipients.
- The average length of stay at ATC was 147.83 days, ranging from 1 days to 288 days.
- 28 (80%) stayed more than 90 days.
- None continued services after discharge.

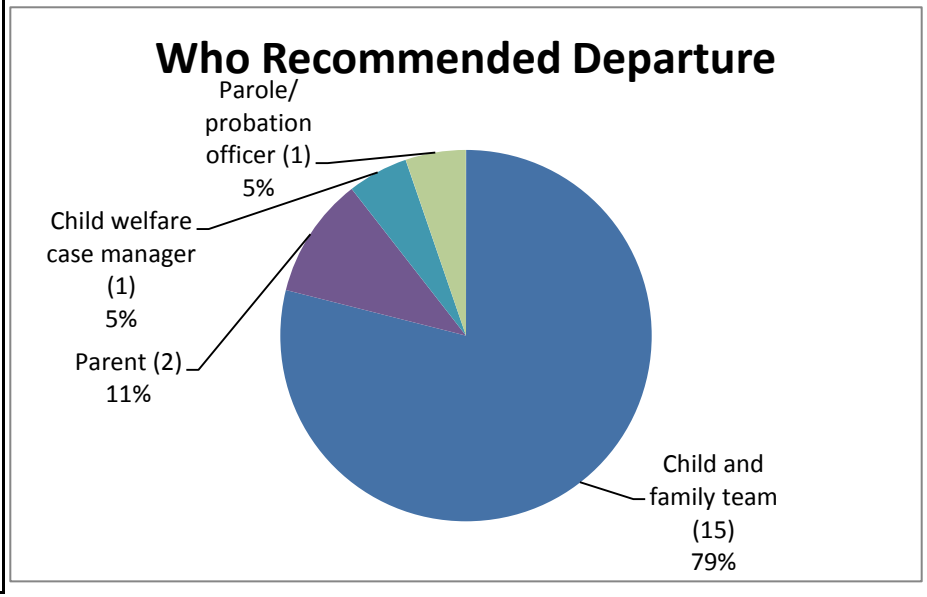
Clinical and Departure Information:

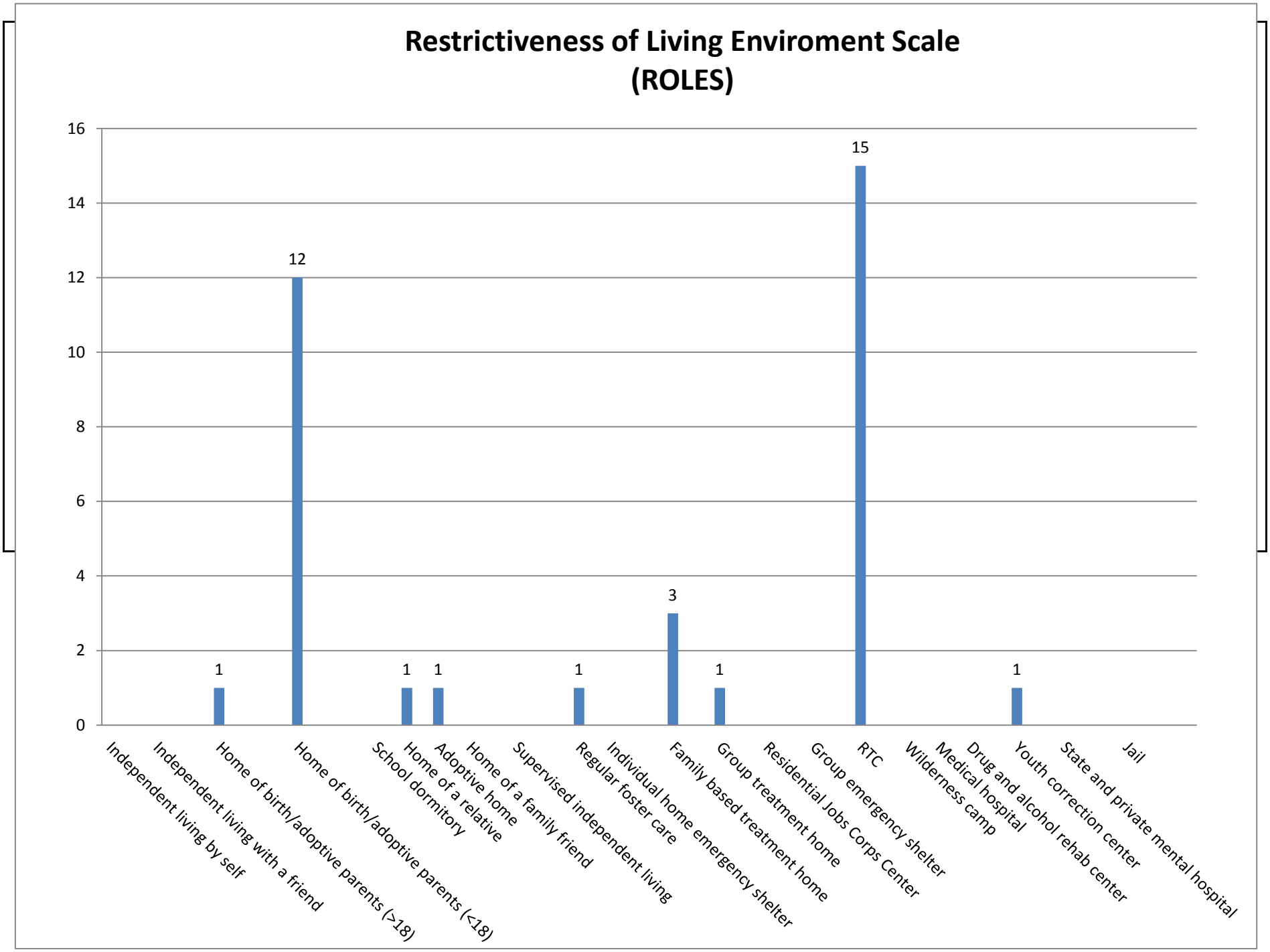
- Bipolar Disorder NOS (5 or 14.29 % of youth) was the most frequent diagnosis at admission followed by Mood Disorder NOS (4 or 11.43%) of youth).
- Missing (6 or 17.14% of youth) was the most frequent diagnosis at discharge followed by Bipolar Disorder NOS (4 or 11.43% of youth).
- The average CASII composite score at admission was 22.43.
- The average CASII composite score at discharge was 21.14.
- 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
2014	11.46	Indiv home emergency shelter
2013	10.11	Regular foster care
2012	8.6	Supervised independent living
2011	10.4	Regular foster care
2010	11.3	Specialized foster care

- In 2014, the ROLES score resulted in an average of 11.46, which equals the restrictiveness score of individual home emergency shelter.





