**MEDICAID REPORT 2016**
**DCFS PERFORMANCE AND QUALITY IMPROVEMENT**
**2015 SUMMARY**

# DCFS 2016 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 2015 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, 2016.

## 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 (Southern Nevada) | Mobile Crisis Response Team (Northern Nevada) |
| *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) | |

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## 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:

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| 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 2835 children served by the DCFS Children's Mental Health Services in Fiscal Year 2015 (July 1, 2014 through June 30, 2015). Demographic descriptors and assessment information were systematically documented in portraying the children and youth in our care.

Of the 2835 children served by DCFS programs, 2033 (71.7%) received services in Clark County and 802(28.2%) were served in Washoe County/Rural.

Of all children served, 43.0% were 13 years of age or older and 51.3% were male. Caucasian children accounted for 75.2% of all those served and African-American children 19.9%. Children of Hispanic origin came to 34.3%.

In FY15, 58.9% of the children admitted to mental health services statewide were in the custody of their parent or family, 39% were in Child Welfare custody, 1.3% were in the custody of their parent or family and on probation, and 0.7% were in Youth Parole custody.

The complete report can be found in the appended DCFS Descriptive Summary of Children's Mental Health Services SFY15. (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 May 4 through June 26 (Spring) of 2015. In the survey, four Neighborhood Family Service Center sites were polled in Las Vegas and two in Reno. Previously there were five sites in Las Vegas but the Central site merged with the West site since last report. Responding to the survey were 362 parents/caregivers and 201 youth. Results of the Spring parent/caregiver and youth surveys are 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 2015 report. (Attachment C).

## Residential and Psychiatric Inpatient Services

DCFS residential programs, Desert Willow Treatment Center (DWTC), the Oasis On-Campus Treatment Homes (Oasis), the Adolescent Treatment Center (ATC), and Family Learning Homes (FLH) 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 2015 report. (Attachment D).

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

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

- The Oasis program received 60% or below positive response on the item related to "My child is better at handling daily life." This was the parent's perception, youth responses were 100% positive for this item. Additionally, only 60% of parents surveyed responded positively concerning improvement in their own ability to handle their family's issues. In order to address these items, the parent management training program Family Check Up and Everyday Parenting will be implemented when appropriate. This program is shown to improve family functioning, parenting skills, monitoring, as well as improve relationships.

- Regarding the Family Learning Homes, 59% of parents responded that they were satisfied with their family life. 88% of youth responded positively. FLH staff will begin to utilize the Family Check Up model when appropriate, with the goal of

fostering the parent/child relationship and will place an emphasis on positive relationship building and maintenance during their parent training sessions. FLH direct care staff and case managers will address healthy and positive family life, and strategies to maintain and develop this during Child and Family Team meetings.

- Parents who had youth at the Adolescent Treatment Center (ATC) were below the threshold for positive responses concerning their child's ability to get along better with others compared to 77% positive responses for youth. To address this, ATC direct care staff and clinicians will focus on developing and maintaining relationships in their interactions with youth. ATC clinicians will place an emphasis during sessions and Child and Family Team Meetings on fostering positive relationships and will utilize the Family Check Up model when appropriate, with the goal of fostering the parent/child relationship.

## 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 E, F and G).

## Supervisor Checklists
[Plan Domain(s): I, III]

The two DCFS/PEU developed service-specific case review checklists are used to help guide 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 integrated the supervisor checklists into Avatar, the DCFS Children's Mental Health management information system, when fully functional it would populate the checklist as items were completed and 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. That workgroup no longer meets formally however managers continue to develop policies and a business process for supervisor use of the checklists. The checklists are utilized by the Planning and Evaluation Unit to conduct periodic audits in Avatar as well as data found in the paper files of clinical staff. As a result of these audits by PEU and 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 2015, DWTC served 203 children in its acute care programs and 95 children in its residential programs. Under the leadership of Nancy Sirkin, LMFT, DWTC 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 the Bureau of Health Care Quality and Compliance (HCQC) under the Nevada State Health Division. 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 nursing positions who review Medication Administration Records on a monthly basis. DCFS/PEU conducts reviews on a regular basis. 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. The Oasis nurse position is currently vacant but recruitment is taking place. PEU has been doing reviews in the meantime.

## 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 were previously 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. Concerns were expressed that numerous exceptions and filters were resulting in a fairly low percentage of the data actually being picked up in the reports. Over the next few months the Planning and Evaluation Unit will be re-evaluating what changes need to be made to the reports to address these concerns as well as any additional reports as a result of DCFS Children's Mental Health receiving a grant from SAMHSA allowing for expansion of the system of care for Nevada's children.

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 has assisted 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. For 2015 team meetings observed were all found to

be individualized and strength based. Out of the ten elements of the model, the area continuing to be a challenge is the incorporation of natural and community supports as part of the team and wraparound plan. In 2015, 9 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 periodically attend 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 once staff are trained to utilize it.

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, and adding cameras at Oasis to further increase accountability and safety for residents and staff. DCFS/PEU also conducts a debriefing session following a seclusion and restraint.

## Additional Program Evaluation Unit Activities

Substance Abuse and Mental Health Services Administration: Mental Health Block Grant and Nevada System of Care for Youth with SED Expansion 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 integrated the mental health and substance abuse services Block Grant application for 2016-2017. The joint Block Grant application and plan increases accountability for funds and outcomes. Beginning in March 2015, DCFS collaborated with SAPTA and the Division of Public and Behavioral Health to plan to submit this application which

was due in September. 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. States also 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. The Comprehensive Uniform Mental Health Assessment (CUMHA) was revised to include more detailed information including client level data measures that will be reported to SAMHSA for the block grant and the system of care expansion grant. DCFS received the expansion grant in September 2015 and is working with community partners and consortia members to develop a strategic plan and a communication plan. Further information will be provided in subsequent reports.

## 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 provide 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 took place to alert staff to changes in the diagnostic classifications with the advent of DSM-V.

[Plan Domain: I]

Mobile Crisis Response Team

The Mobile Crisis Response Team (MCRT) serves 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. 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. 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. In FY2015 the State of Nevada MCRT had an 85% hospital diversion rate, spending the majority of its time and resources on maintaining youth safely in their homes and communities. PEU has a Psychologist primarily dedicated to evaluating this program and providing clinical consultation. Results from recent evaluations indicate that 60 to 90 days post-discharge from mobile crisis services, only 1 out of 10 youth have visited an Emergency Department for mental health reasons and only 1 out of 10 have been admitted to a psychiatric hospital, while 6 out of 10 youth continue to receive long-term mental health services.

## 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. Addressing secondary trauma as well as increasing understanding around trauma informed care are both components of the system of care expansion grant.

## Family Management Program

DCFS/PEU along with clinical staff continue to implement 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. Implementation has been challenging due to technical concerns with the required upload of recorded sessions to a web portal, concerns regarding additional paperwork requirements, as well as difficulties finding families to participate and staff who were trained leaving DCFS for other endeavors or relocating. To address these challenges, the model's developers are offering eLearning and additional online support, have simplified the required paperwork as well as the web portal, and are coming to Reno as well as Las Vegas in February 2016 in order to offer refresher training and support. Requirements for certification have also been simplified and refined.

## 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 particularly as part of the system of care expansion and providing training for the community in evidence based practices.

## Assistance to Other DCFS Programs

DCFS/PEU has been providing support and consultation to other DCFS entities such as DCFS Youth Parole and DCFS Child Welfare. Staff from PEU have been designing and evaluating the implementation of a therapeutic foster care program in Washoe County and Rural Nevada since 2013. Clients in this program, Together Facing the Challenge, have had positive outcomes, including improvements in their functioning, fewer hospitalizations and placement changes. During the last legislative session, it was determined that the program would be implemented statewide and DCFS would have oversight as well as continue to conduct the evaluation of the program. In rural Nevada PEU staff are still implementing the program until additional staff can be hired and trained by Child Welfare.

DCFS/PEU has provided staff for debriefings of critical incidents in DCFS Child Welfare as well as Washoe County and were available to assist school staff in Reno following youth suicides.

DCFS/PEU staff have most recently assisted Youth Parole in programming for Summit View and will conduct evaluation and quality assurance at that facility when it opens. PEU staff have also assisted in training the staff from Children's Cabinet who are implementing the First Episode Psychosis (ENLIVEN) program.

A DCFS/PEU staff has recently assumed the role of the Division's HIPAA Privacy and Compliance Officer and participates in Department meetings related to HIPAA.

## 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 2016 DCFS Performance and Quality Improvement 2015 Summary and are pleased to submit it on behalf of all of our dedicated DCFS Children's Mental Health Services program managers and staff.

Approved by:

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| _____ | _____ |
| Katherine Mayhew, Clinical Program Planner 3<br>Planning and Evaluation Unit, DCFS | Date |
| _____ | _____ |
| Kelly Wooldridge, Deputy Administrator<br>Children's Mental Health, DCFS | Date |
| _____ | _____ |
| Nabil Jouni, M.D.<br>Medical Director, Southern Nevada Child<br>and Adolescent Services, DCFS | Date |
| _____ | _____ |
| Darryl McClintock, M.D.<br>Medical Director, Northern Nevada Child<br>and Adolescent Services, DCFS | Date |
| _____ | _____ |
| Jane Gruner, Acting Administrator<br>Division of Child and Family Services | Date |

**MEDICAID REPORT 2016**
**DCFS PERFORMANCE AND QUALITY IMPROVEMENT**
**2015 SUMMARY**

# ATTACHMENT INDEX

# ATTACHMENT A

DCFS Children's Mental Health Services
Performance and Quality Improvement Plan
2016-2017

DIVISION OF CHILD AND FAMILY SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
PERFORMANCE AND QUALITY IMPROVEMENT PLAN: 2016-17

## PURPOSE

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

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

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:

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| **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. |

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| **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, and cultural sensitivity, adequacy of education, social connectedness, and positive treatment outcomes.<br>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<br>**SC 1.1.2** Compile, analyze and report to Commission data collected regarding CMHS Seclusion and Restraint Denial of Rights. Develop strategies to decrease the use of seclusion and restraint in facilities. |
| | **SC 1.2** Provide support to the Division's administrators (i.e., | **SC 1.2.1** Work together with the Statewide Children's Mental |

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| | Administrator, Deputy Administrator, program managers and supervisors) with PQI initiatives, reports, data, and other requests. | Health Managers to develop and implement a plan for quality assurance, quality improvement and program evaluation.<br>**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.<br>**SC 1.2.3** Work together with identified program area personnel in designing PQI processes for addressing selected areas found in need of remediation.<br>**SC 1.2.4** Work with identified program area personnel in developing agreed upon plan for re-assessment of remediated areas.<br>**SC 1.2.5** Be available to the Deputy Administrator to respond to Legislative requests for data<br>**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 and will be reflect Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care values and principles. |

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| **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<br>**SC 3.1.2** In accordance with Consumer Complaint Policy and Procedures, PEU develops and maintains a database for Complaint/Grievance report data<br>**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.<br>**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.<br>**SC 4.1.3** PEU developed a monthly Physical Plant Checklist for Oasis On-Campus Treatment Home. Expand to other DCFS residential programs. |

| | | |
|---|---|---|
| **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.<br>**SC 5.1.2** Checklist items are integrated into the Avatar IMS for ease of use. Qualitative items will be reviewed by supervisors or PEU. 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<br><br>**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.<br>**SC 6.1.1.2** Interview service youth, parent/caregivers and Wraparound facilitators by utilizing the WFI.<br>**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.<br>**SC 6.1.1.4** Develop a report with recommendations.<br>**SC 6.2.1** Analysis of data for feedback on adherence to Team indicators<br>**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.<br>**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<br>**SE 1.1.2** Compile report elements<br>**SE 1.1.3** Produce summary report<br>**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<br>**SE 2.1.2** Develop standard set of tools for capturing review data<br>**SE 2.1.3** Schedule and conduct provider reviews<br>**SE 2.1.4** Compile and assess review data results<br>**SE 2.1.5** The PEU will conduct reviews on the implementation of the Policy on Medication Administration and Management with DCFS treatment homes.<br>**SE 2.1.6** The PEU will conduct reviews on the physical condition of the treatment homes using Physical Plant Checklist.<br>**SE 2.1.7** The PEU will provide training on medication administration and management policies at Oasis and train on trauma informed care for all treatment homes.<br>**SE 2.1.8** The PEU will conduct documentation reviews on open Oasis cases.<br>**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<br>**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<br>**SEF 1.1.2** Track/modify the PEU annual work plan during regular PEU meetings |
| **SEF 2.** Provide an information system that accurately captures, maintains and reports client clinical, financial, demographic and other service related information | **SEF 2.1** Ensure that the Avatar database contains accurate, complete and timely information | **SEF 2.1.1** Track and report on client cases open>= 6 months and >= 90 days with no activity. PEU will assist in closing inactive cases.<br>**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<br><br>**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<br><br>**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.<br>**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<br>**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<br><br>**SEF 5.2** CMHS supervisors will work with direct service staff to support and enhance service productivity | **SEF 5.1.1** Periodically coordinate with supervisors a time period during which audits are conducted on clinical files utilizing the Supervisor Checklists.<br>**SEF 5.1.2** Enter checklist data into supervisor checklist database<br>**SEF 5.1.3** Perform comparative / other data analysis<br>**SEF 5.1.4** Report results to supervisors<br><br>**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<br>**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 | **SEF 7.1** Review active cases open for more that 24 months to ensure that case | **SEF 7.1.1** Download for review Avatar report for cases open longer than 24 months |

| | | |
|---|---|---|
| fluid, flexible and appropriate to the needs of the individual child | documentation is complete and indicates movement | **SEF 7.1.2** Group report data into 2-3 years, 4-5 years, and 6 years or more<br>**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, consider implementing survey at discharge as well conducting a point in time survey.<br>**SQ 1.1.2** Collect, compile and analyze survey data results<br>**SQ 1.1.3** Make results available to all service providers, program managers, stakeholders and service recipients<br>**SQ 1.1.4** Incorporate survey results as required for federal block grant reporting |
| | **SQ 1.2** CMHS will conduct client satisfaction surveys at discharge for its psychiatric inpatient and residential treatment mental health services | **SQ 1.2.1** Implement survey in accordance with protocol<br>**SQ 1.2.2** Collect, compile and analyze survey data results<br>**SQ 1.2.3** Make results available to all service providers, program managers, stakeholders and service recipients.<br>**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
SFY15

# Division of Child and Family Services

## *DESCRIPTIVE SUMMARY OF DCFS CHILDREN'S MENTAL HEALTH SERVICES 2015*

**CONTENTS**



# INTRODUCTION

The following is the annual descriptive summary of DCFS Children's Mental Health Services for Fiscal Year (FY) 2015, from July 1, 2014 through June 30, 2015. The FY 2015 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 2835 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/NNCAS) 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) | Children's Clinical Services (CCS) |
| 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) | Mobile Crisis Response Team (MCRT) |
| *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

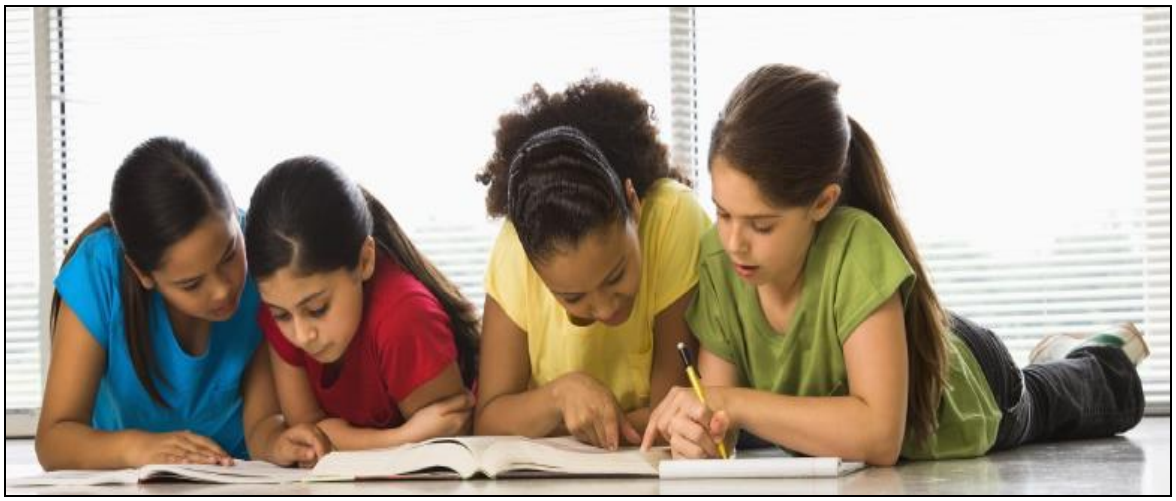
| Statewide | NNCAS | SNCAS |
|---|---|---|
| 2835 | 802 | 2033 |