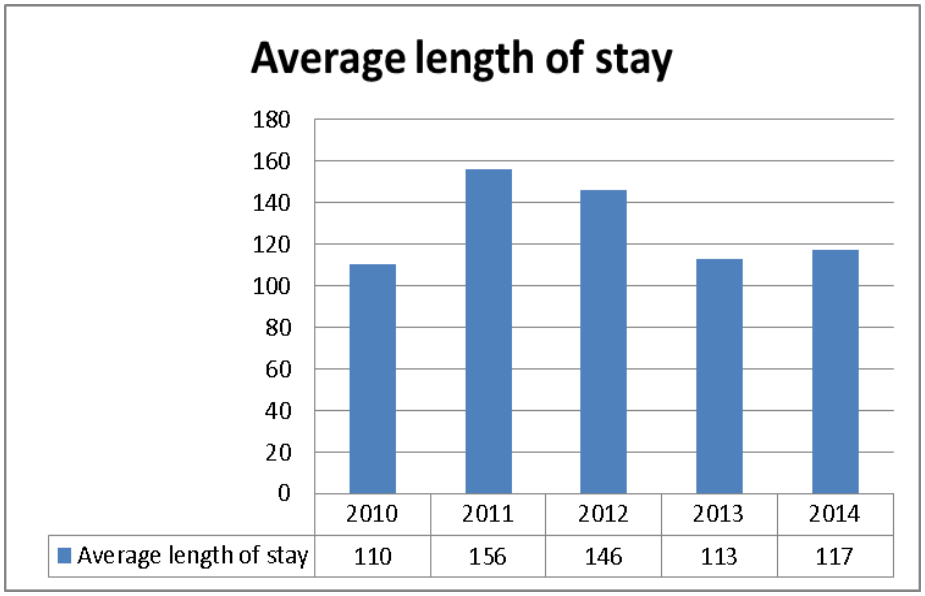

Restrictiveness of Living Enviroment Scale
(ROLES)
16
14
12
10
8
6
4
2
0
1
12
1
1
1
3
1
15
1
Independent living by self
Independent living with a friend
Home of birth/adoptive parents (>18)
Home of birth/adoptive parents (<18)
School dormitory
Home of a relative
Adoptive home
Home of a family friend
Supervised independent living
Regular foster care
Individual home emergency shelter
Family based treatment home
Group treatment home
Residential Jobs Corps Center
Group emergency shelter
RTC
Wilderness camp
Medical hospital
Drug and alcohol rehab center
Youth correction center
State and private mental hospital
Jail

Departure Conditions - Youth in Child Welfare Custody

Of the 35 discharges reported by ATC in the 2014 reporting period, 9 were in the custody of a public child welfare agency.

Descriptive Information:

- 7 (77.78%) were female and 2 (22.22%) were male.
- Average age was 15.78 (range: 14 - 17 years)
- Race
  6 (66.67%) Caucasian
  2 (22.22%) African American
  1 (11.11%) Mixed
- 1 (11.11%) was Hispanic.
- The average length of stay at ATC was 117.67 days, ranging from 6 days to 246 days.



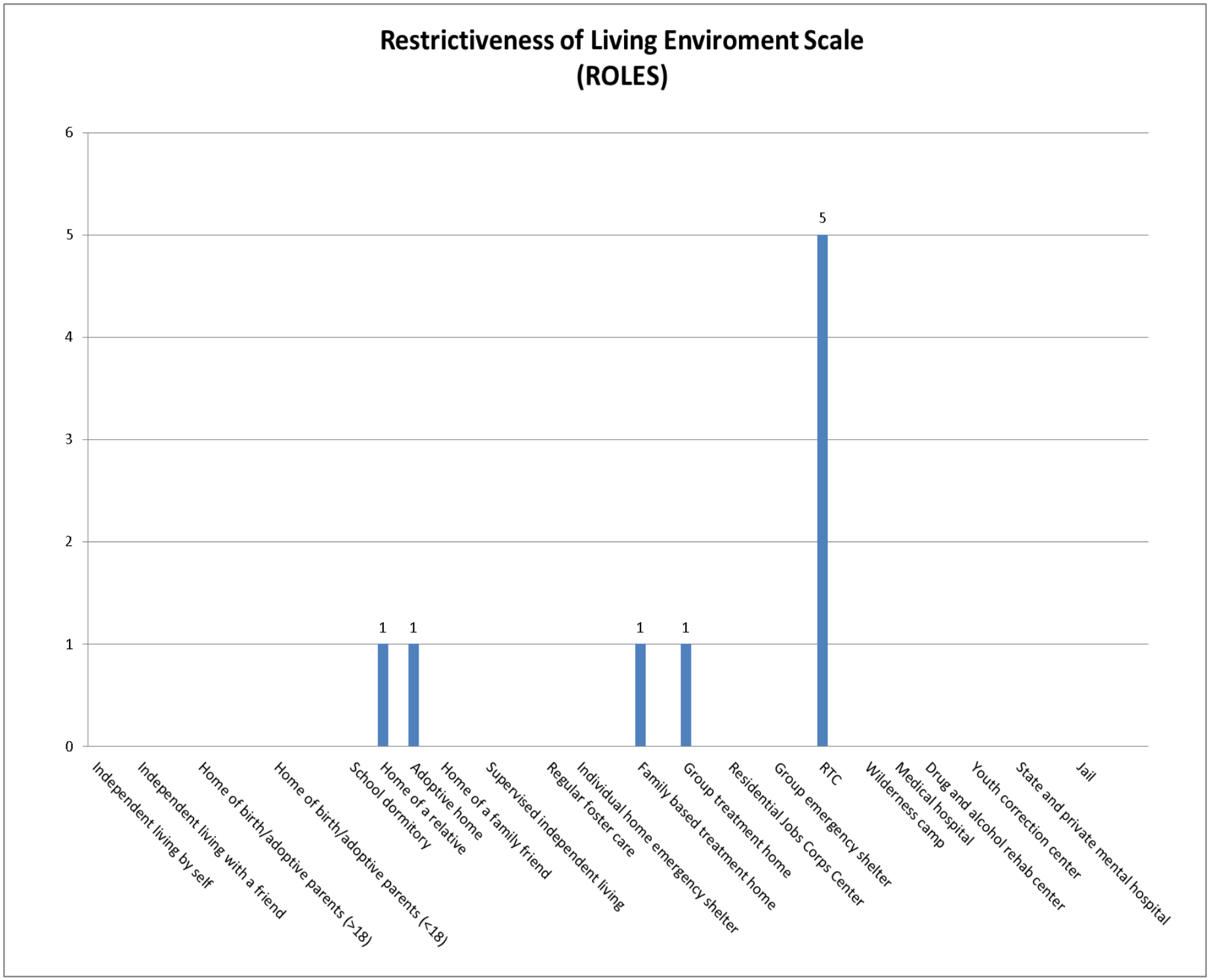
RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	ictiveness Score	Setting
2014	13.89	Group treatment home
2013	12.5	Family Based Treatment Home
2012	11.4	Regular Foster Care
2011	11.6	Specialized Foster Care
2010	12.9	Family Based Treatment Home

- In 2014, the ROLES score resulted in an average of 13.89, which equals the restrictiveness score of Group Treatment Home.
- Departure was determined by the child and family team in all cases.

Clinical and Departure Information:

- Bipolar Disorder NOS (3 or 33.33% of youth) was the most frequent diagnosis at admission followed by PTSD (2 or 22.22% of youth).
- Missing (3 or 33.33% of youth) was the most frequent diagnosis at discharge followed by PTSD (2 or 22.22% of youth).
- The average CASII composite score at admission was 22.67.
- The average CASII composite score at discharge was 21.83.
- 6 (66.67%) stayed more than 90 days.
- None continued services after discharge.
- All were in child welfare custody and had medicaid.

- 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 Enviroment Scale
(ROLES)
6
5
4
3
2
1
0
1
1
1
1
5
Independent living by self
Independent living with a friend
Home of birth/adoptive parents (>18)
Home of birth/adoptive parents (<18)
School dormitory
Home of a relative
Adoptive home
Home of a family friend
Supervised independent living
Regular foster care
Individual home emergency shelter
Family based treatment home
Group treatment home
Residential Jobs Corps Center
Group emergency shelter
RTC
Wilderness camp
Medical hospital
Drug and alcohol rehab center
Youth correction center
State and private mental hospital
Jail

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 two attempted suicides in the 2014 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:

- 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.

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.