## Admissions

| Statewide | NNCAS | SNCAS |
|---|---|---|
| 1703 | 377 | 1326 |

## Discharges

| Statewide | NNCAS | SNCAS |
|---|---|---|
| 1731 | 374 | 1357 |



# CHILDREN'S DEMOGRAPHIC CHARACTERISTICS

## Statewide and by Region

### Age

The average age of children served Statewide was 10.60 years, NNCAS was 9.54 years and SNCAS was 11.02 years.

| Age Group | Statewide | NNCAS | SNCAS |
|---|---|---|---|
| 0–5 years old | 738 | 225 | 502 |
| 6–12 years old | 885 | 270 | 570 |
| 13 + years old | 1212 | 222 | 961 |

### Gender

| Gender | Statewide | NNCAS | SNCAS |
|---|---|---|---|
| Male | 1455 | 436 | 1019 |
| Female | 1377 | 365 | 1012 |
| Unknown | 3 | 1 | 2 |

## Race and Ethnicity

| Race | Statewide | NNCAS | SNCAS |
|---|---|---|---|
| American Indian/Alaskan Native | 34 | 17 | 17 |
| Asian | 46 | 7 | 39 |
| Black/African American | 563 | 79 | 486 |
| Native Hawaiian/Other Pacific Islander | 29 | 6 | 23 |
| White/Caucasian | 2131 | 694 | 1437 |
| Unknown | 31 | 0 | 31 |
| **Ethnicity** | **Statewide** | **NNCAS** | **SNCAS** |
| Hispanic Origin | 971 | 184 | 787 |

## Custody Status

| Custody Status | Statewide | NNCAS | SNCAS |
|---|---|---|---|
| Parent/Family | 1669 | 384 | 1285 |
| Child Welfare Court Ordered | 962 | 402 | 560 |
| ICPC | 8 | 2 | 6 |
| Voluntary Custody | 2 | 1 | 1 |
| Protective Custody | 134 | 8 | 126 |
| DCFS Youth Parole | 19 | 3 | 16 |
| Parental Custody On Probation | 36 | 1 | 35 |
| Unknown | 5 | 1 | 4 |

## Severe Emotional Disturbance Status

| Statewide | NNCAS | SNCAS |
|---|---|---|
| 2370 | 692 | 1678 |

# 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 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.

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

### Number of Children Served

| Statewide | CCS-NNCAS | CCS-SNCAS |
|---|---|---|
| 1105 | 360 | 745 |

### Age

The average age of children served Statewide was 13.14, CCS-NNCAS was 12.29, and CCS-SNCAS was 13.52.

| Age Group | Statewide | CCS- NNCAS | CCS-SNCAS |
|---|---|---|---|
| 0–5 years old | 12 | 7 | 5 |
| 6–12 years old | 440 | 176 | 264 |
| 13 + years old | 653 | 177 | 476 |

### Gender

| Gender | Statewide | CCS-NNCAS | CCS-SNCAS |
|---|---|---|---|
| Male | 535 | 195 | 340 |
| Female | 570 | 165 | 405 |

### Race and Ethnicity

| Race | Statewide | CCS-NNCAS | CCS-SNCAS |
|---|---|---|---|
| American Indian/Alaskan Native | 12 | 4 | 8 |
| Asian | 23 | 5 | 18 |
| Black/African American | 154 | 37 | 117 |
| Native Hawaiian/Other Pacific | 14 | 2 | 12 |
| White/Caucasian | 894 | 312 | 582 |
| Unknown | 8 | 0 | 8 |
| **Ethnicity** | **Statewide** | **CCS-NNCAS** | **CCS-SNCAS** |
| Hispanic Origin | 467 | 97 | 370 |

## Custody Status

| Custody Status | Statewide | CCS-NNCAS | CCS-SNCAS |
|---|---|---|---|
| Parent/Family | 896 | 236 | 660 |
| Child Welfare | 172 | 114 | 58 |
| ICPC | 4 | 1 | 3 |
| Protective Custody | 18 | 4 | 14 |
| DCFS Youth Parole | 3 | 3 | 0 |
| Parental Custody / Probation | 9 | 0 | 9 |
| Unknown | 2 | 1 | 1 |

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

## Number of Children Served

| Statewide | ECMHS (NNCAS) | ECMHS (SNCAS) |
|---|---|---|
| 828 | 268 | 560 |

## Age

The average age of children served by ECMHS Statewide was 4.21, ECMHS (NNCAS) was 4.40, and ECMHS (SNCAS) was 4.12.

| Age Group | Statewide | ECMHS (NNCAS) | ECMHS (SNCAS) |
|---|---|---|---|
| 0–5 years old | 705 | 218 | 487 |
| 6–12 years old | 123 | 50 | 73 |
| 13 + years old | 0 | 0 | 0 |

## Gender

| Gender | Statewide | ECMHS (NNCAS) | ECMHS (SNCAS) |
|---|---|---|---|
| Male | 476 | 141 | 335 |
| Female | 349 | 126 | 223 |
| Unknown | 3 | 1 | 2 |

## Race and Ethnicity

| Race | Statewide | ECMHS (NNCAS) | ECMHS (SNCAS) |
|---|---|---|---|
| American Indian/Alaskan Native | 10 | 4 | 6 |
| Asian | 3 | 0 | 3 |
| Black/African American | 210 | 28 | 182 |
| Native Hawaiian/Other Pacific | 3 | 1 | 2 |
| White/Caucasian | 594 | 235 | 359 |
| Unknown | 8 | 0 | 8 |
| **Ethnicity** | **Statewide** | **ECMHS (NNCAS)** | **ECMHS (SNCAS)** |
| Hispanic Origin | 209 | 57 | 152 |

## Custody Status

| Custody Status | Statewide | ECMHS (NNCAS) | ECMHS (SNCAS) |
|---|---|---|---|
| Parent/Family | 199 | 91 | 108 |
| Child Welfare | 531 | 175 | 356 |
| ICPC | 3 | 1 | 2 |
| Protective Custody | 93 | 1 | 92 |

## WIN Statewide and by Region

### Number of Children Served

| Statewide | North | Rural | South |
|---|---|---|---|
| 653 | 193 | 95 | 365 |

### Age

The average age of children served Statewide was 12.46, North was 12.22, Rural was 11.05, and South was 12.96.

| Age Group | Statewide | North | Rural | South |
|---|---|---|---|---|
| 0–5 years old | 19 | 5 | 12 | 2 |
| 6–12 years old | 310 | 99 | 48 | 163 |
| 13 + years old | 324 | 89 | 35 | 200 |

### Gender

| Gender | Statewide | North | Rural | South |
|---|---|---|---|---|
| Male | 370 | 109 | 60 | 201 |
| Female | 283 | 84 | 35 | 164 |

### Race and Ethnicity

| Race | Statewide | North | Rural | South |
|---|---|---|---|---|
| American Indian/Alaskan Native | 10 | 3 | 6 | 1 |
| Asian | 7 | 1 | 1 | 5 |
| Black/African American | 135 | 22 | 2 | 111 |
| Native Hawaiian/Other Pacific | 9 | 3 | 1 | 5 |
| White/Caucasian | 488 | 164 | 85 | 239 |
| Unknown | 4 | 0 | 0 | 4 |
| **Ethnicity** | **Statewide** | **North** | **Rural** | **South** |
| Hispanic Origin | 176 | 53 | 10 | 113 |

### Custody Status

| Custody Status | Statewide | North | Rural | South |
|---|---|---|---|---|
| Parent/Family | 298 | 65 | 41 | 192 |
| Child Welfare | 340 | 126 | 50 | 164 |
| ICPC | 2 | 0 | 0 | 2 |
| Protective Custody | 19 | 2 | 3 | 14 |
| Parental Custody / Probation | 4 | 0 | 1 | 3 |

## 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 |
|---|---|---|---|
| 141 | 45 | 51 | 45 |

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 13.70, ATC was 14.92, FLH was 12.21, and OCTH was 14.17.

| Age Group | Statewide | ATC | FLH | OCTH |
|---|---|---|---|---|
| 0–5 years old | 2 | 0 | 2 | 0 |
| 6–12 years old | 41 | 3 | 26 | 12 |
| 13 + years old | 98 | 42 | 23 | 33 |

### Gender

| Gender | Statewide | ATC | FLH | OCTH |
|---|---|---|---|---|
| Male | 74 | 28 | 25 | 21 |
| Female | 67 | 17 | 26 | 24 |

## Race and Ethnicity

| Race | Statewide | ATC | FLH | OCTH |
|---|---|---|---|---|
| American Indian/Alaskan Native | 1 | 0 | 1 | 0 |
| Asian | 1 | 0 | 0 | 1 |
| Black/African American | 29 | 6 | 11 | 12 |
| Native Hawaiian/Other Pacific Islander | 1 | 0 | 0 | 1 |
| White/Caucasian | 109 | 39 | 39 | 30 |
| **Ethnicity** | **Statewide** | **ATC** | **FLH** | **OCTH** |
| Hispanic Origin | 38 | 11 | 17 | 10 |

## Custody Status

| Custody Status | Statewide | ATC | FLH | OCTH |
|---|---|---|---|---|
| Parent/Family | 68 | 27 | 19 | 22 |
| Child Welfare | 60 | 16 | 30 | 14 |
| Protective Custody | 6 | 1 | 0 | 5 |
| DCFS Youth Parole | 5 | 1 | 2 | 2 |
| ICPC | 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 |
|---|---|
| 203 | 95 |

### Age

The average age of children served by Desert Willow Acute was 15.55, and it was for the Desert Willow Residential Treatment Center 15.26.

| Age Group | Acute | RTC |
|---|---|---|
| 6–12 years old | 13 | 9 |
| 13 + years old | 190 | 86 |

### Gender

| Gender | Acute | RTC |
|---|---|---|
| Male | 72 | 54 |
| Female | 131 | 41 |

### Race and Ethnicity

| Race | Acute | RTC |
|---|---|---|
| American Indian/Alaskan Native | 2 | 0 |
| Asian | 5 | 0 |
| Black/African American | 37 | 15 |
| Native Hawaiian/Other Pacific Islander | 4 | 1 |
| White/Caucasian | 155 | 79 |
| **Ethnicity** | **Acute** | **RTC** |
| Hispanic Origin | 91 | 28 |

## Mobile Crisis

### Number of Children Served

| Statewide | North | South |
|---|---|---|
| 599 | 134 | 465 |

### Age

The average age of children served Statewide was 14.23, North was 13.83, and South was 14.34.

| Age Group | Statewide | North | South |
|---|---|---|---|
| 6–12 years old | 168 | 40 | 128 |
| 13 + years old | 431 | 94 | 337 |

### Gender

| Gender | Statewide | North | South |
|---|---|---|---|
| Male | 240 | 49 | 191 |
| Female | 358 | 85 | 273 |
| Unknown | 1 | 0 | 1 |

### Race and Ethnicity

| Race | Statewide | North | South |
|---|---|---|---|
| American Indian/Alaskan Native | 5 | 2 | 3 |
| Asian | 17 | 5 | 12 |
| Black/African American | 117 | 8 | 109 |
| Native Hawaiian/Other Pacific | 8 | 2 | 6 |
| White/Caucasian | 428 | 117 | 311 |
| Unknown | 24 | 0 | 24 |
| **Ethnicity** | **Statewide** | **North** | **South** |
| Hispanic Origin | 286 | 61 | 225 |

### Custody Status

| Custody Status | Statewide | North | South |
|---|---|---|---|
| Parent/Family | 548 | 123 | 425 |
| Child Welfare | 12 | 8 | 4 |
| ICPC | 1 | 0 | 1 |
| Protective Custody | 7 | 1 | 6 |
| DCFS Youth Parole | 3 | 2 | 1 |
| Parental Custody / Probation | 14 | 0 | 14 |

# CHILDREN'S CLINICAL CHARACTERISTICS AND OUTCOMES

## Presenting Problems at Admission

At admission, parents and caregivers are asked to identify problems their children have encountered. Fifty two (52) problems had been presented at least once at admission, the 10 identified below (and listed in order of prevalence) accounted for 60.6% of all primary presenting problems reported at admission. The top six presenting problems listed below are the same (in order of prevalence) as the previous year.

- Suicide Attempt-Threat (10.0%)
- Depression (9.7%)
- Child Neglect Victim (6.5%)
- Parent-Child Problems (6.0%)
- Physical Aggression (5.2%)
- Oppositional (5.1%)
- Anxiety (5.1%)
- School Problems (4.7%)
- Adjustment Problems (4.3%)
- Coping Problems (4.1%)

## Diagnosis

In FY 2015, 25.9 percent of children served met criteria for more than one diagnostic category. The tables below show the most prevalent diagnoses of children by age category and gender.

### Age Group 0-5.99

| | |
|---|---|
| 995.52 | 19.1% |
| 312.9 | 16.8% |
| 300.00 | 7.1% |
| 300 | 5.2% |
| 225 | 4.9% |
| 995.54 | 4.0% |
| 309.81 | 3.9% |

### Age Group 6-12.99

| | | | |
|---|---|---|---|
| 309.81 | 13.2% | 314.01 | 13.6% |
| 314.01 | 6.4% | 309.81 | 8.2% |
| 995.52 | 5.9% | 313.81 | 7.6% |
| 296.90 | 5.7% | 296.90 | 6.8% |
| 309.4 | 5.6% | 312.9 | 5.5% |
| 311 | 4.5% | 300.00 | 4.4% |
| 313.81 | 4.3% | 309.4 | 4.4% |
| 309.0 | 4.0% | | |

### Age Group 13-17.99

| | | | |
|---|---|---|---|
| 309.81 | 10.9% | 296.90 | 11.0% |
| 296.90 | 8.6% | 313.81 | 8.7% |
| 296.23 | 8.3% | 314.01 | 5.4% |
| 296.33 | 7.6% | 309.81 | 5.3% |
| 311 | 6.3% | 296.80 | 4.2% |
| 313.81 | 4.3% | 296.33 | 3.7% |
| | | 311 | 3.4% |
| | | 296.23 | 3.2% |

## 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.

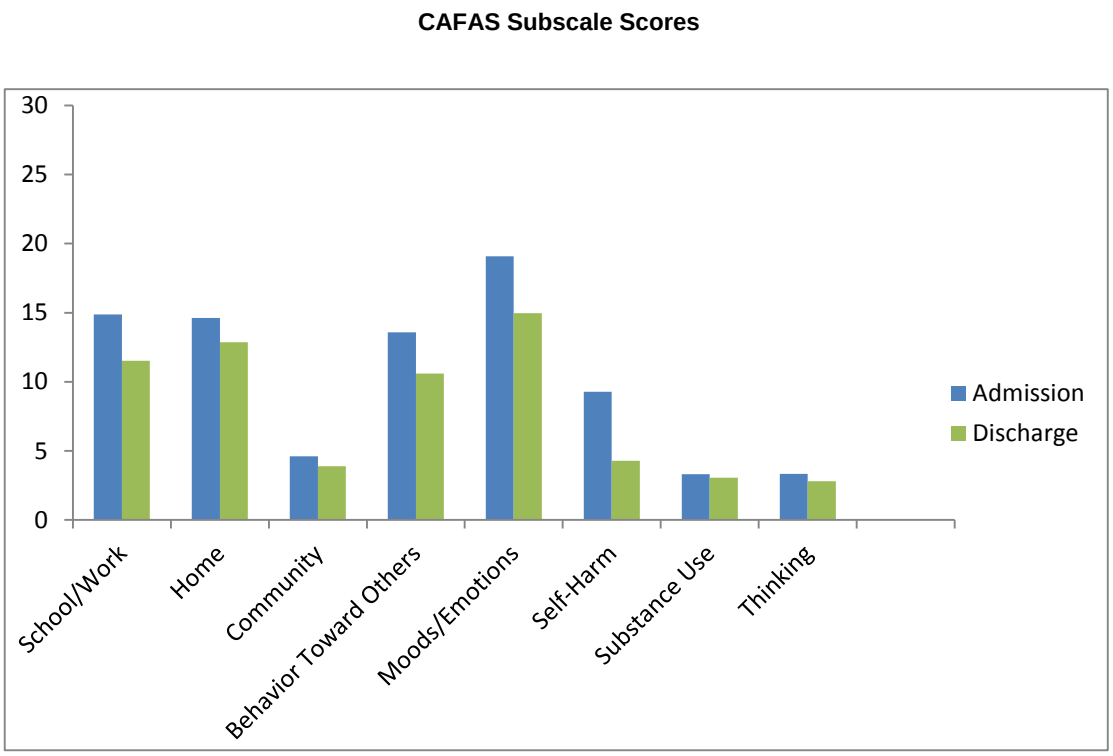
The Preschool and Early Childhood Functional Assessment Scale (PECFAS)[2] was also designed to assess degree of impairment in functioning of children ages 3 to 7 years with behavioral, emotional, psychological or psychiatric problems. Total PECFAS scores range from 0 to 210, with a higher total score 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 2015 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.

## CCS-NNCAS and Children's Clinical Services

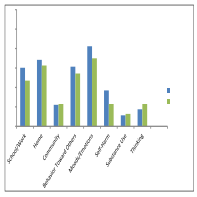
The graph below shows the admission and discharge CAFAS subscale scores for CCS-NNCAS (NNCAS) and Children's Clinical Services (SNCAS) statewide.




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 182 (47.4%) of 384 qualified DCFS CCS-NNCAS clients statewide. The mean total score for all clients at admission was 82.66 and the mean total score at discharge was 64.48. Clients were qualified if they had been discharged and if the CAFAS was rated at both admission and discharge.

## CCS-NNCAS (NNCAS)

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



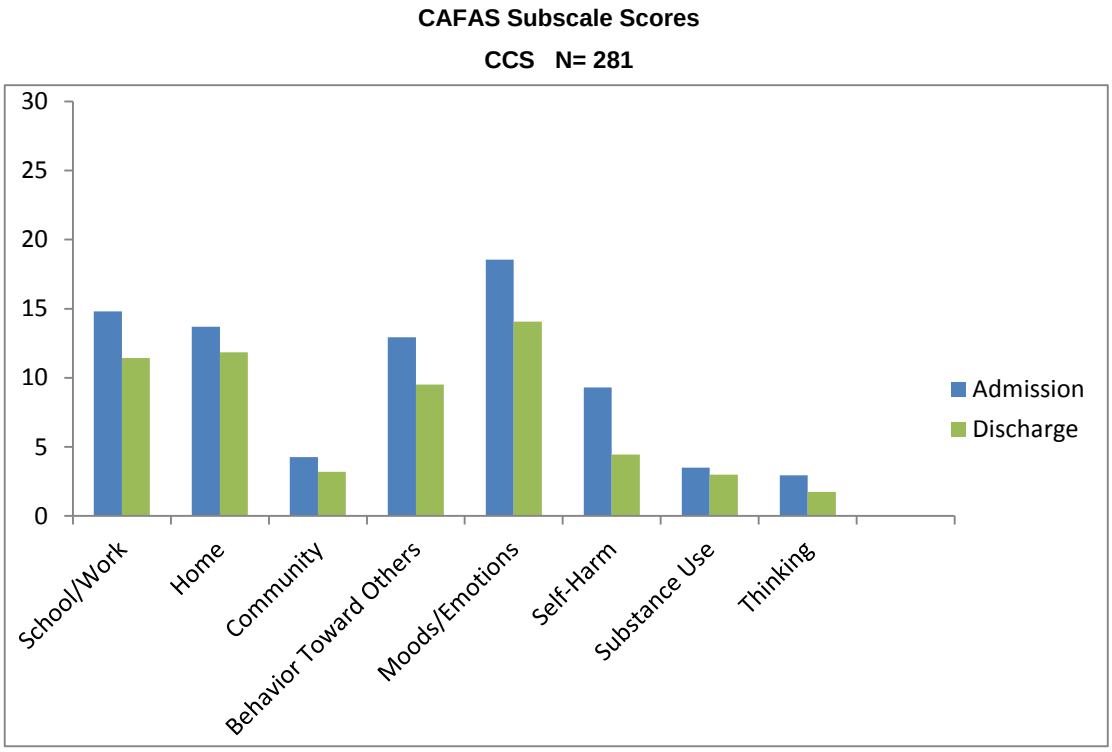
Of those served, 43 (41.7%) of 103 qualified DCFS North Region CCS-NNCAS Services clients showed clinically significant improvement. The mean total score for all clients at admission was 90.00 and the mean total score at discharge was 78.83. Clients were qualified if they had been discharged and if they received CAFAS testing at admission and discharge.

30
25
20
15
10
5
0

Admission
Discharge

## Children's Clinical Services (SNCAS)

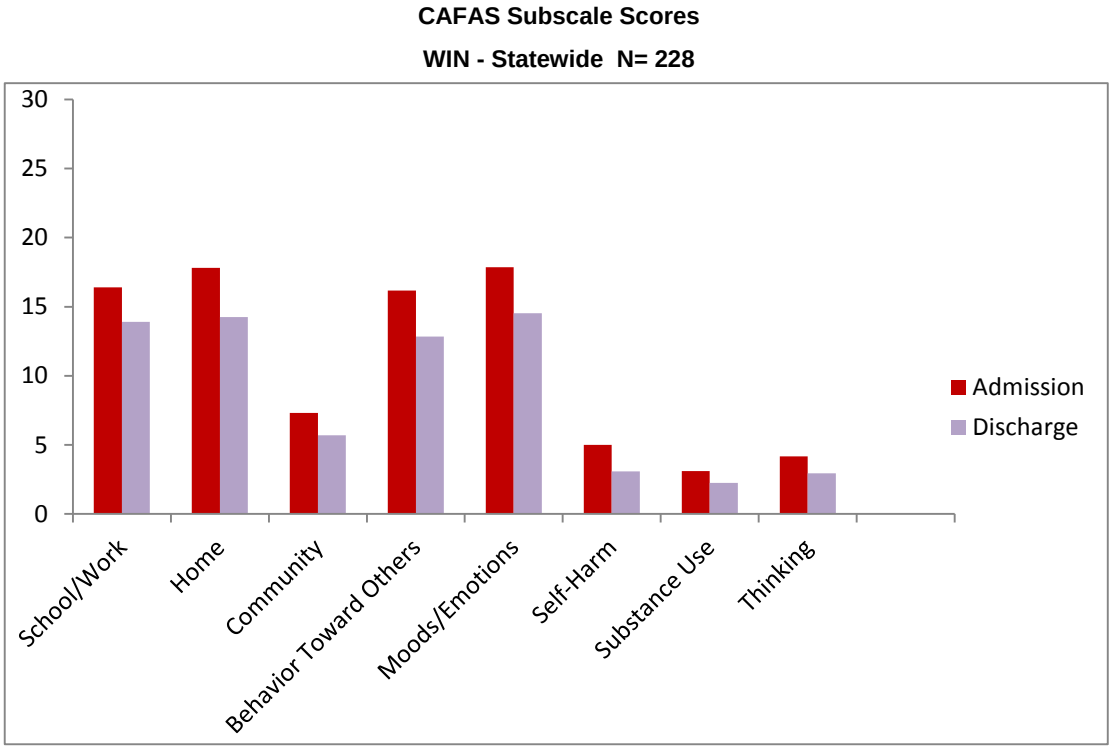
The following illustrates the admission and discharge CAFAS subscale scores for Children's Clinical Services (CCS).




Clinically significant improvement was observed for 139 (49.5%) of 281 qualified DCFS South Region Children's Clinical Services clients. The mean total score for all clients at admission was 79.96 and the mean total score at discharge was 59.22. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

## WIN

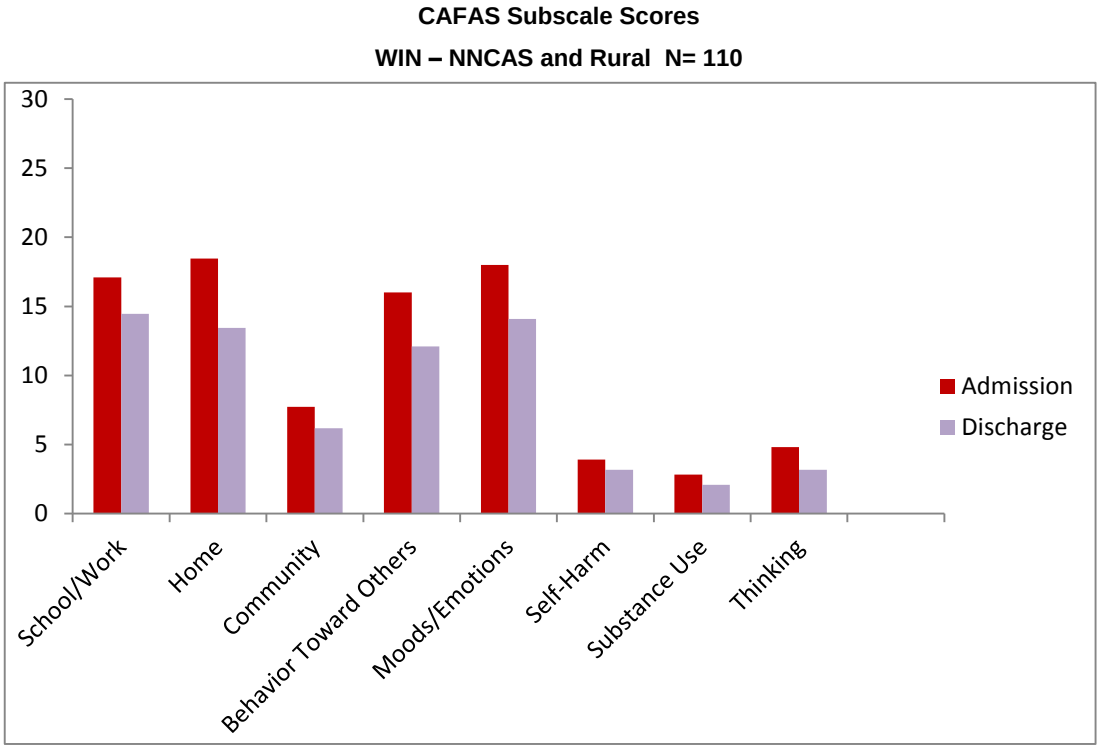
The graph below shows the admission and discharge CAFAS subscale scores for WIN statewide.




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 120 (52.6%) of 228 qualified DCFS Wraparound In Nevada (WIN) clients statewide. The mean total score for all clients at admission was 87.85 and the mean total score at discharge was 69.47. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## WIN-NNCAS and Rural

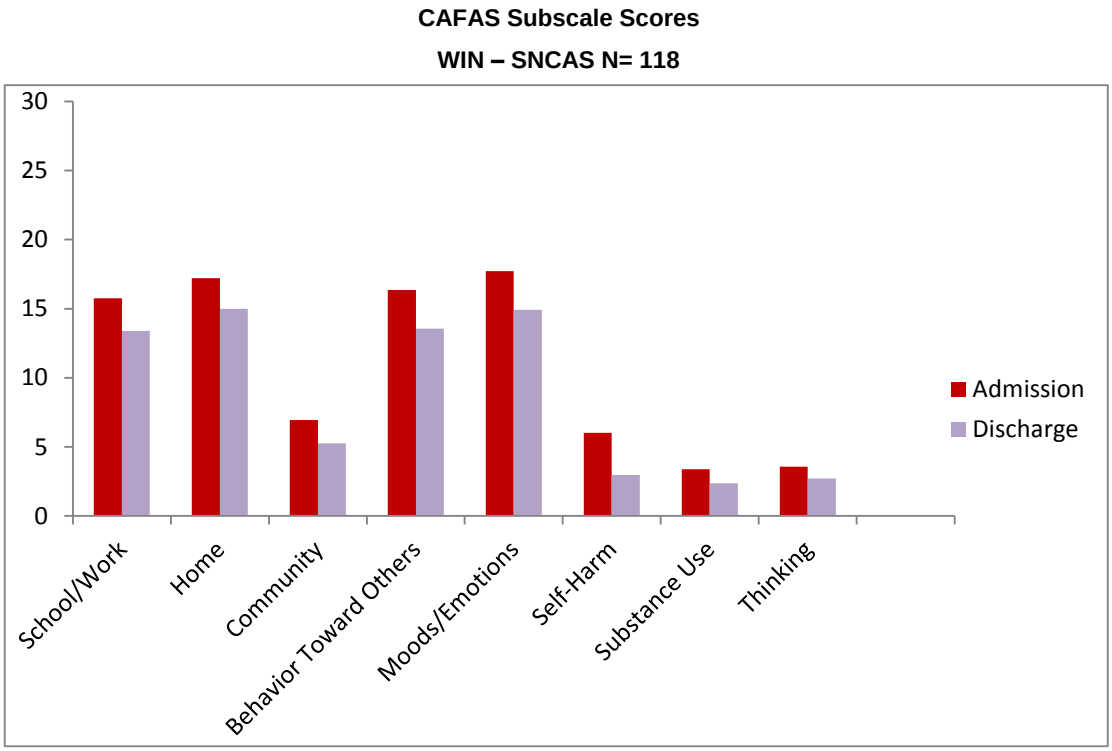
The following graph shows the admission and discharge CAFAS subscale scores for WIN at NNCAS and Rural.




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 62 (56.4%) of 110 qualified DCFS Northern and Rural Region WIN clients. The mean total score for all clients at admission was 88.82 and the mean total score at discharge was 68.73. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## WIN-SNCAS

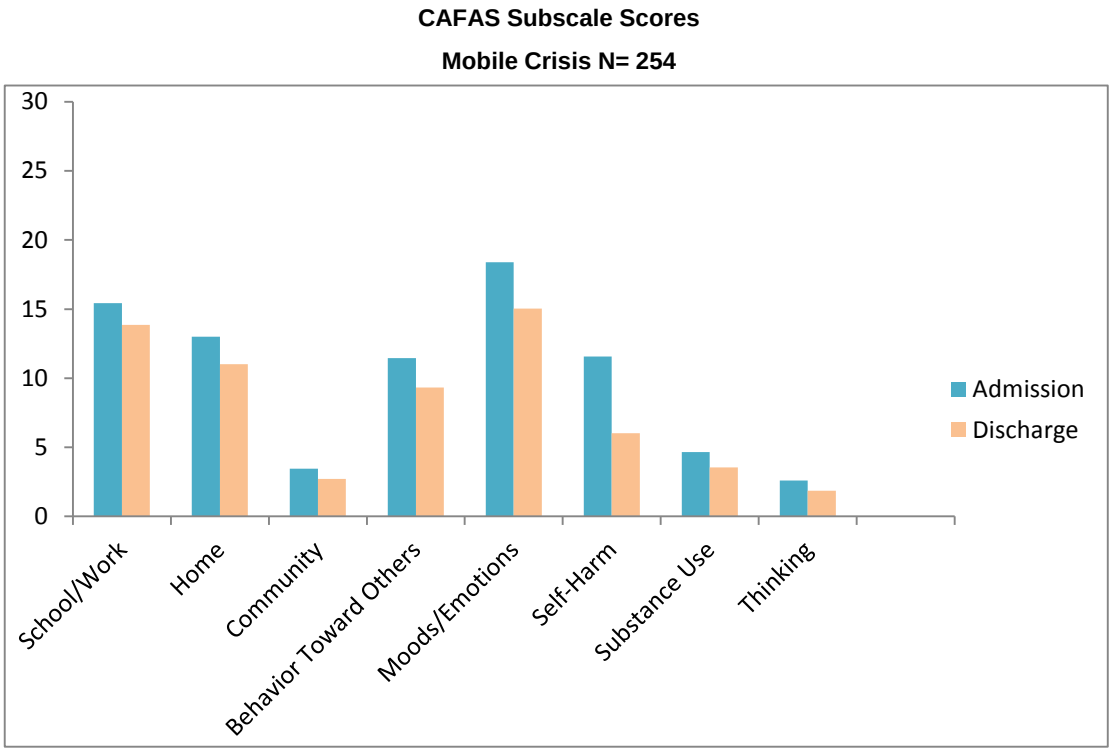
The admission and discharge CAFAS subscale scores for WIN at SNCAS are depicted below.




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 58 (49.2%) of 118 qualified DCFS Southern Region WIN clients. The mean score for all clients at admission was 86.95 and the mean score at discharge was 70.17. Clients were qualified if they had been discharged and if they were rated on the CAFAS at admission and discharge.