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, 18 of the youth were placed in less restrictive settings.
- Most of the (31 or 88.57%) discharges were recommended by the Child and Family Team (CFT).

Children in Child Welfare Custody Highlights:

- Upon discharge, 3 of the youth returned to a less restrictive environment.
- Upon discharge, 2 of the youth reached permanency (i.e., discharge to the home of birth or adoptive parents or other relatives).
- Of the 9 departures for children in the custody of a child welfare agency all 9 or 100% were recommended by a CFT. In 2013, 100% of departures for children in the custody of a child welfare agency were also 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 2014, ATC did not complete any Trauma Informed Care training.

Summary

ATC submitted all of its 2014 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 2014 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 2014 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
2014 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 2014 report is the fifth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2014 through December 2014. Family Learning homes submitted a timely and complete data set in 2014. 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

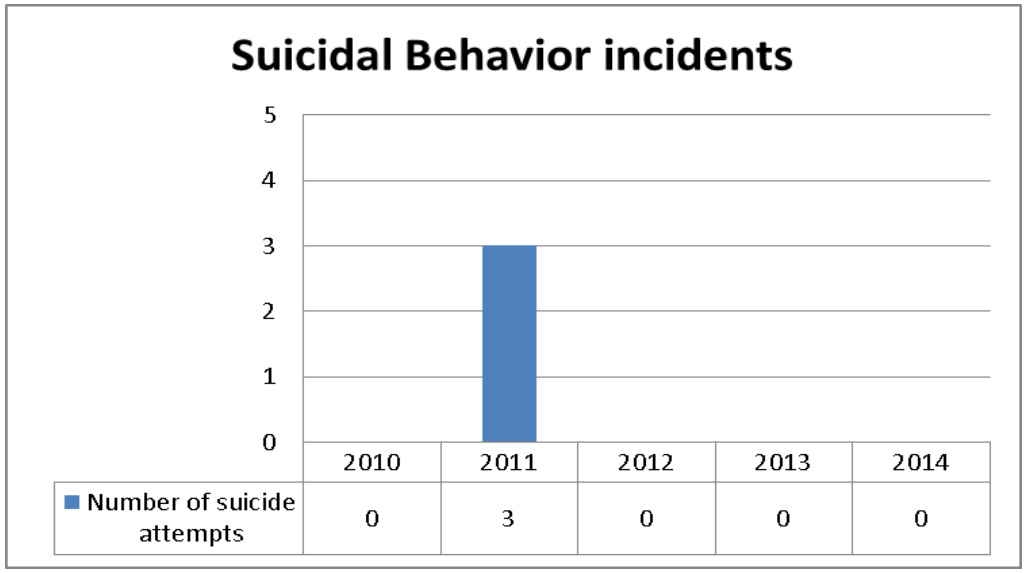
This report for Family Learning Homes is the analysis of risk measure and departure conditions data collected from January 2014 through December 2014. Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number 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	
2014	17.25 Range: 13 to 20	2014	20.42 Range: 18 to 23
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

Suicidal Behavior

There were no attempted or completed suicides during the 2014 reporting period.