## Mobile Crisis

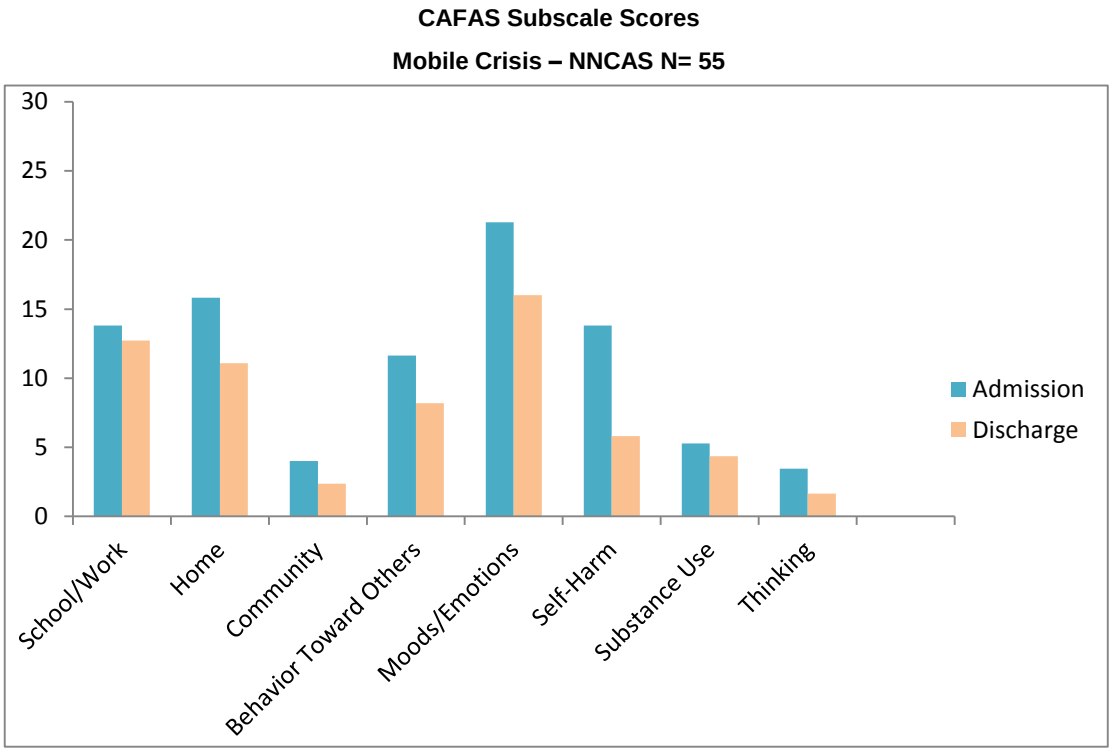
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis Statewide.




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 114 (44.9%) of 254 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 80.55 and the mean total score at discharge was 63.39. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## Mobile Crisis - NNCAS

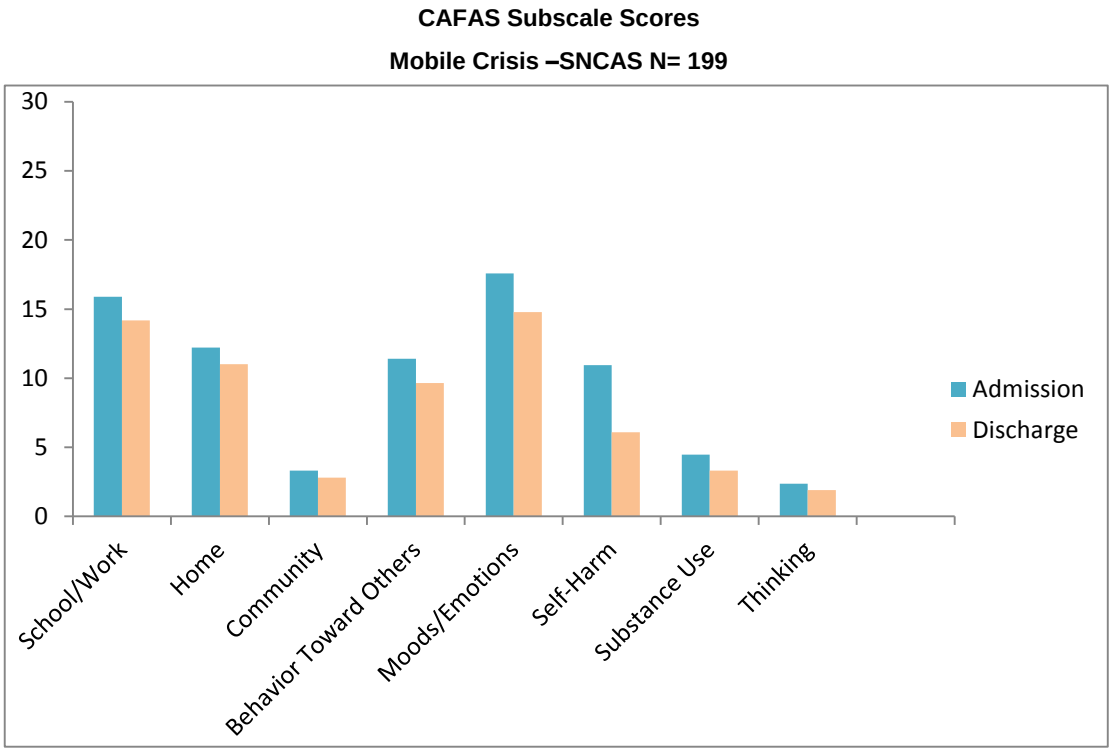
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis - NNCAS.




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 32 (58.2%) of 55 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 89.09 and the mean total score at discharge was 62.18. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## Mobile Crisis - SNCAS

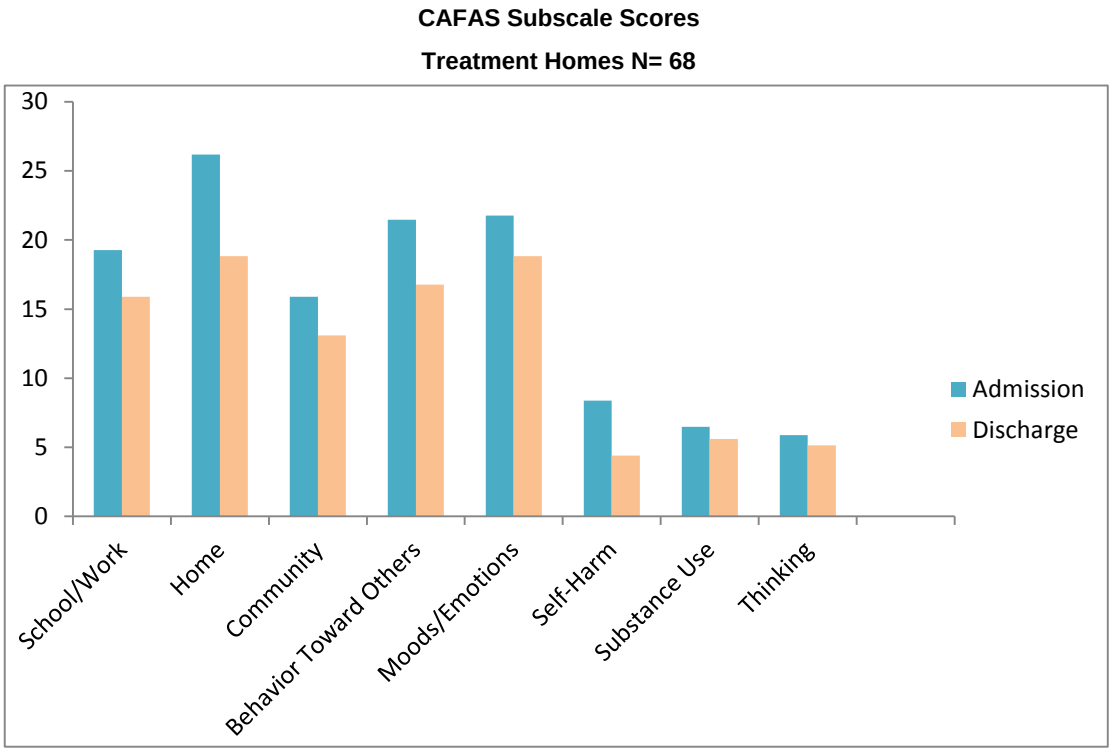
The graph below shows the admission and discharge CAFAS subscale scores for Mobile Crisis SNCAS.




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 82 (41.2%) of 199 qualified DCFS Mobile Crisis clients. The mean total score for all clients at admission was 78.19 and the mean total score at discharge was 63.72. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## Treatment Homes

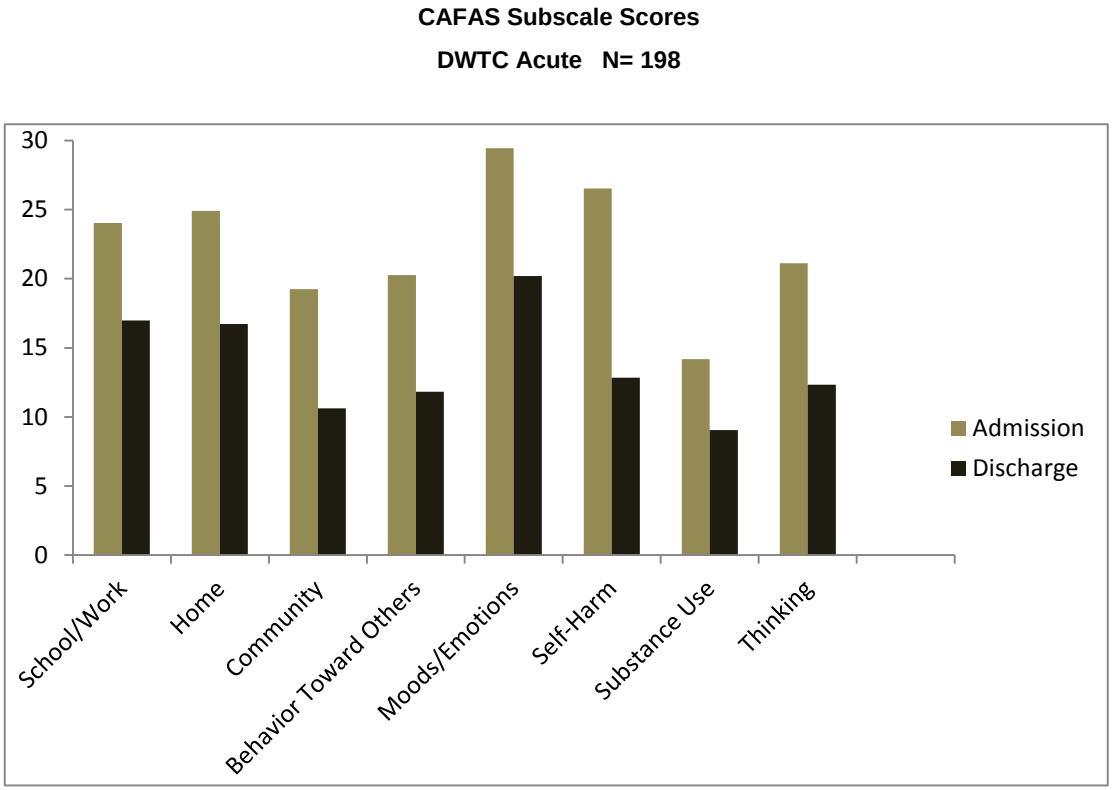
The graph below shows the admission and discharge CAFAS subscale scores for Treatment Homes Statewide.




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 47 (69.1%) of 68 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 125.29 and the mean total score at discharge was 98.53. Clients were qualified if they had been discharged and if they received CAFAS ratings at admission and discharge.

## Desert Willow Treatment Center Acute Hospital

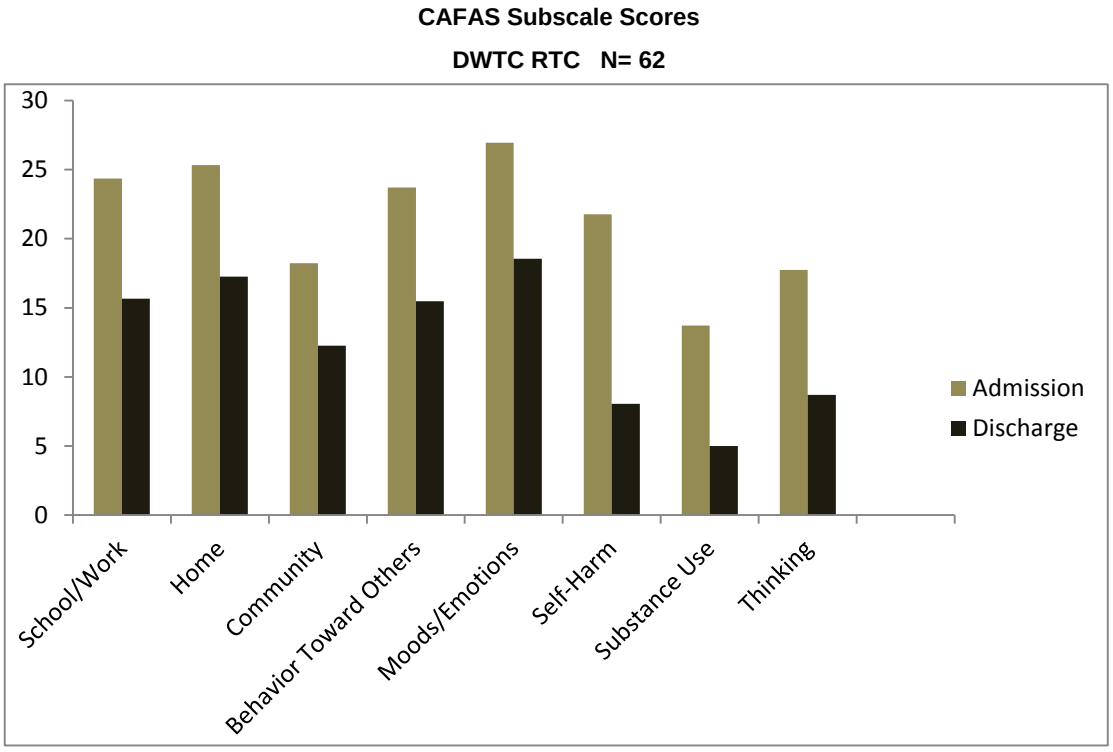
The admissions to discharge CAFAS subscale scores for Desert Willow Treatment Center Acute Hospital are depicted below.




In terms of improvement, 176 (88.9%) of 198 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 179.70 and the mean total score at discharge was 110.51. 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

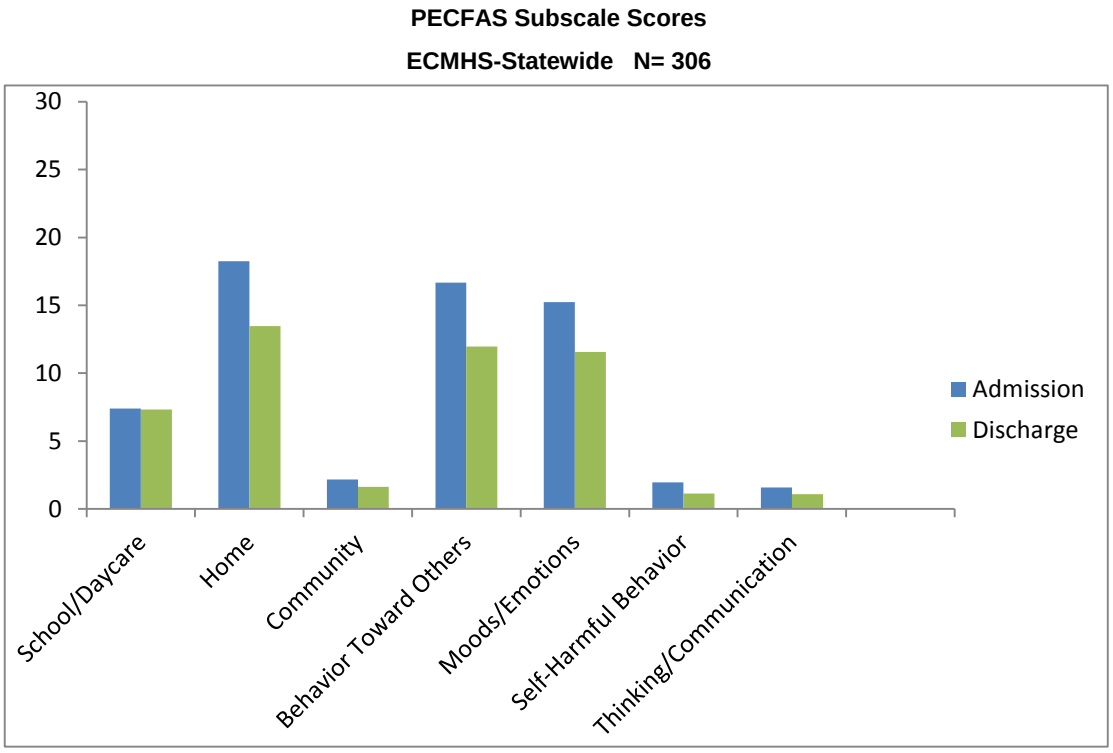
The graph below shows the admission to discharge CAFAS subscale scores for Desert Willow Residential Treatment Center.




Clinically significant improvement was observed for 48 (77.4%) of 62 qualified DCFS Desert Willow Residential Treatment Center (RTC) clients. The mean total score for all clients at admission was 171.77 and the mean total score at discharge was 100.97. Clients were qualified if they had been discharged and if they received CAFAS ratings at both admission and discharge.

## Early Childhood Mental Health Services

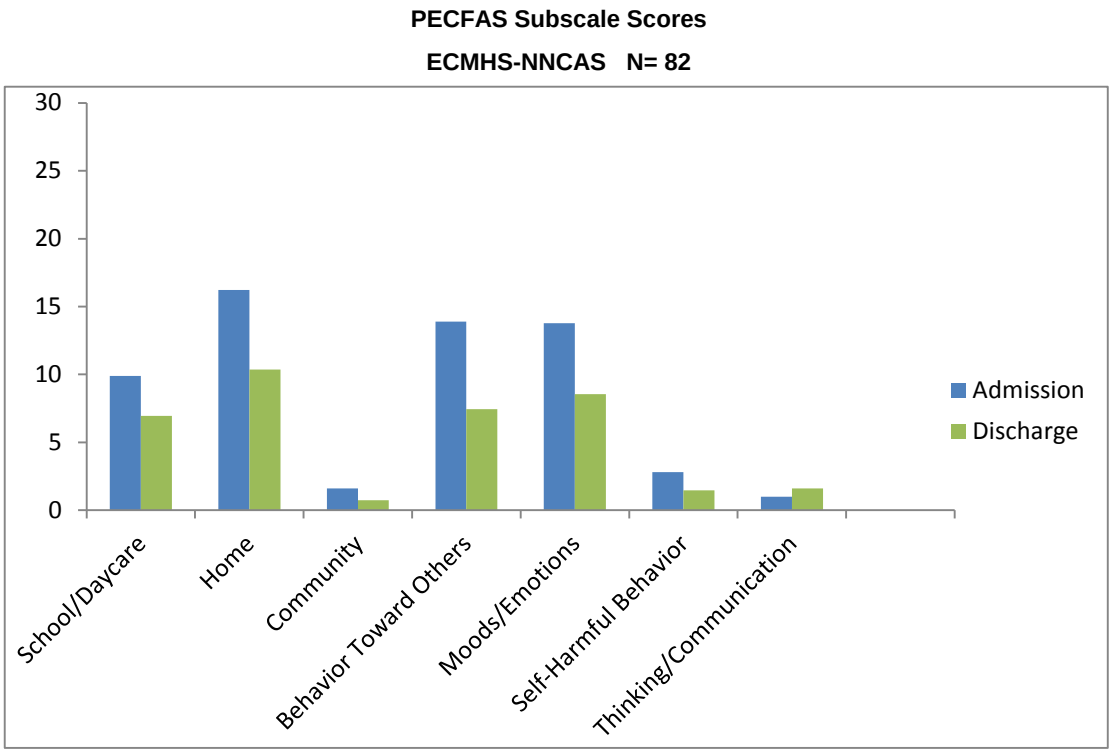
The graph below shows the admission to discharge PECFAS subscale scores for Early Childhood Mental Health Services statewide.




Similar to the CAFAS, although with one less subscale, 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 (47.4%) of 306 qualified DCFS Early Childhood clients statewide. The mean total score for all clients at admission was 63.20 and the mean total score at discharge was 48.17. 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

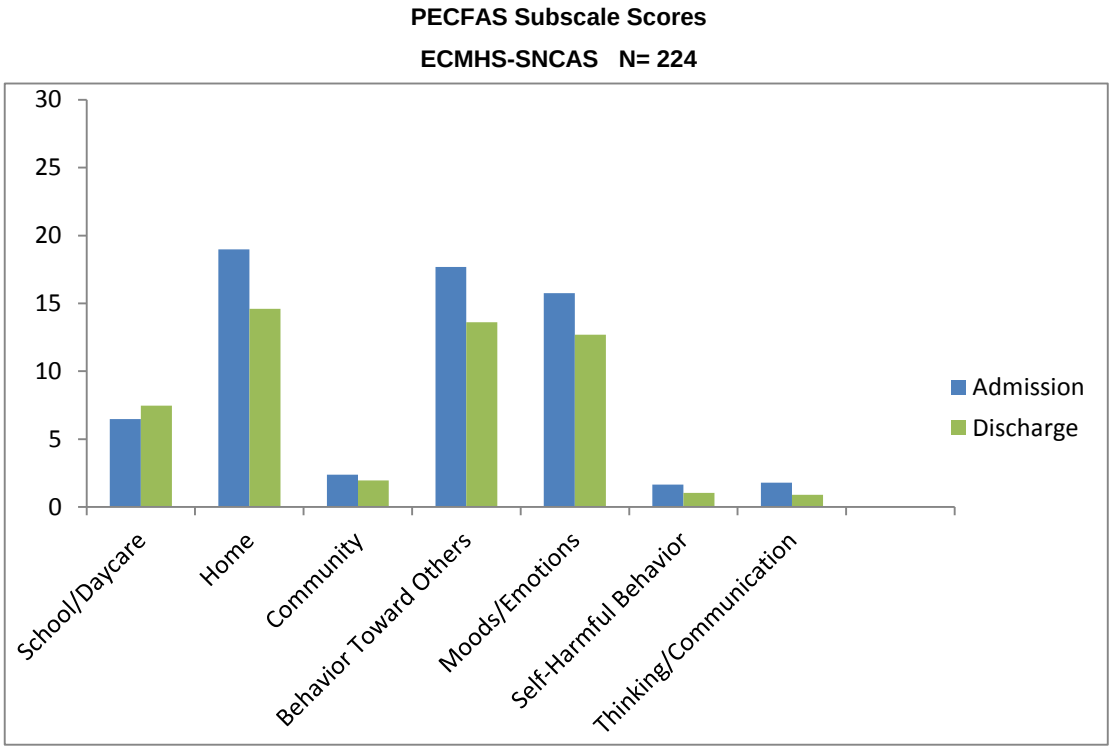
The graph below shows the admission to discharge for PECFAS subscale scores for Early Childhood Mental Health Services at NNCAS.




Regarding improvement, 50 (61.0%) of 82 qualified DCFS Early Childhood clients in NNCAS had clinically significant improvement in total scores. The mean total score for all clients at admission was 59.15 and the mean total score at discharge was 37.07. 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 95 (42.4%) of 224 qualified discharged clients who had ratings at both admission and discharge. The mean total score at admission was 64.69 and the mean total score at discharge was 52.23.

## 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.

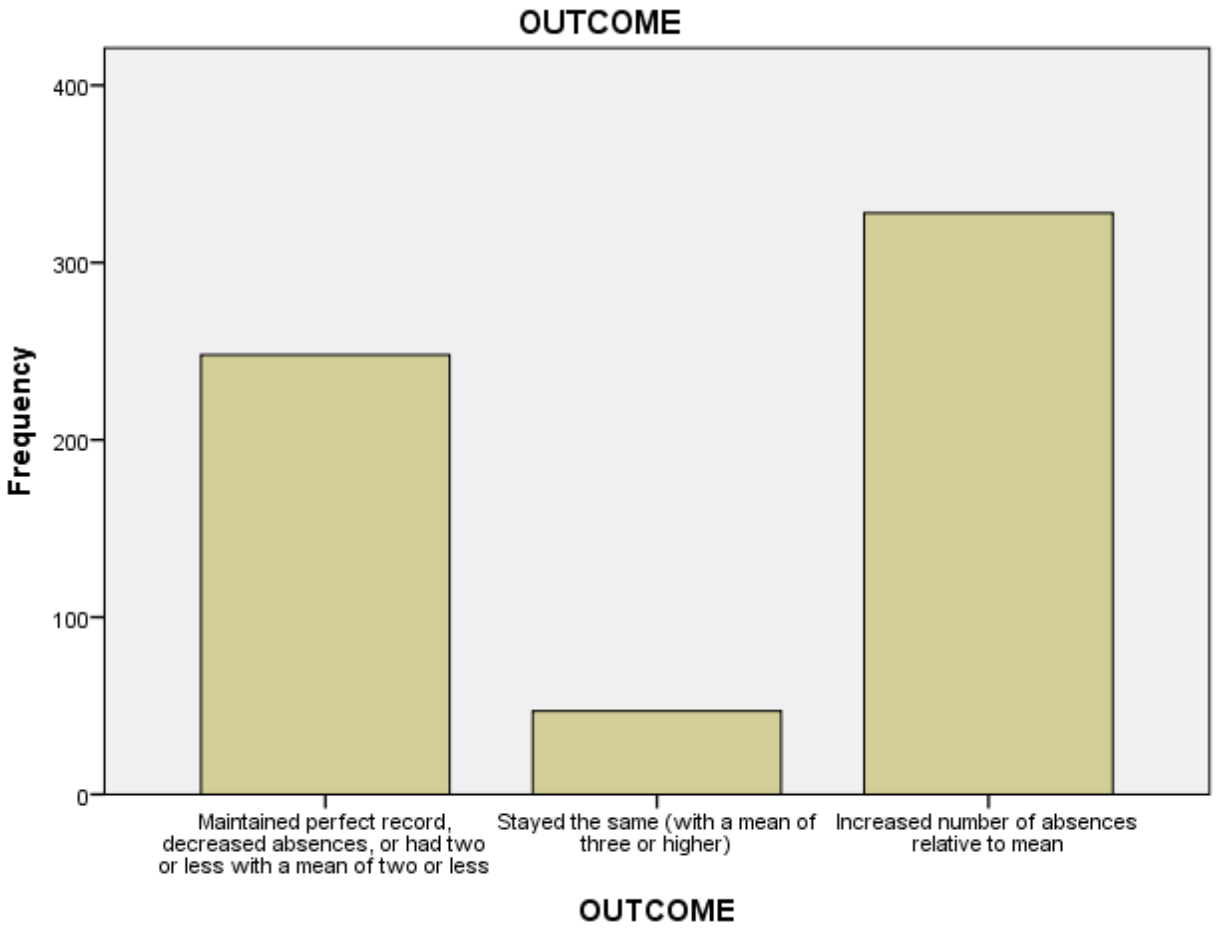
Performance was classified into three categories:

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).

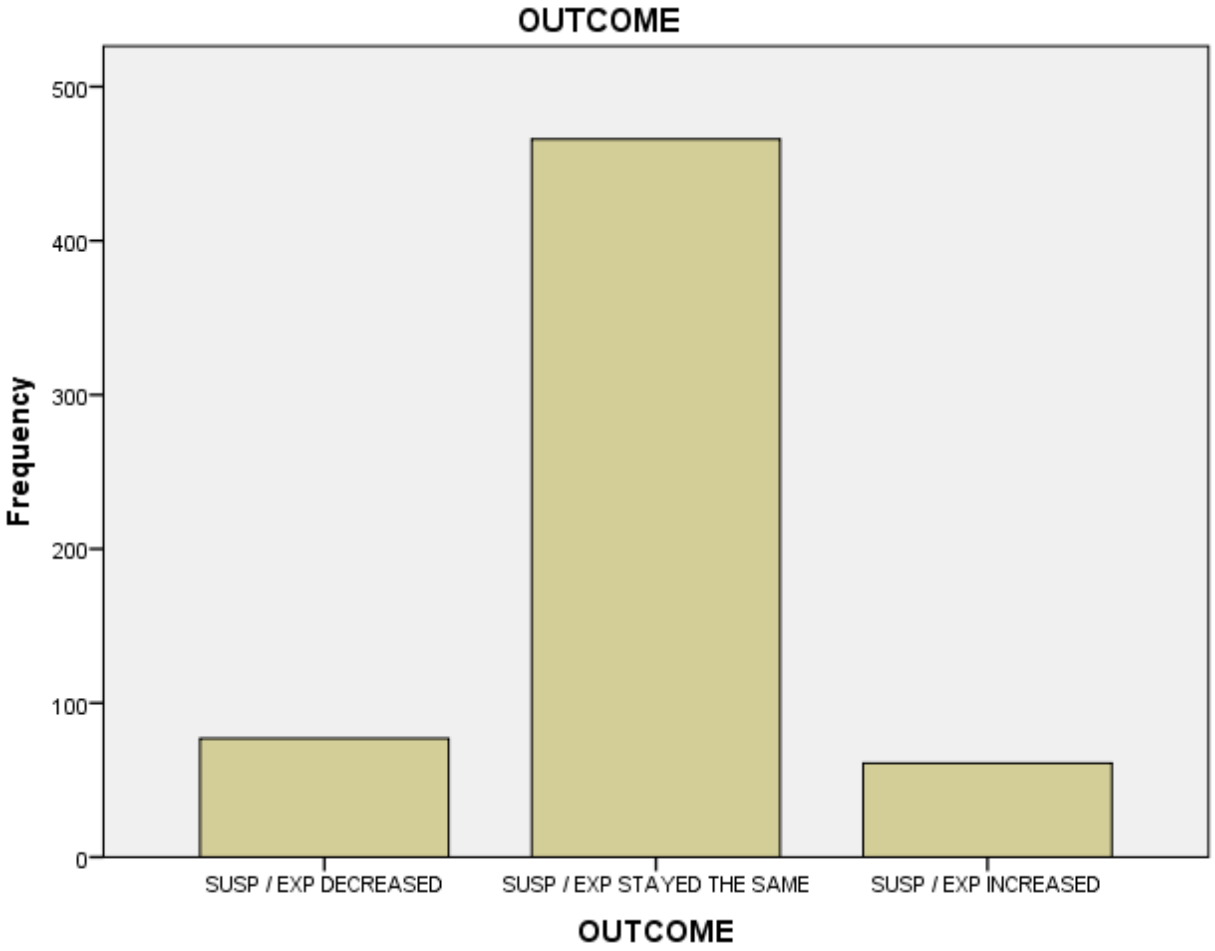
3. A client was considered to have decreased in performance if he or she had:
   - A historical average of three or more per period and more than his or her historical average in the most recent period, or an average from zero to two and absences in the most recent period of three or more (absences only),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



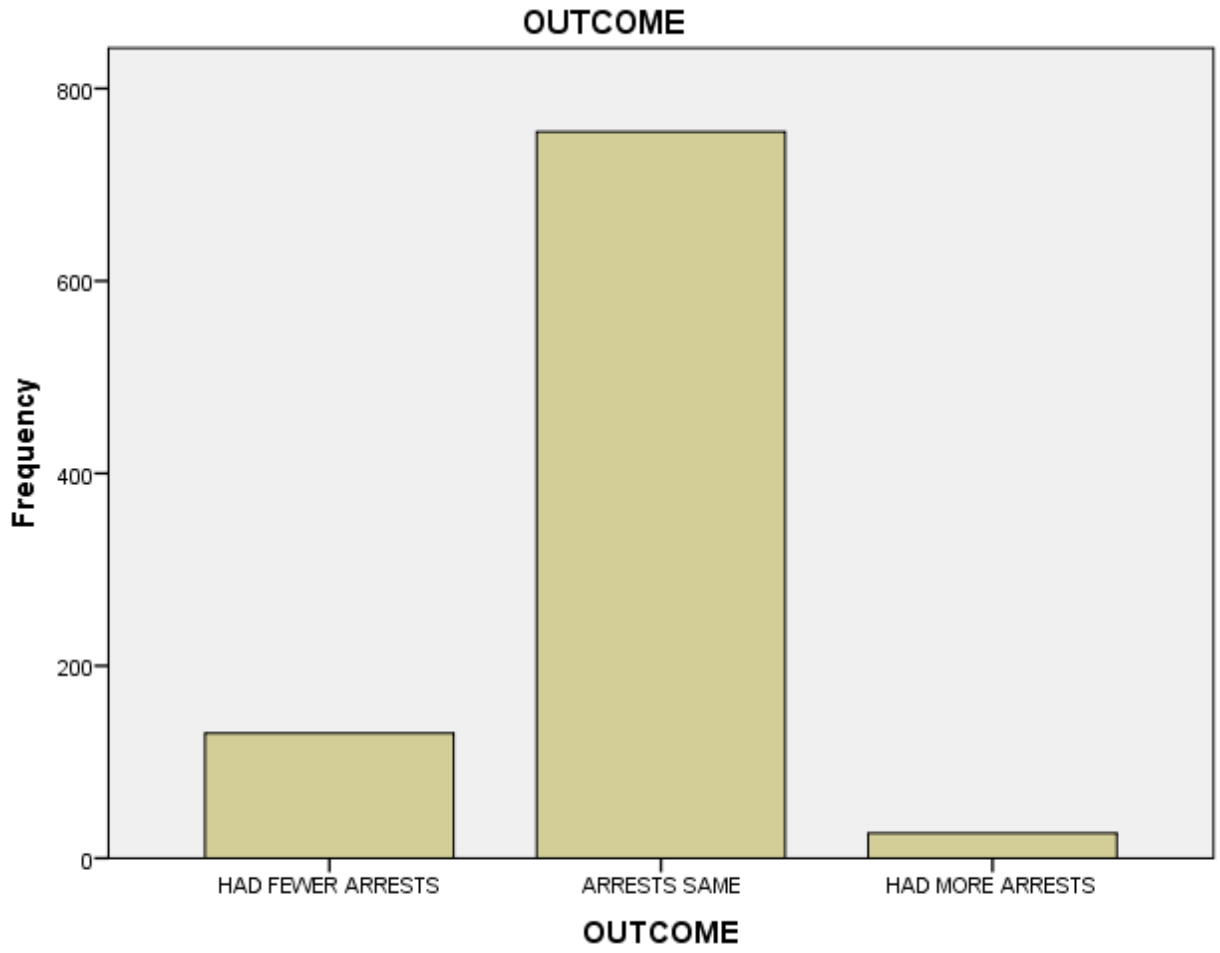

In FY2015, 633 clients had absences data for at least two grade periods from which an average could be constructed. Absences declined, a perfect attendance record was maintained (no absences), or the client had two or fewer absences in the most recent period compared with a mean school absence of two or fewer for 248 (39.2%) of the clients. Absences remained the same at three or more compared with a mean of three or more for 47 (7.4%) clients. Absences increased to three or more and the client average was greater than two days for 328 (51.8%) of the clients.