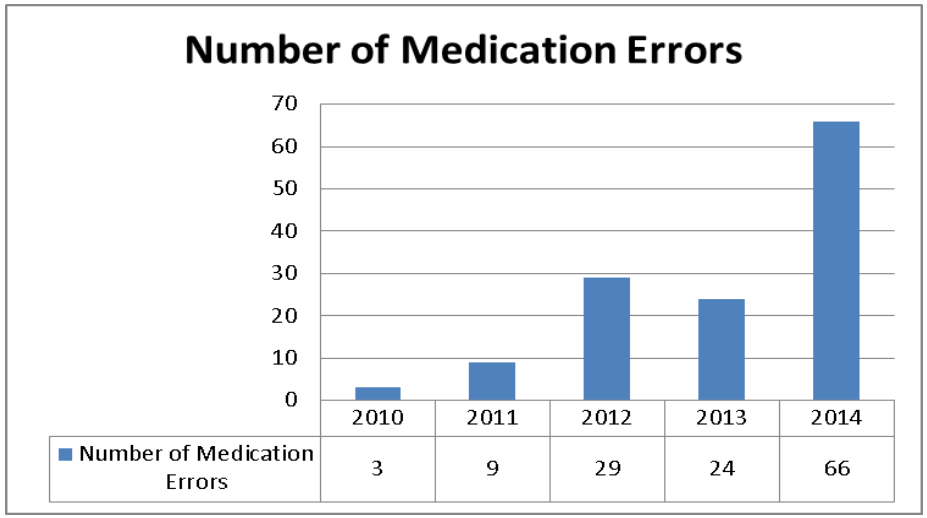
Medication Errors

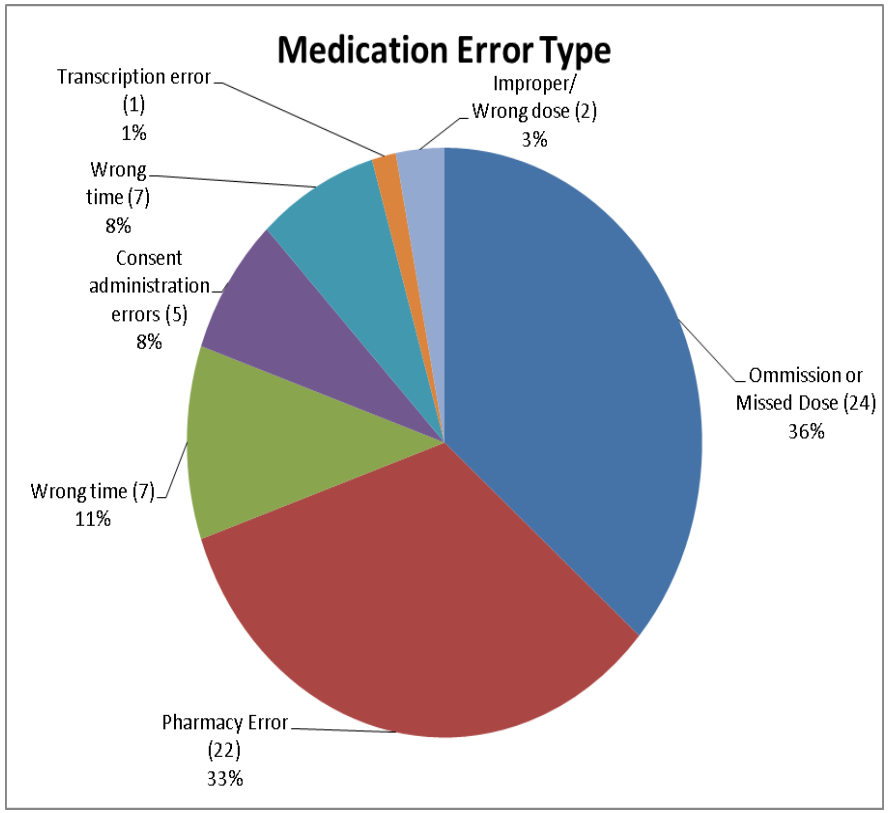
Medication Error Location

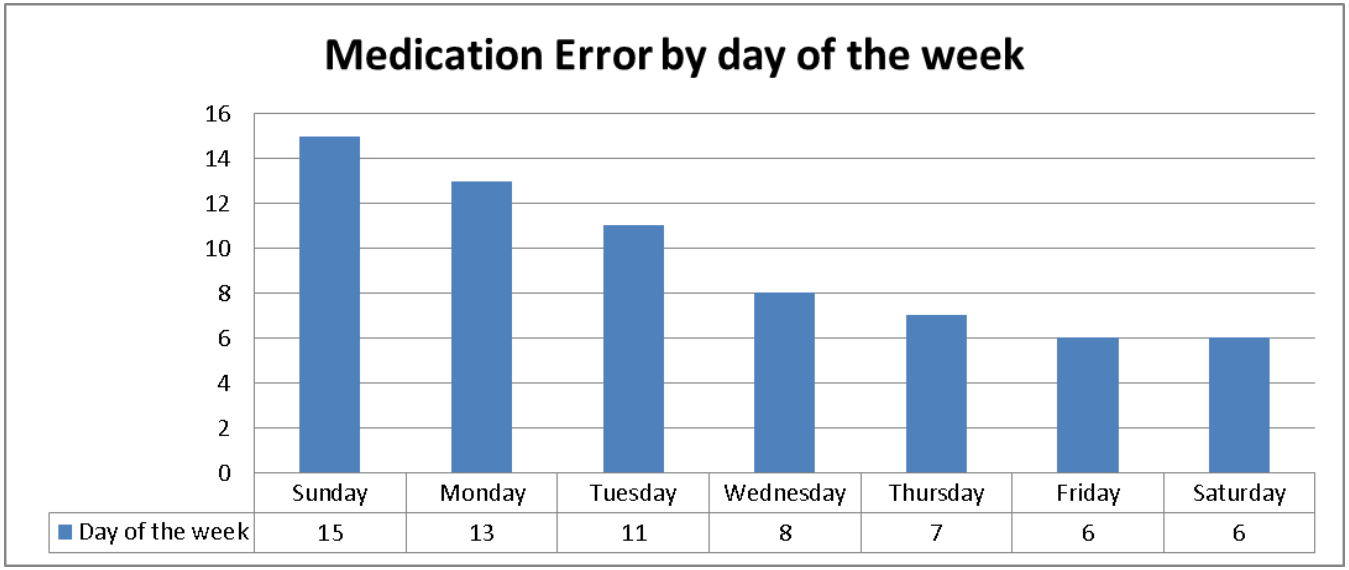
- 48 (72.73%) of the errors occurred in the home
- 13 (19.70%) of the errors occurred on a client pass
- 5 (7.58%) of the errors occurred on at school

Medication Error Type Information:

- 15 (22.73%) of the medication errors were with non-psychotropic medication.
- 46 (69.70%) of the medication errors were with psychotropic medication.
- 5 (7.58%) of the medication errors were with over the counter medication.







AWOL

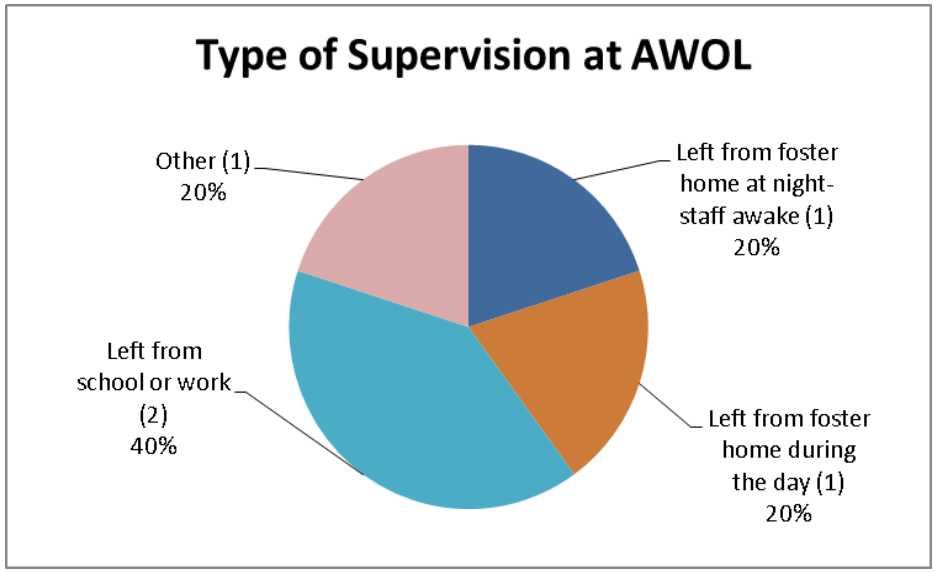
Descriptive Information:

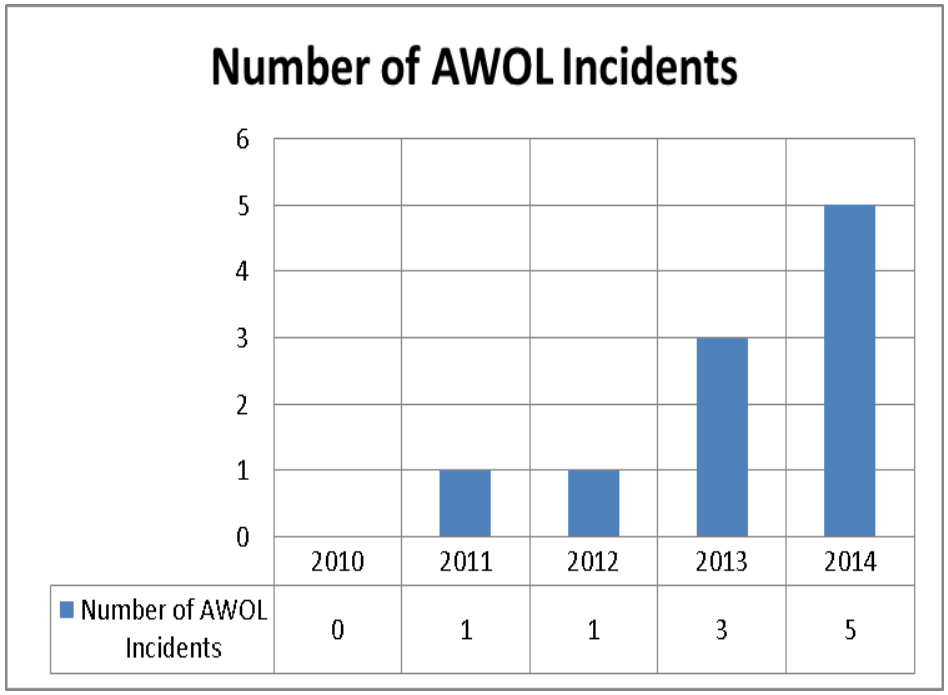
- 4 (80%) were female and 1 (20%) were male.
- Average age was 15.40 (range: 14 - 16 years)
- Race
  3 (60%) Caucasian 1 (20%) was Hispanic
  2 (40%) African American

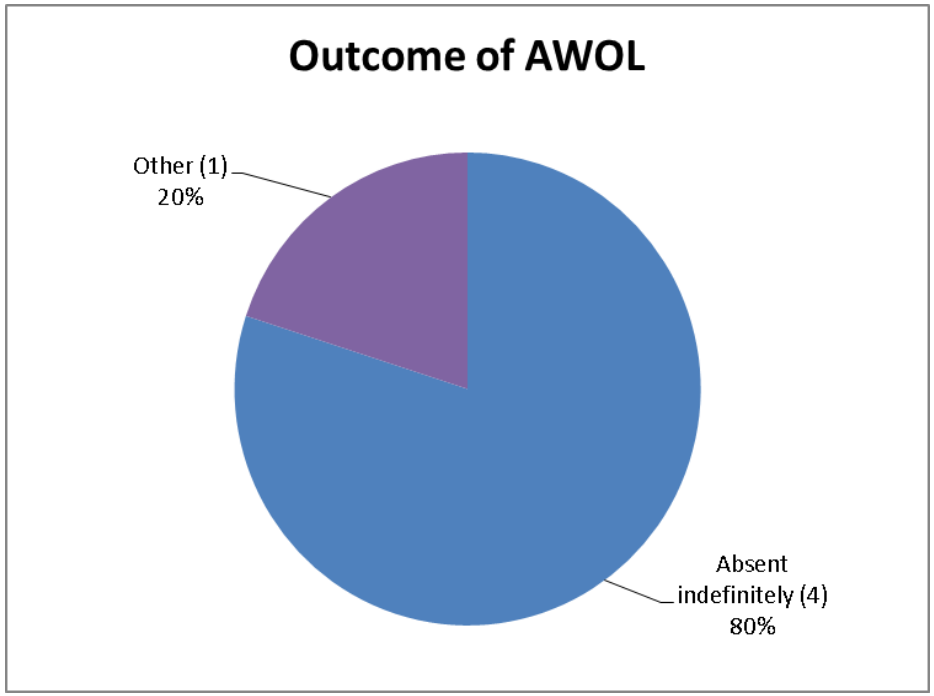
- Custody Status
  4 (80%) Child Welfare Custody
  1 (20%) Parental Custody on Probation

Clinical and AWOL Information:

- Mood Disorder NOS (2 or 40% of youth) was the most frequent diagnosis.
- 5.80 (range: 5 - 7) of days AWOL
- 5 (100%) of the youth had a history of AWOL.







Restraint and Manual Guidance

Descriptive Information:

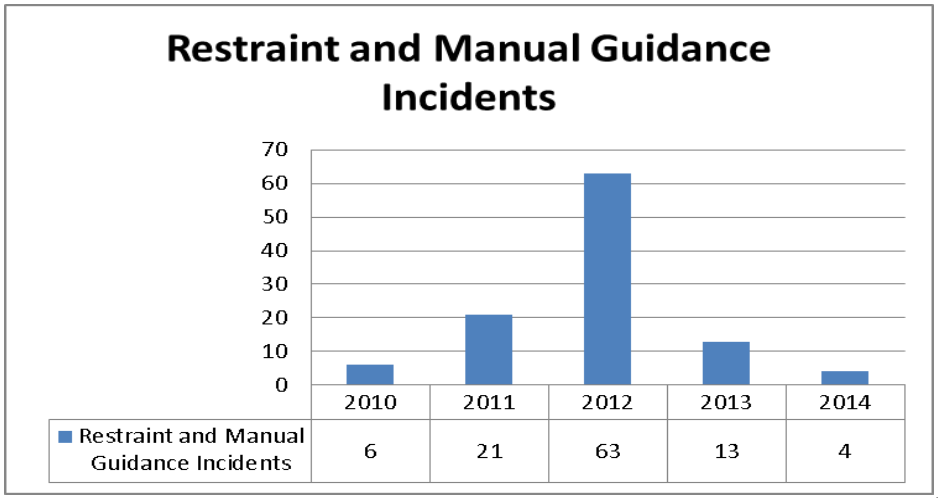
- All were male.
- Average age was 10.25 (range: 8- 12 years)
- Race
  1 (25%) Caucasian
  3 (75%) African American

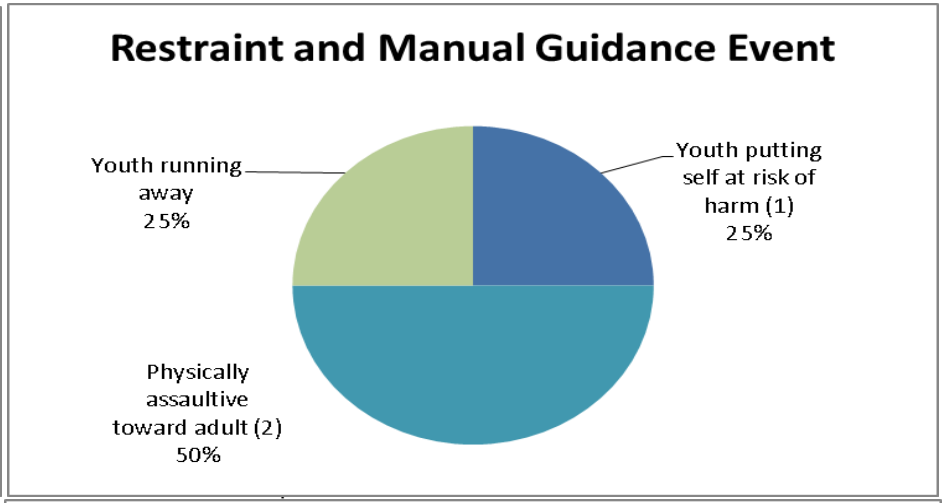
- None were Hispanic.

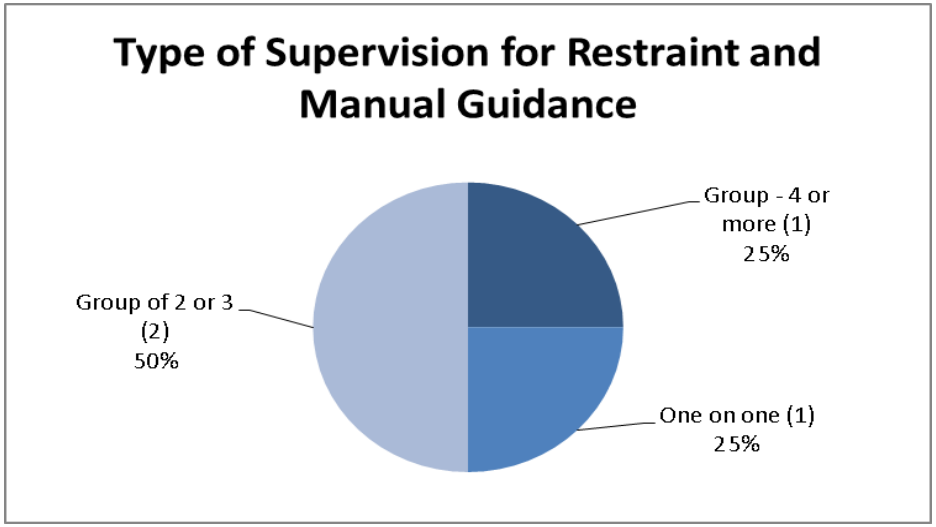
- Custody Status
  1 (25%) Child Welfare Custody
  3 (75%) Parental Custody on Probation

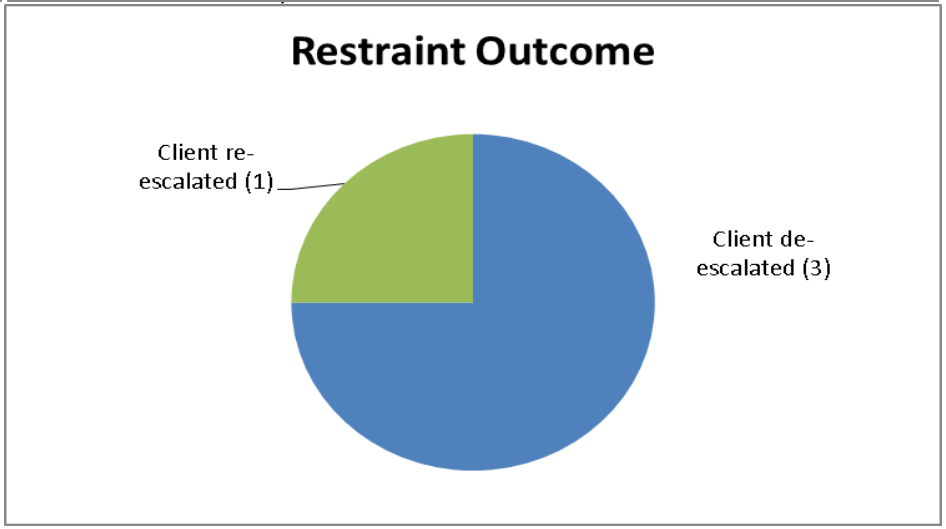
Clinical and Restraint and Manual Guidance Information:

- Mood Disorder NOS (2 or 50% of youth) was the most frequent diagnosis.
- 3 (75%) of the youth had a history of restraint and manual guidance
- A manual guidance was used during each restraint
- 8.50 (range: 1 - 16) average length of restraint in minutes
- Evening (3 or 75%) was the most common time for a restraint.
- All of the restraints included a debriefing.
- Encourage self timeout was the most common restraint intervention used for all of the incidents.
- Each restraint averaged a total of four interventions.