## Suspensions and Expulsions: Statewide/All Programs




In FY2015, 604 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 77 (12.7%) of the clients. For 466 (77.2%) 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 61 (10.1%) of the clients.

## Arrests: Statewide/All Programs




In FY2015, 911 clients had prior arrest data to compare to current period arrests. Of the 911 clients with arrest data, 719 (78.9%) had no arrests current or prior. Arrests decreased or remained the same versus prior periods for 755 (82.9%) clients and 130 (14.3%) clients had fewer arrests than in prior periods. Arrests increased versus prior periods for 26 (2.9%) 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 2015 | Youth % positive | Parent % positive | National Benchmark for Parent Response[1] |
|---|---|---|---|
| Services are seen as accessible and convenient regarding location and scheduling | 86 | 94 | 82.8% |
| Services are seen as satisfactory and helpful | 85 | 94 | 87.2% |
| Clients get along better with family and friends and are functioning better in their daily life | 78 | 78 | 67.3% |
| Clients feel they have a role in directing the course of their treatment | 75 | 93 | 87% |
| Staff are respectful of client religion, culture and ethnicity | 93 | 98 | 93% |
| Clients feel supported in their program and in their community | 81 | 96 | 83.9% |
| Clients are better able to cope and are doing better in work or school | 77 | 79 | 69.5% |

| Residential Discharge Services Survey | Youth % positive | Parent % positive |
|---|---|---|
| Services are seen as accessible and convenient regarding location and scheduling | 86 | 87 |
| Services are seen as satisfactory and helpful | 94 | 82 |
| Clients get along better with family and friends and are functioning better in their daily life | 86 | 74 |
| Clients feel they have a role in directing the course of their treatment | 89 | 79 |
| Staff are respectful of client religion, culture and ethnicity | 97 | 88 |
| Clients are better able to cope and are doing better in work or school | 92 | 74 |

[1] 2014 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at www.samhsa.gov/dataoutcomes/urs/2014/nevada.pdf

# ATTACHMENT C

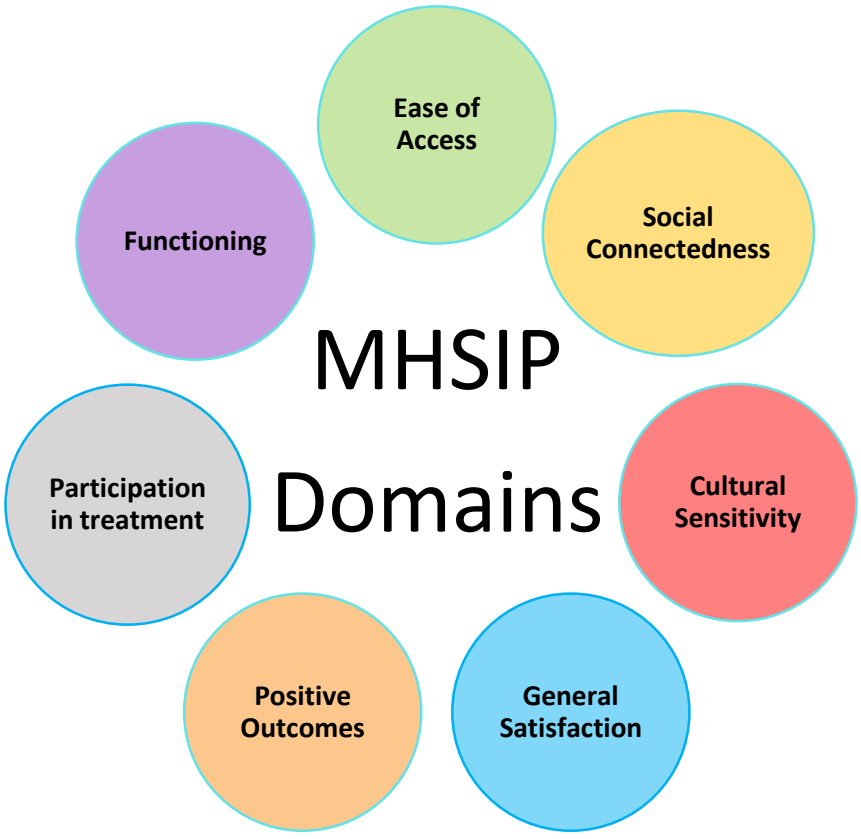
DCFS Community Based Services Parent/Caregiver –
Youth Survey Results Statewide
Spring 2015 report

# DCFS Community-Based Services
# Parent / Caregiver – Youth Survey Results
# Statewide Spring 2015

## Introduction

From May 4 to June 26, 2015 The Division of Child and Family Services conducted its spring survey of children's community-based behavioral health service programs. Parents/caregivers with children in treatment and the youth 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 "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness (see Figure 1). Also included were items related to client treatment, confidentiality issues, family dynamics/relating skills, client awareness of available community support services, overall satisfaction with the psychiatric care, and lastly how treatment information, as well as alternatives, were presented to the youth and parents/caregivers.

Figure 1. Federal Mental Health Statistical Improvement Program Domains



## Survey Population

Parents/caregivers with children in community-based mental health treatment and the children themselves when age appropriate were participants in this Spring Survey. The total number of children in community-based mental health treatment was 1,442. Responding to the survey were 362 parents/caregivers and 201 youth in program services. Of the 362 parent/caregiver surveys, 35 respondents chose to complete the Spanish language survey. Survey participation was 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, or completed at home and mailed to Planning and Evaluation Unit offices. Survey participation was voluntary, and survey responses were anonymous and confidential.

The following table presents the number of parents/caregivers and the number of youth surveys received from each region and treatment site. The parents/caregivers section of the table includes the percentage of clients served who were sampled by the respective area's survey. Youth percentages are not reported due to the age eligibility of participants. Only youth aged 11 or older participated in the survey process.

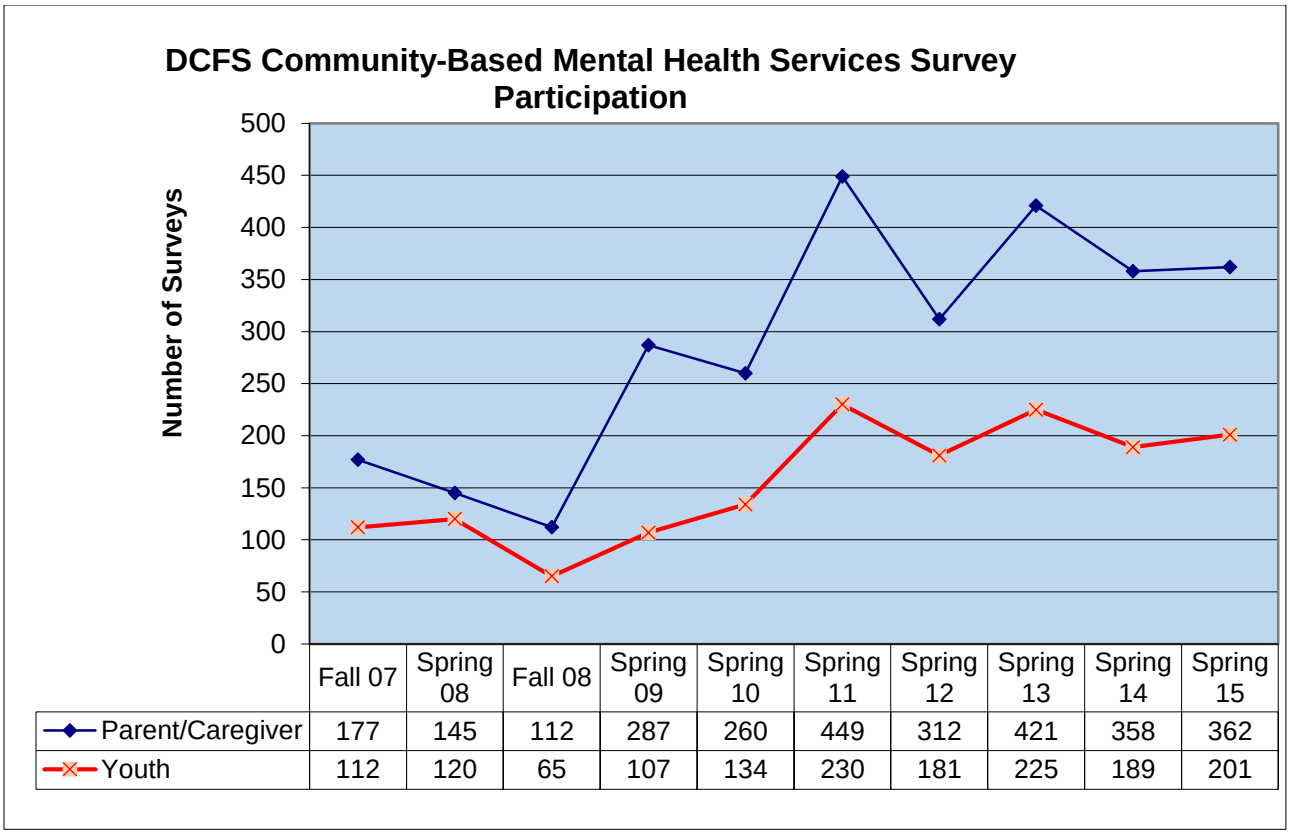
| REGION & SITE | SURVEYS | | | |
|---|---|---|---|---|
| | Parent/Caregiver | | | Youth |
| | Number of Surveys | Number of Clients Served | Survey Sample Percent | Number of Surveys |
| **SNCAS** | | | | |
| Children's Clinical Services | 78 | 411 | 19% | 74 |
| WIN | 68 | 211 | 32% | 49 |
| Early Childhood Mental Health Services | 59 | 270 | 22% | N/A |
| **SNCAS Total** | **205** | **892** | **23%** | **123** |
| **NNCAS** | | | | |
| Outpatient Services | 74 | 231 | 32% | 35 |
| WIN–Reno/Rural | 53 | 166 | 32% | 43 |
| Early Childhood Mental Health Services | 30 | 153 | 21% | N/A |
| **NNCAS Total** | **157** | **550** | **29%** | **78** |
| **Statewide Total** | 362 | 1442 | 25% | 201 |

## Survey Demographics

The graphics within the report represent the demographics of those participating in the 2015 Community-Based Services Survey. Data collected includes both parent/caregiver responses as well as the self-reporting of youth, aged 11 and older. Please note that not every parent/caregiver completing a survey was cross walked to link to a youth survey. Percentages are listed as whole numbers so totals may not always equal 100%.

## Survey Participation

This current survey is the tenth statewide children's Community-Based Services Survey to date conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past ten surveys.




| | Fall 07 | Spring 08 | Fall 08 | Spring 09 | Spring 10 | Spring 11 | Spring 12 | Spring 13 | Spring 14 | Spring 15 |
|---|---|---|---|---|---|---|---|---|---|---|
| Parent/Caregiver | 177 | 145 | 112 | 287 | 260 | 449 | 312 | 421 | 358 | 362 |
| Youth | 112 | 120 | 65 | 107 | 134 | 230 | 181 | 225 | 189 | 201 |

The current survey shows a statewide increase (1%) in parent/caregiver participation and a corresponding increase (6%) in youth participation when compared to the same survey conducted in the spring of 2014.
Statewide there was a combined total of 563 agency parent/caregiver and youth survey participants. There was an overall statewide participation increase of (3%) from the spring 2014 survey.

This year a Spanish version of both the youth and the parent/caregiver survey instruments were available for this project. Of the 201 youth surveys returned statewide, 0 were in Spanish and of the 362 parent/caregiver surveys returned statewide, 35 were in Spanish.

### Survey Results Format

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 representing 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. Under the Medical Practitioner Services domain, two questions represent the number of responses for each possible answer that was available for selection by the survey participant.

Any statement on the survey with a 60% or less positive response rating is highlighted. Programs having highlighted items will monitor these particular items and develop improvement plans to address the matters.

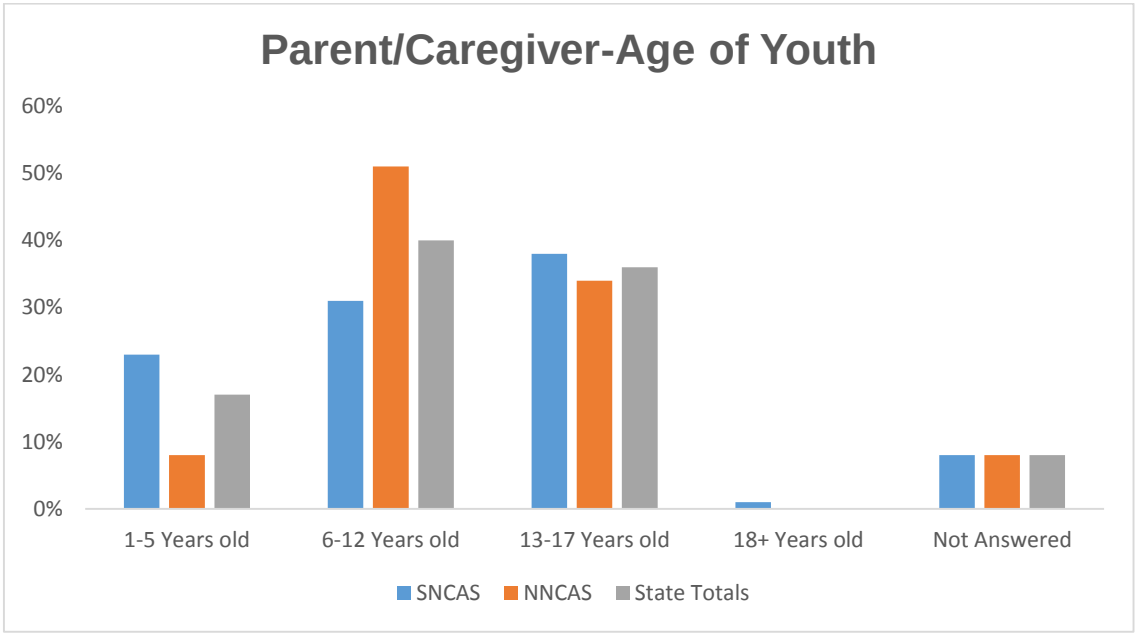
## SNCAS/NNCAS

Statewide the individuals completing the parent/caregiver survey were birth parents (49%), foster parents (25%), adoptive parents (13%), grandparents (5%), other (4%), step-parent (3%), or a sibling (1%). The majority of the respondents statewide indicated that the youth was covered by Fee for Service Medicaid. Approximately 5% statewide had an immediate family member in the military.

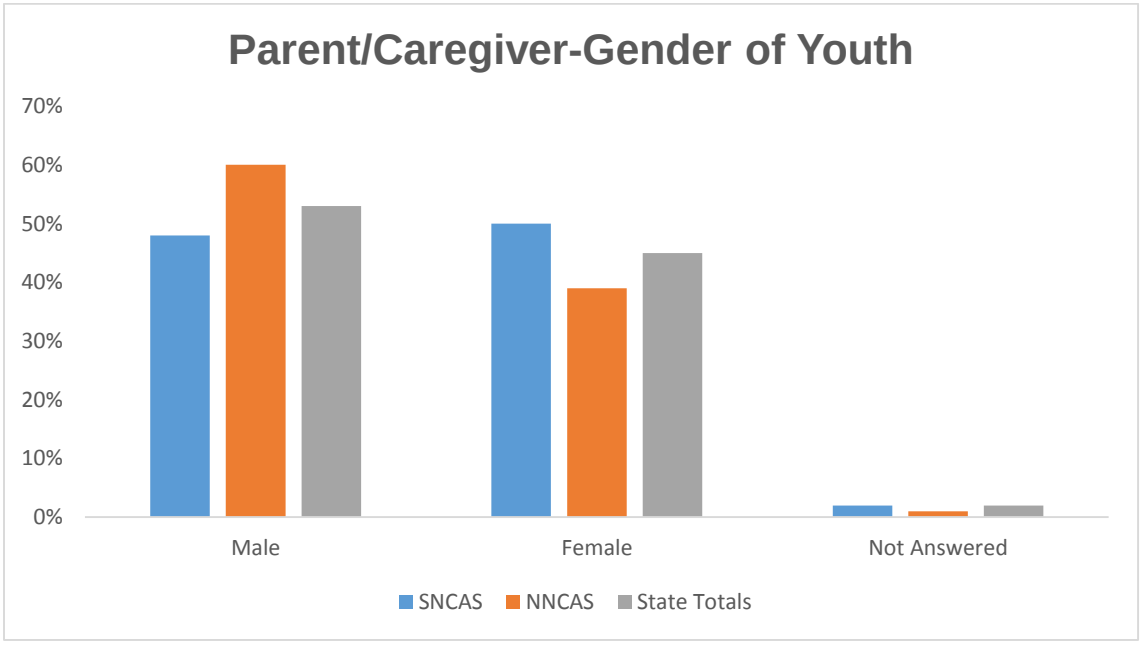
## Demographics

### Age/Gender/Race/Ethnicity of Youth

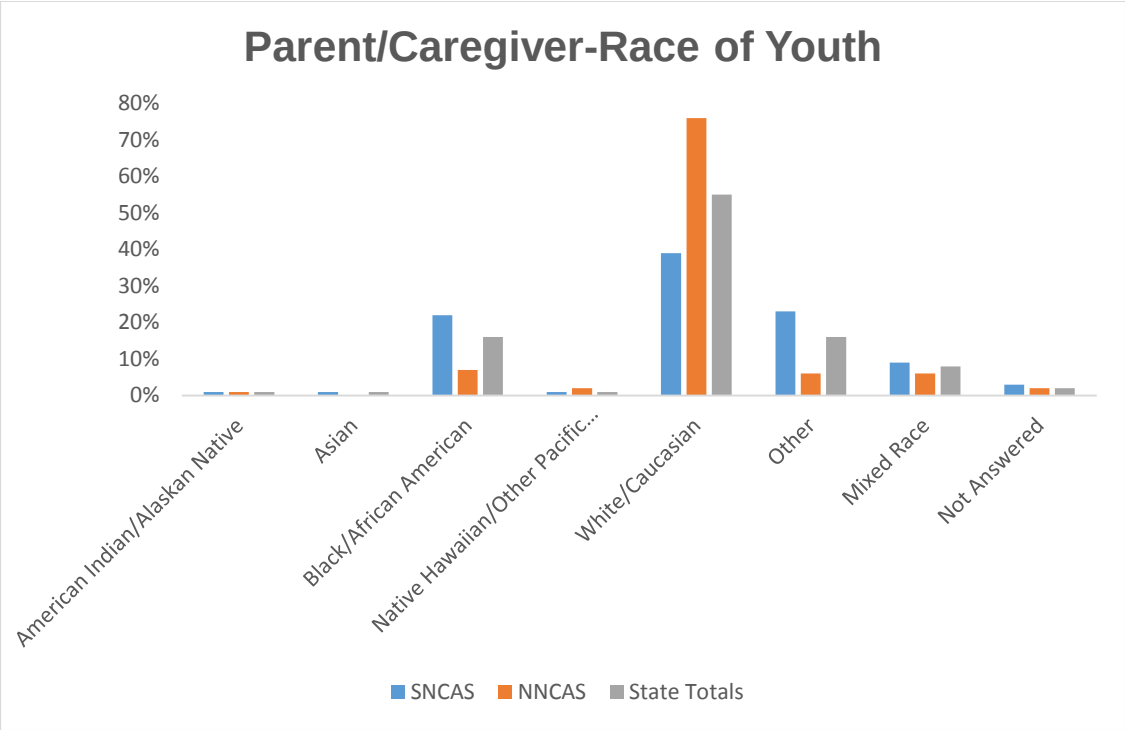
Parents/caregivers statewide reported that youth in services were between the ages of 1-5 (17%), 6-12 (40%), 13-17 (36%), and (17%) did not answer.



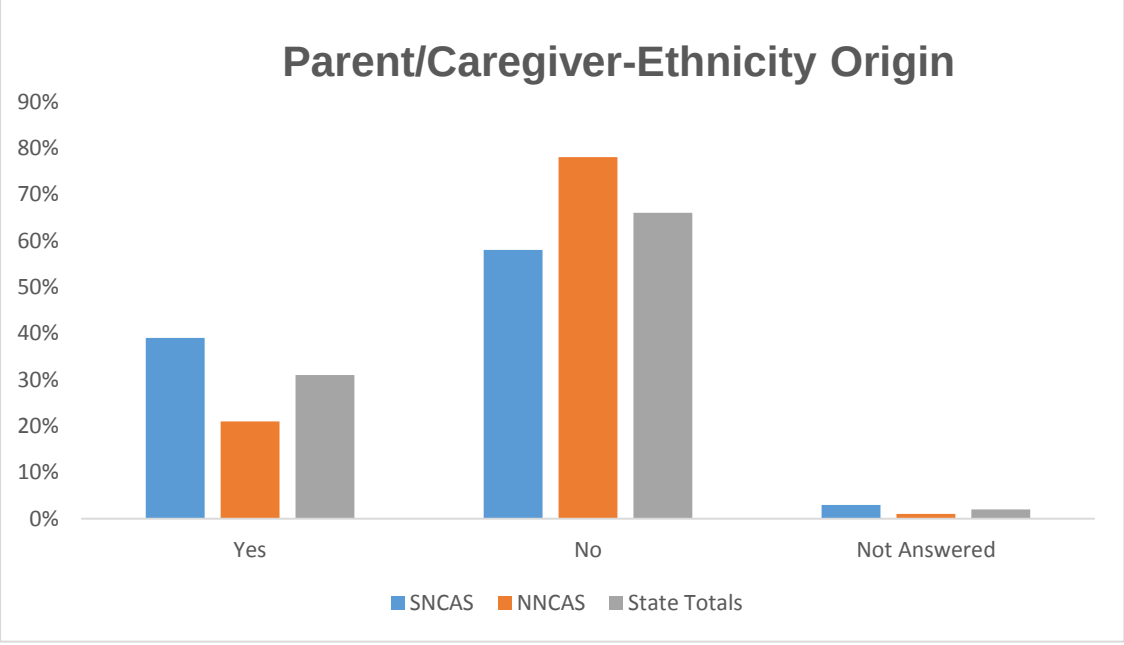

Parents/caregivers statewide reported that youth in services were (53%) Male, (45%) Female, and (2%) did not answer the question.



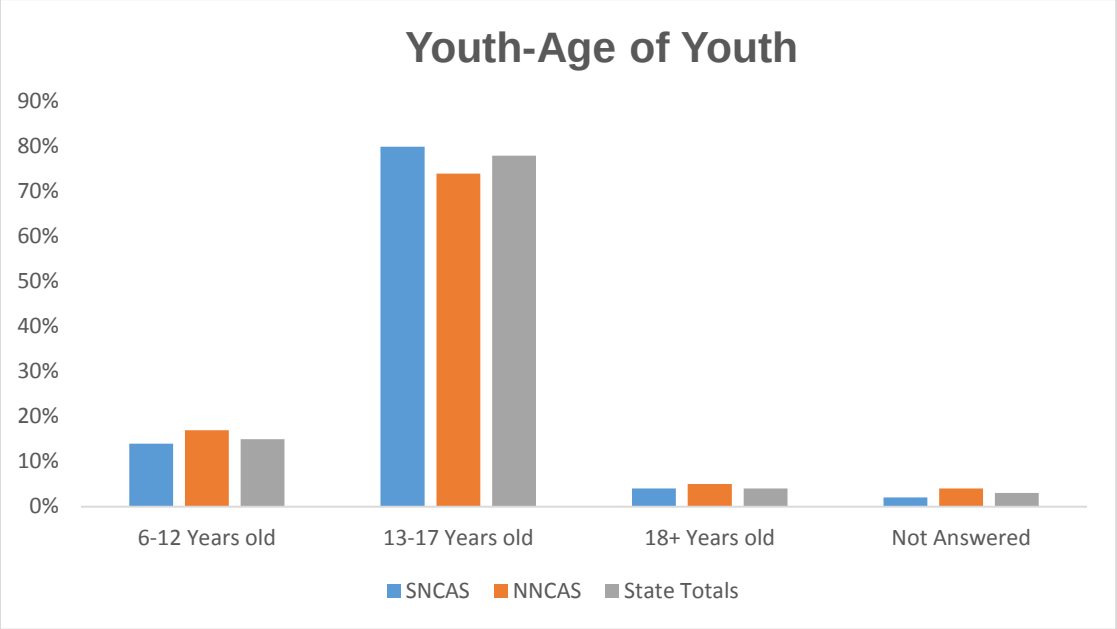
Parents/caregivers statewide reported that (55%) of the youth were White/Caucasian,  Other (16%), Black/African American (16%), Mixed Race (8%), American Indian/Alaskan Native (1%), Asian (1%), or Native Hawaiian/Other Pacific Islander (1%) and (3%) did not answer this question.



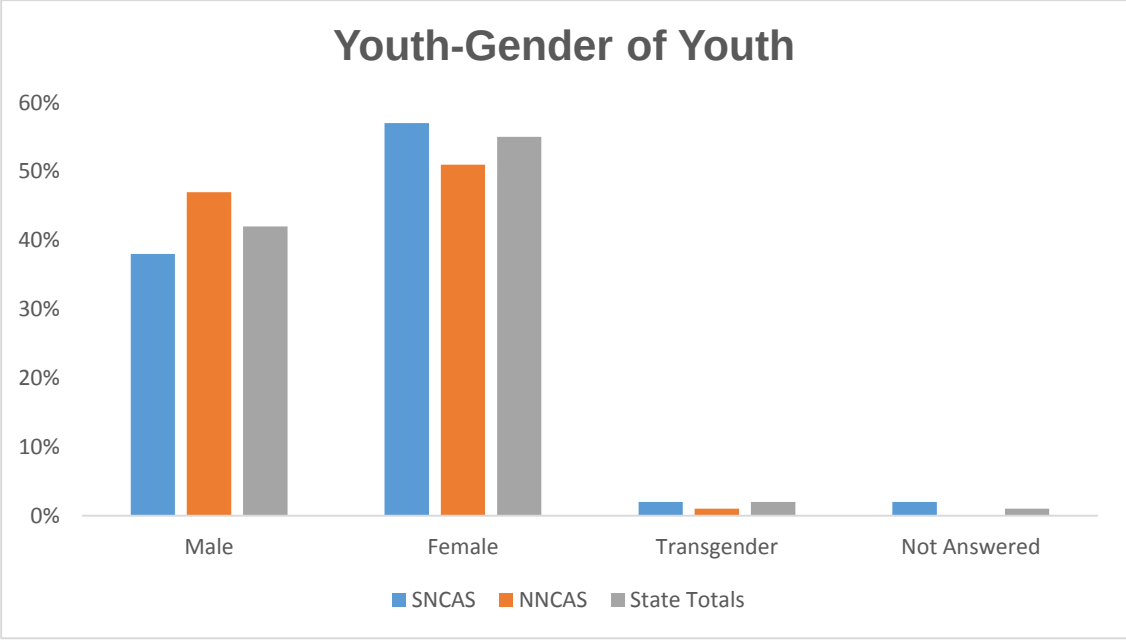

Regarding ethnicity, (66%)  not of Spanish, Hispanic, Mexican or Latino origin, (32%) Spanish, Hispanic, Mexican or Latino origin, and (2%) no response.



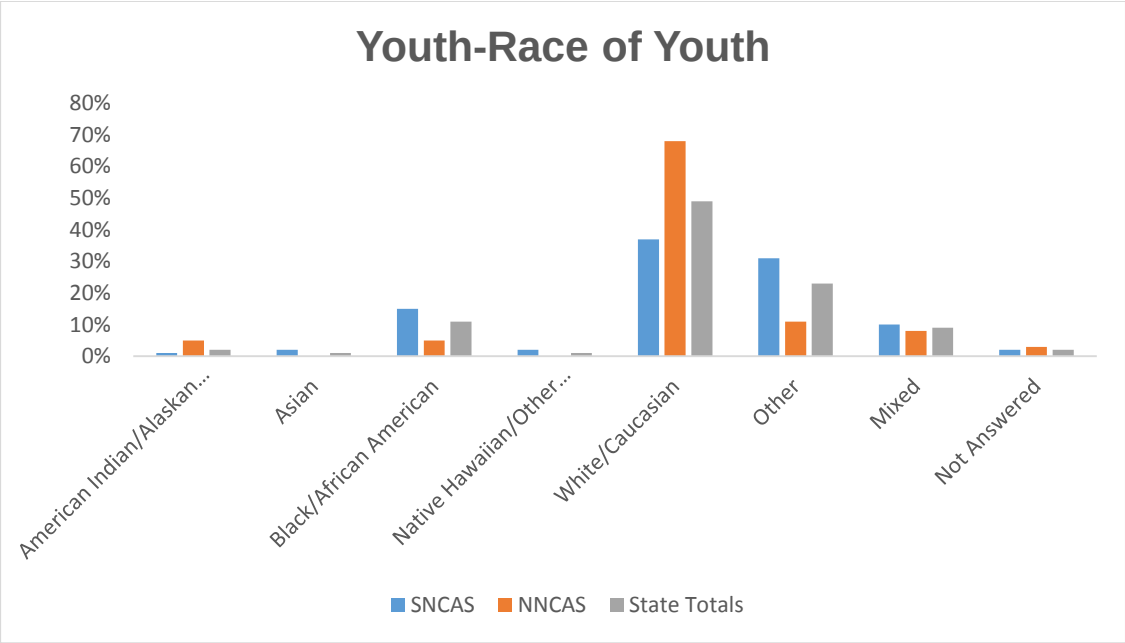
Only youth over the age of 11 were asked to complete surveys, their age distribution was 13-17 (78%), 6-12 (15%), or 18 or older (4%) and (3%) did not answer the question.



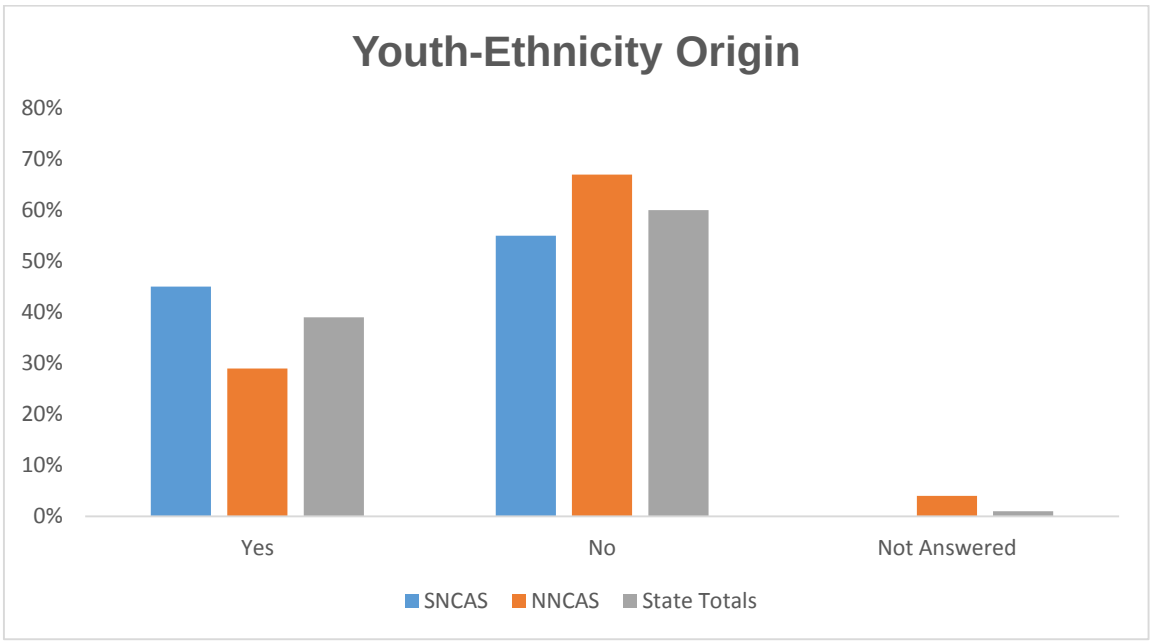

Youth statewide reported their gender as (55%) Female, (42%) Male, (2%) Transgender, and (1%) did not answer the question.



Youth statewide reported their race as (49%) White/Caucasian. They also listed Other (23%), Black/African American (11%), Mixed Race (9%), American Indian/Alaskan Native (2%), Asian (1%), or Native Hawaiian/Other Pacific Islander (1%) as their race, and (2%) did not answer the question.