Departure Conditions

Family Learning Homes reported 40 discharges in the 2014 reporting period.

Descriptive Information:

- 15 (37.50%) were female and 25 (62.50%) were male.
- Average age was 12.53 (range: 6 - 18 years)
- Race
  34 (85%) Caucasian
  2 (5%) African American
  2 (5%) American Indian/Alaskan Native
  2 (5%) Mixed

- 9 (22.50%) were Hispanic.

- Custody Status
  19 (47.50%) Child Welfare Custody
  7 (17.50%) Parental Custody on Probation
  14 (35%) Parental Custody and no Juvenile Probation involvement

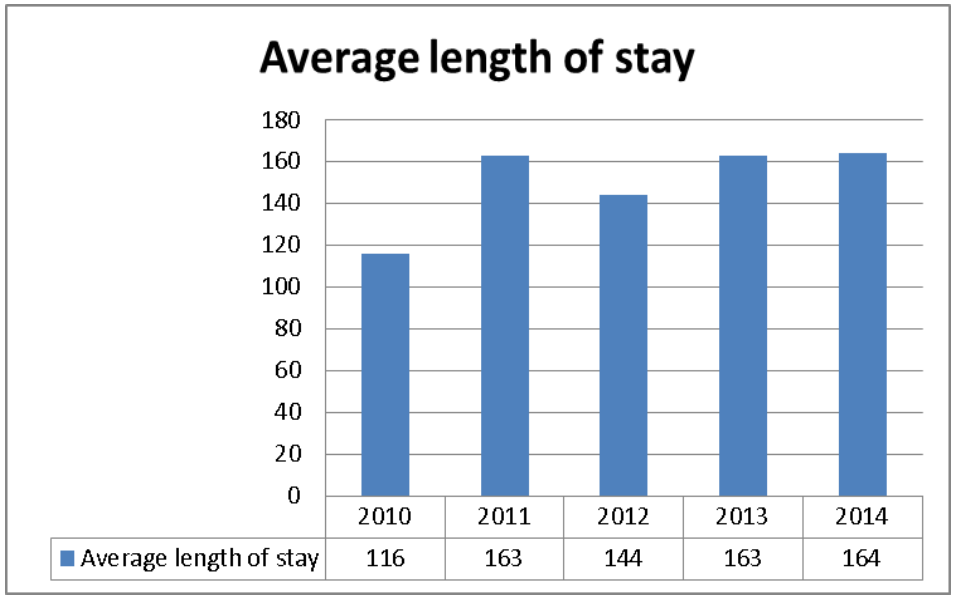
- 36 (90%) were Medicaid recipients.
- The average length of stay at Family Learning Homes was 164.73 days, ranging from 13 days to 273 days (0.75 years).

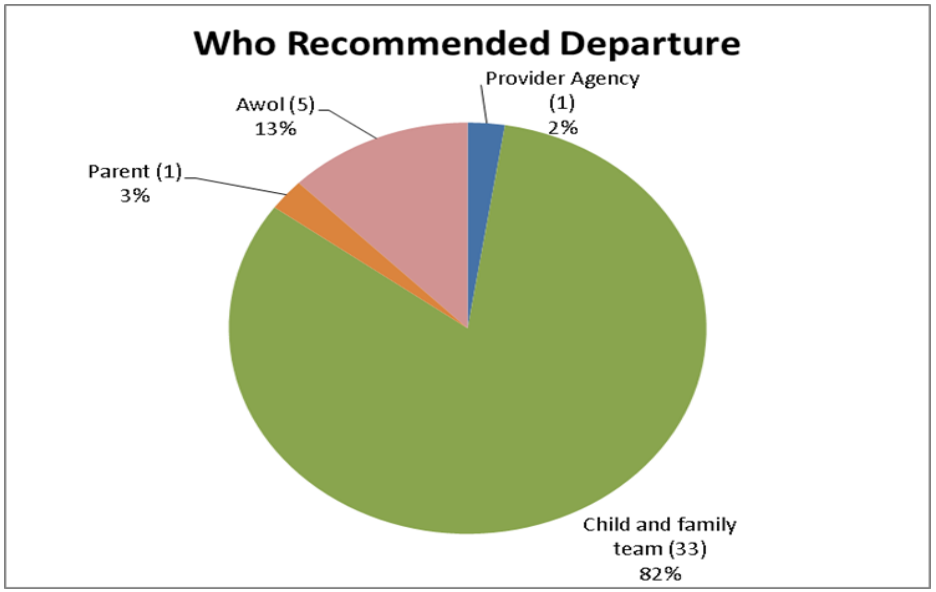
Clinical and Departure Information:

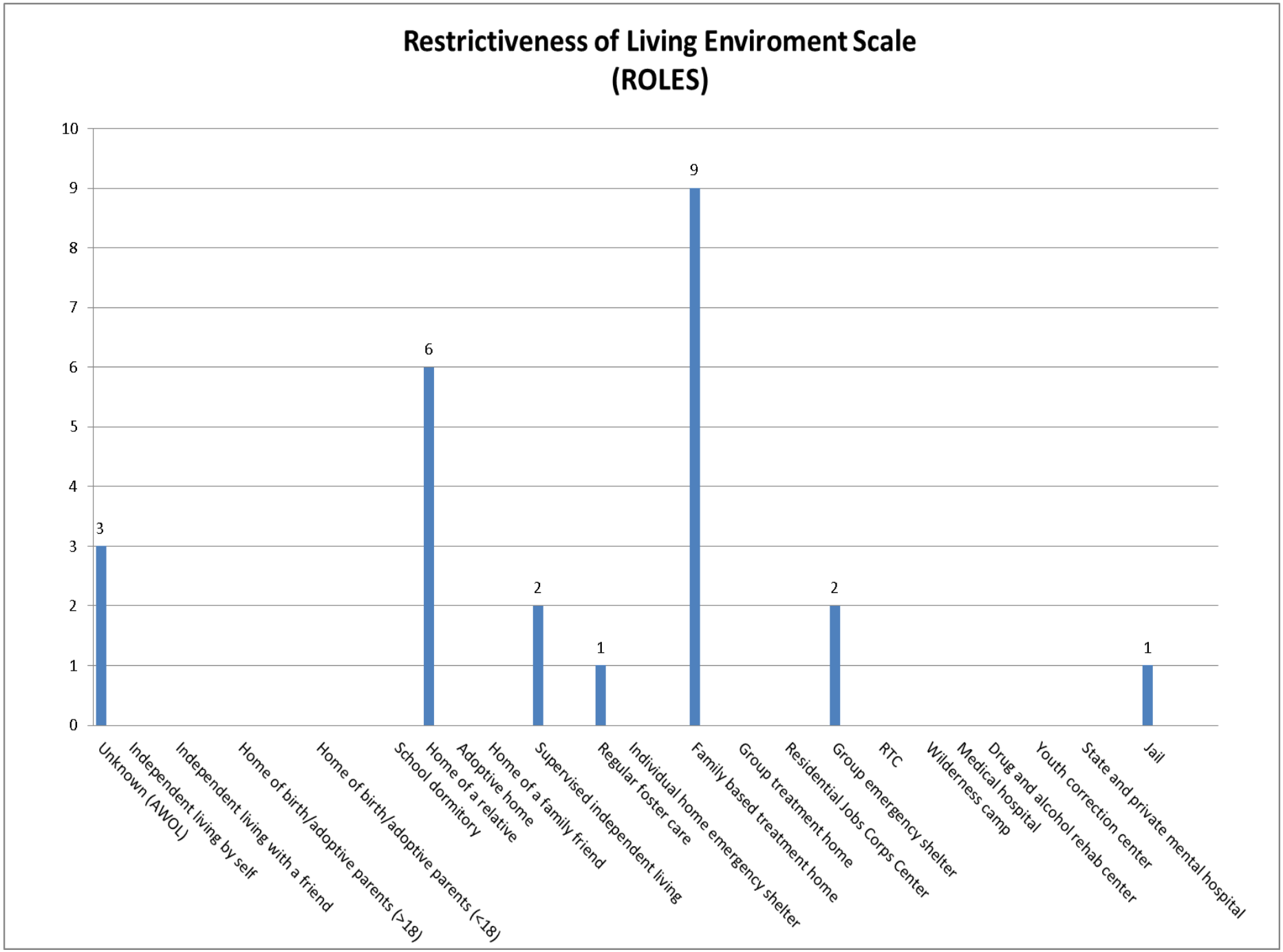
- PTSD (11 or 27.50% of youth) was the most frequent diagnosis at admission followed by Bipolar Disorder NOS (6 or 15% of youth).
- PTSD (8 or 20% of youth) was the most frequent diagnosis at discharge followed by Bipolar Disorder NOS (8 or 20% of youth).
- The average CASII composite score at admission was 22.90.
- The average CASII composite score at discharge was 20.60.
- 36 (90%) stayed more than 90 days.
- 20 (50%) continued services after discharge.
- 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
2014	8.16	Home of a family friend
2013	8.6	Supervised independent living
2012	9.74	Regular foster care
2011	6.6	Adoptive Home
2010	11.3	Specialized foster care

- In 2014, the ROLES score resulted in an average of 8.16, which equals the restrictiveness score of home of a family friend.






Restrictiveness of Living Enviroment Scale
(ROLES)
10
9
8
7
6
5
4
3
2
1
0
3
6
2
1
9
2
1
Unknown (AWOL)
Independent living by self
Independent living with a friend
Home of birth/adoptive parents (>18)
Home of birth/adoptive parents (<18)
School dormitory
Home of a relative
Adoptive home
Home of a family friend
Supervised independent living
Regular foster care
Individual home emergency shelter
Family based treatment home
Group treatment home
Residential Jobs Corps Center
Group emergency shelter
RTC
Wilderness camp
Medical hospital
Drug and alcohol rehab center
Youth correction center
State and private mental hospital
Jail

Departure Conditions - Youth in Child Welfare Custody

Of the 40 discharges reported by Family Learning Homes in the 2014 reporting period, 19 (47%) were in the custody of a public child welfare agency.

Descriptive Information:

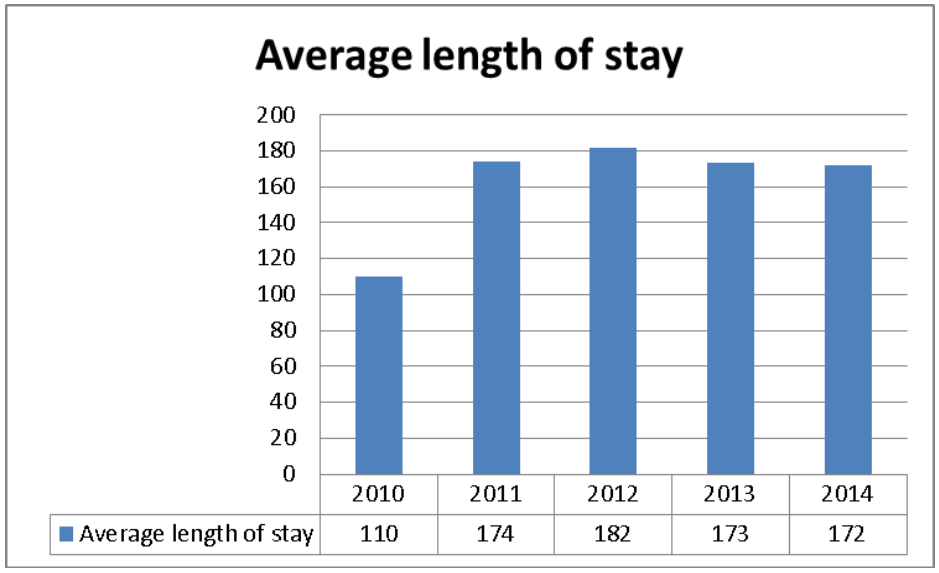
- 13 (68.42%) were female and 6 (31.58%) were male.
- Average age was 12.26 (range: 6 - 18 years)
- Race
  17 (89.47%) Caucasian 2 (10.53%) American Indian/Alaskan Native
- 5 (26.32%) were Hispanic.
- The average length of stay at Family Learning Homes was 171.74 days, ranging from 21 days to 273 days (0.75 years).

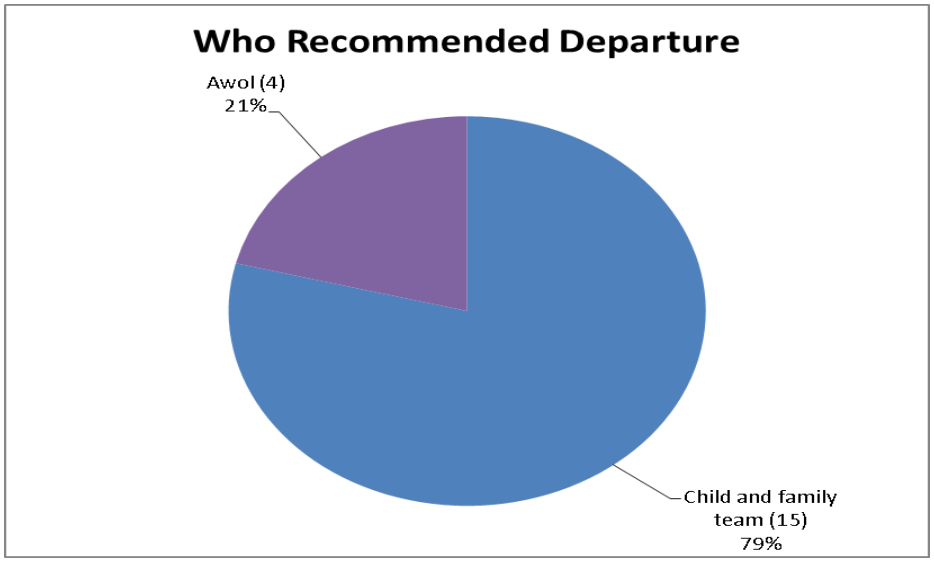
Clinical and Departure Information:

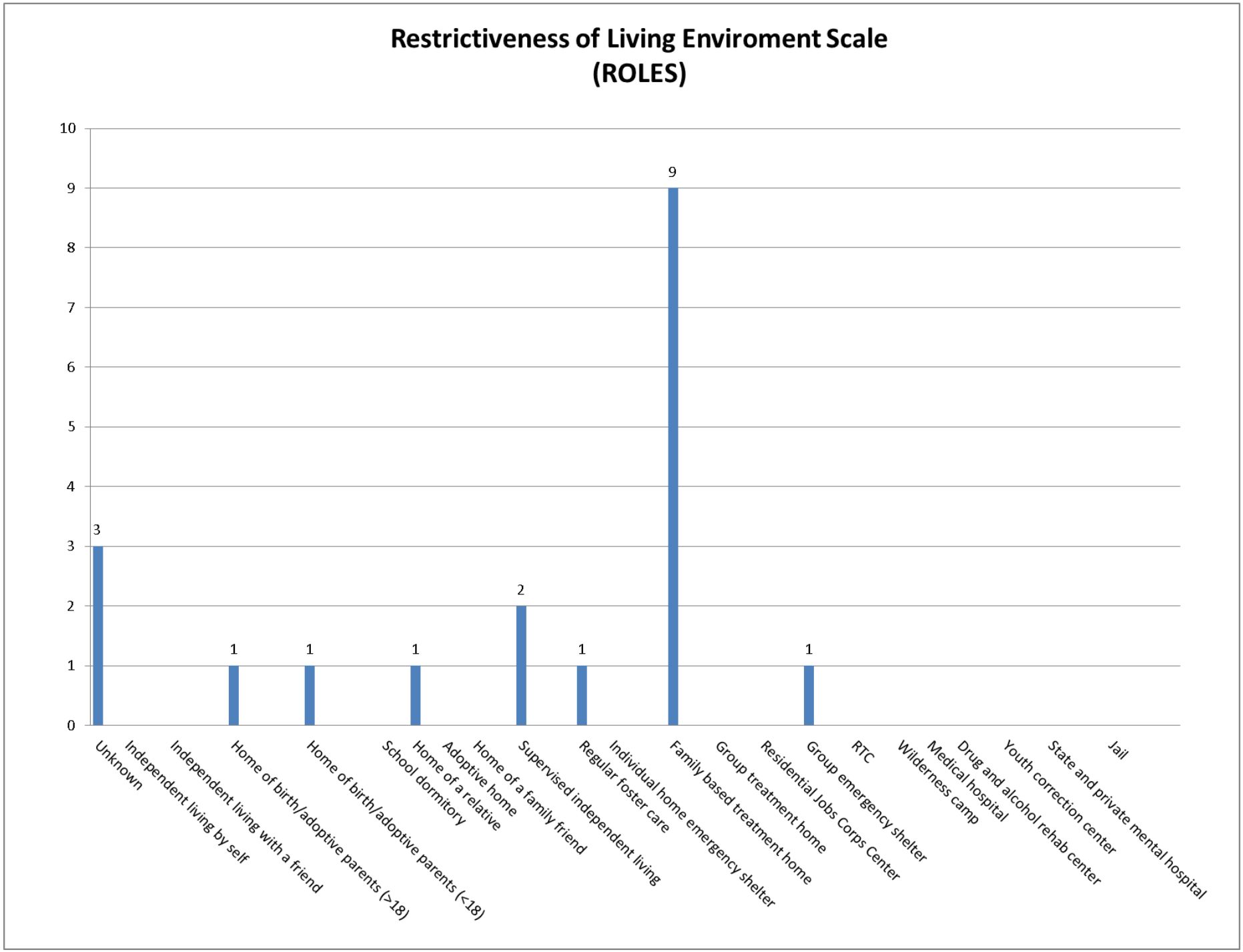
- PTSD (9 or 47.37% of youth) was the most frequent diagnosis at admission followed by ADHD NOS (1 or 5.26% of youth).
- PTSD (7 or 36.84% of youth) was the most frequent diagnosis at discharge followed by ADHD NOS (4 or 21.05% of youth).
- The average CASII composite score at admission was 22.63.
- The average CASII composite score at discharge was 21.32.
- 17 (89.47%) stayed more than 90 days.
- 7 (36.84%) continued services after discharge.
- All were in child welfare custody and had medicaid.

RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)		
Reporting Period	Restrictiveness Score	Setting
2014	10.94	Specialized foster care
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 2014, the ROLES score resulted in an average of 10.94, which equals the restrictiveness score of Specialized foster care.
- 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 Enviroment Scale
(ROLES)
10
9
8
7
6
5
4
3
2
1
0
3
1
1
1
2
1
9
1
Unknown
Independent living by self
Independent living with a friend
Home of birth/adoptive parents (>18)
Home of birth/adoptive parents (<18)
School dormitory
Home of a relative
Adoptive home
Home of a family friend
Supervised independent living
Regular foster care
Individual home emergency shelter
Family based treatment home
Group treatment home
Residential Jobs Corps Center
Group emergency shelter
RTC
Wilderness camp
Medical hospital
Drug and alcohol rehab center
Youth correction center
State and private mental hospital
Jail

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.

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

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:

- 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.
- 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.

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 number of restraints has declined significantly this year as compared to last year.
- There were no reported injuries to youth, peers or staff during any of the restraint incidents.

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, 25 of the youth were placed in less restrictive settings.

Children in Child Welfare Custody Highlights:

- Upon discharge, 6 of 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 19 departures for children in the custody of a child welfare agency 15 or 78.95% were recommended by a CFT. In 2013, 18 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:

- Only 15 of the departures for children in the custody of a child welfare agency were recommended by a CFT. In 2013, 18 of departures for children in the custody of a child welfare agency were recommended by a CFT. CFTs are the best venue to determine changes to a child's treatment plan and placement. This format is not only best practice, but it is also a Medicaid reimbursement requirement for children placed in specialized foster care. Providers should consider convening or requesting a CFT whenever consideration is given to changing a youth's treatment plan.
- During the pre-placement process, a placement preparation plan should be developed by the CFT which addresses the child's emotional, psychological, developmental, and relationship connectedness needs to support placement stability.
- Focus on supporting placement stability, facilitating permanency, and minimizing the trauma of separation and loss by providing for pre-placement visitation whenever possible as this best practice helps to diminish fears and worries of the unknown, helps with the transfer of attachments, helps to initiate the grieving process, helps to empower the new caregivers/staff and, helps the youth in making commitments for the future (Falhberg, 1991).
- During the pre-placement process, an assessment of the child's previous placement history should be conducted by the CFT to determine the trauma risk factors and the provider's ability to address these factors in facilitating new attachments and relationships in the specialized foster care home.
- Ensure staff and treatment parents receive training in trauma informed care. By recognizing the impact of trauma on children's lives or viewing behaviors through the "lens" of their traumatic experiences, their behaviors begin to make more sense (Grillo and Lott, 2010). Using an understanding of trauma as a foundation, the CFT can then formulate effective strategies to address challenging behaviors and help children develop new, more positive coping skills.

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, Family Learning Homes did not complete any Trauma Informed Care training.

Summary

Family Learning homes submitted all of its 2014 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 2014 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of AWOL's medication errors, restraints and departure conditions.
In partnership with the Provider Support Team, the Planning and Evaluation Unit has prioritized areas for program improvement and has developed action steps for implementation of some program improvement initiatives. For example, the PEU has developed and distributed policy implementation and review tools for medication management, crisis triage, structured therapeutic environment, discipline, restraint and use of force, privacy and confidentiality and dispute resolution. The PEU would encourage the provider's use of these tools to assist in developing their own program improvement planning to address some of the areas identified in their 2014 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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