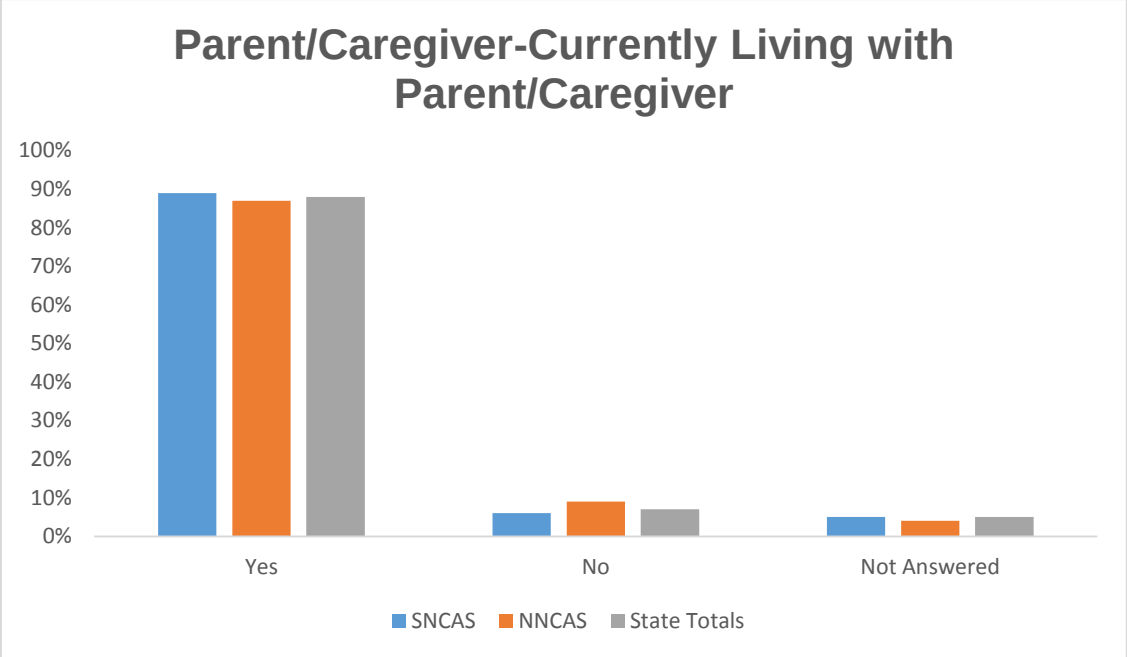



Youth statewide reported 60%) of their parents were not of Spanish, Hispanic, Mexican or Latino origin. The remaining (39%) were of Spanish, Hispanic, Mexican or Latino origin and (1%) did not answer the question.

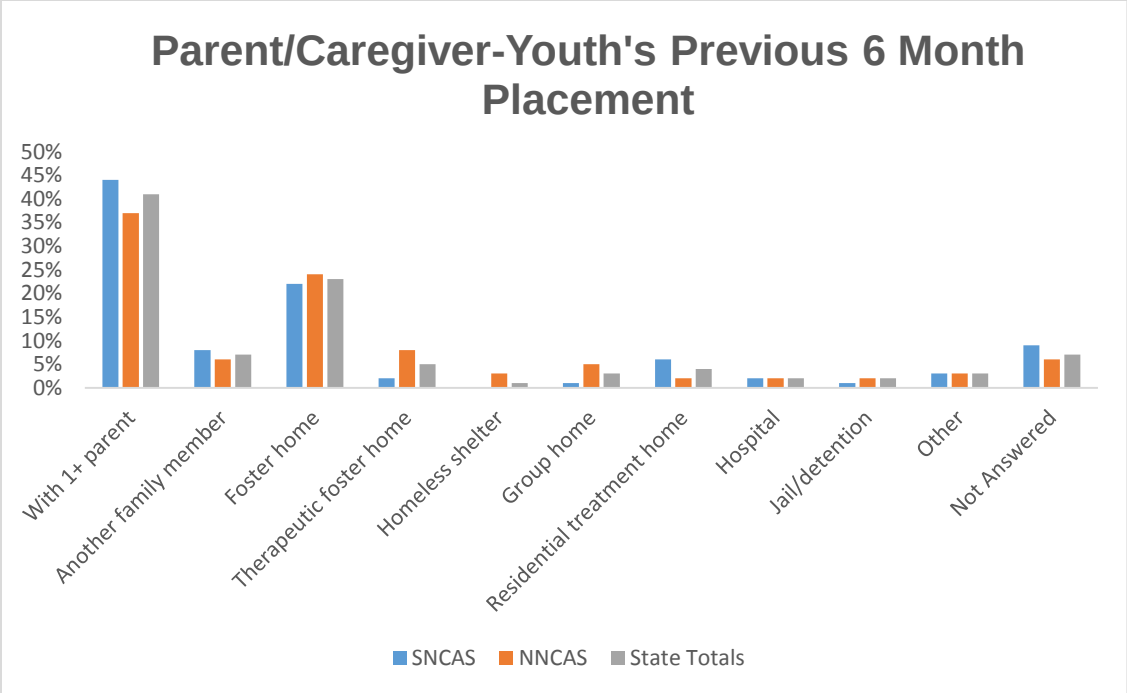


**Current/Previous Living Situation of Youth**

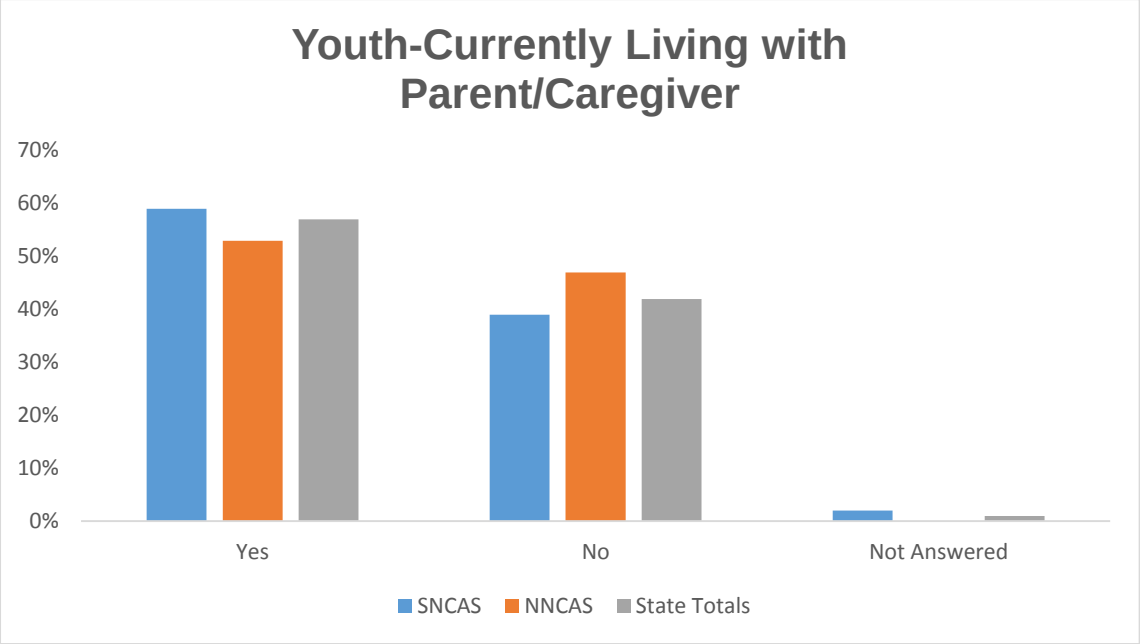
(88%) were living with parents/caregivers at the time of the survey. (7%) were not living with parents/caregivers and (5%) did not answer the question.



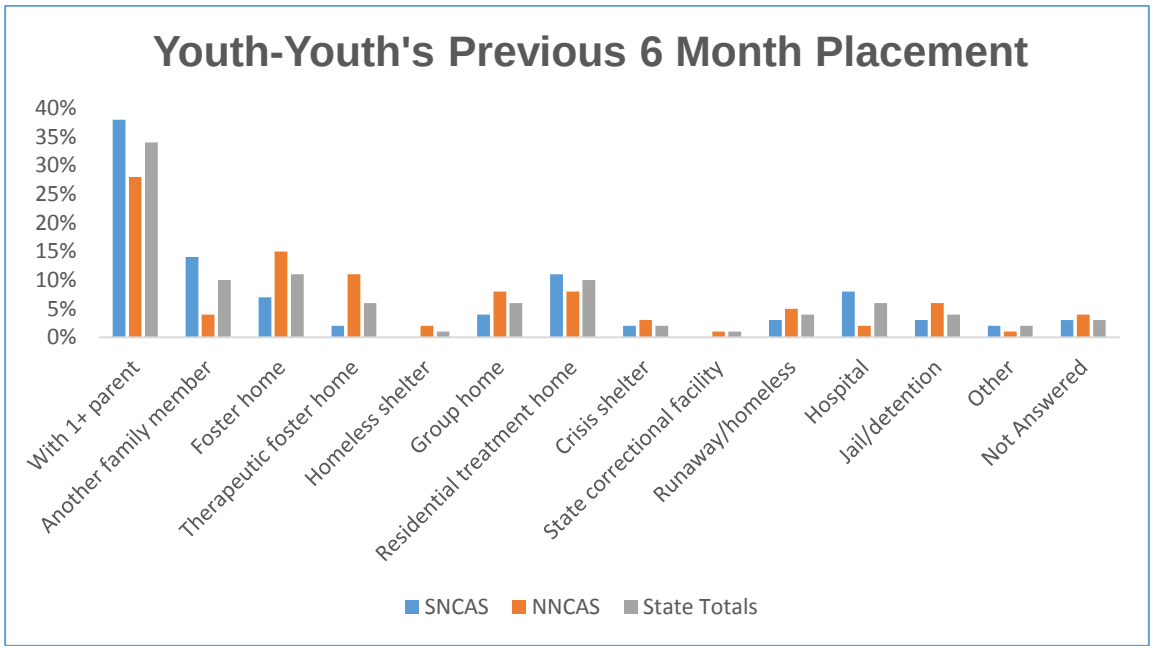

Youth's residence last six months, one or more parents (41%), foster care (23%), another family member (7%), theraupeutic foster home (5%), residential treatment home (4%), other (3%), group home (3%), hospital (2%), jail/detention(2%), homeless shelter (1%), and (7%)no response.



Youth statewide reported that they were living with parents/caregivers (57%), (42%) reported that they were not living with parents/caregivers, and (1%) did not answer the question.




Youth reported they had resided with one or more parent (34%), foster home (11%), other family member (10%), residential treatment (10%), therapeutic foster home, (6%) group home (6%), hospital (6%), runaway/homeless (4%), jail/detention (4%), other (2%), crisis shelter (2%), homeless shelter (1%), state correctional facility (1%) and (3%) did not answer the question.



**Length of time in services -Statewide**

Both parents/caregivers and youth statewide completed the question regarding the amount of time the youth had been in services. Parents/caregivers reported their child had been in services for (31%) more than one year, (31%) 6 months to one year, (25%) 3 to 5 months, (10%) less than 2 months, (3%) did not answer the question. Youth reported the length of service as being more than one year (35%), 6 months to one year (27%), 3 to 5 months (34%), less than 2 months (11%), and (3%) did not answer the question.

**SNCAS/NNCAS-Community-based Service Survey Results**

SNCAS' highest positive responses were in the areas of Cultural Sensitivity (97%), Social Connectedness (95%), and both General Satisfaction and Interest Items were (92%). NNCAS' highest positive response averages were in the areas of Cultural Sensitivity (96%), Social Connectedness (92%), and both Access to Services and General Satisfaction (90%). The area with the lowest positive response for both SNCAS and NNCAS was in the Medical Practitioner Services. Parent/Caregiver and youth survey participants reported that doctors/healthcare providers did not discuss side effects of medication, why the parent/child would want or not want to take medication, if there were other options available for the child, and what the pros and cons of treatment were. These areas are highlighted below to indicate a less than 60% positive response.

## SNCAS/NNCAS-Community-Based Services Survey Results

| **Parents/Caregivers N = 362 Youth N = 201<br>Total Served = 1442 Sample = 25%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
|---|---|---|
| **ACCESS TO SERVICES** | | |
| SNCAS | 90 | 85 |
| NNCAS | 90 | 83 |
| Statewide Totals | 91 | 84 |
| **GENERAL SATISFACTION** | | |
| SNCAS | 92 | 84 |
| NNCAS | 90 | 82 |
| Statewide Totals | 91 | 83 |

| POSITIVE OUTCOMES | | |
|---|---|---|
| SNCAS | 76 | 70 |
| NNCAS | 77 | 71 |
| Statewide Totals | 76 | 71 |
| **PARTICIPATION IN TREATMENT** | | |
| SNCAS | 90 | 78 |
| NNCAS | 89 | 70 |
| Statewide Totals | 90 | 75 |
| **CULTURAL SENSITIVITY** | | |
| SNCAS | 97 | 92 |
| NNCAS | 96 | 88 |
| Statewide Totals | 96 | 90 |

| SOCIAL CONNECTEDNESS | | |
|---|---|---|
| SNCAS | 95 | 81 |
| NNCAS | 92 | 79 |
| Statewide Totals | 93 | 80 |
| **FUNCTIONING** | | |
| SNCAS | 76 | 72 |
| NNCAS | 78 | 75 |
| Statewide Totals | 77 | 73 |
| **INTEREST ITEMS** | | |
| SNCAS | 92 | 81 |
| NNCAS | 87 | 76 |
| Statewide Totals | 90 | 79 |
| **PSYCHIATRIST/MD** | | |
| SNCAS | 87 | 85 |
| NNCAS | 86 | 83 |
| Statewide Totals | 86 | 84 |

| MEDICAL PRACTITIONER SERVICES- | Parent/Caregiver Response % | | | | | Youth Response % | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Never | Some-times | Usually | Always | Not answered | Never | Some-times | Usually | Always | Not answered |
| In the last 6 months, my child's doctor or other healthcare provider and I, talked about specific things you could do to prevent illness in your child. | | | | | | | | | | |
| SNCAS | 24 | 25 | 21 | 19 | 11 | 27 | 38 | 17 | 12 | 6 |
| NNCAS | 22 | 29 | 13 | 21 | 15 | 22 | 40 | 18 | 11 | 9 |
| Statewide Totals | 23 | 27 | 17 | 20 | 13 | 25 | 39 | 17 | 12 | 7 |

| MEDICAL PRACTITIONER SERVICES | Parent/Caregiver Response % | | | | | Youth Response % | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered |
| In the last twelve months, my child did see a medical doctor (or nurse) for a health checkup or because he/she was sick. | | | | | | | | | | |
| SNCAS | 67 | 4 | 23 | 2 | 2 | 51 | 12 | 28 | 7 | 2 |
| NNCAS | 64 | 7 | 22 | 3 | 3 | 62 | 13 | 14 | 11 | 0 |
| Statewide Totals | 66 | 6 | 23 | 3 | 3 | 55 | 12 | 22 | 9 | 1 |

| | Parent/Caregiver Positive Response % | Youth Positive Response % |
|---|---|---|
| My child is on medication for emotional/behavioral problems. | | |
| SNCAS | 36 | 55 |
| NNCAS | 54 | 65 |
| Statewide Totals | 44 | 59 |
| **My child's doctor or nurse did tell me and/or my child what side effects to watch for.** | | |
| **SNCAS** | 29 | 42 |
| **NNCAS** | 46 | 58 |
| **Statewide Totals** | 37 | 48 |
| **My child's doctor or other healthcare provider and I did talk about the reasons my child might want to take medication.** | | |
| **SNCAS** | 44 | 64 |
| **NNCAS** | 57 | 76 |
| **Statewide Totals** | 50 | 69 |
| **My child's doctor or other healthcare provider did talk about the reasons my child might NOT want to take medication.** | | |
| **SNCAS** | 35 | 39 |
| **NNCAS** | 48 | 58 |
| **Statewide Totals** | 40 | 46 |
| **When we talked about starting or stopping a prescription medicine, my child's doctor or other healthcare provider did ask what I thought was best for my child.** | | |
| **SNCAS** | 43 | 52 |
| **NNCAS** | 62 | 69 |
| **Statewide Totals** | 51 | 59 |
| **In the last 6 months, if there was more than 1 choice for my child's treatment or health care, a doctor or other healthcare provider did ask me which choice I thought was best for my child.** | | |
| **SNCAS** | 45 | 51 |
| **NNCAS** | 50 | 60 |
| **Statewide Totals** | 47 | 55 |
| **In the last 6 months, my child's doctor or other healthcare provider did talk with me about the pros and cons of each choice for my child's treatment or health care.** | | |
| **SNCAS** | 52 | 52 |
| **NNCAS** | 56 | 63 |
| **Statewide Totals** | 54 | 56 |

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. Individual program reports are available upon request.

# ATTACHMENT D

DCFS Residential Discharge Survey Report Parent/Caregiver -
Youth Survey Results Statewide
FY 2015

Division of Child and Family Services

# 2015 RESIDENTIAL DISCHARGE SURVEY RESULTS

Report provided by: *DCFS Planning and Evaluation Unit*

# DCFS Residential Discharge Survey Report
# Parent / Caregiver – Youth Survey Results
# Statewide FY 2015

## Introduction

From July 1, 2014 to June 30, 2015, DCFS collected discharge surveys from children's residential mental health service programs. Parents/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 "domains" that the Federal Mental Health Statistical Improvement Program (MHSIP) prescribes whenever evaluating mental health programming effectiveness. The domain pertaining to "Social Connectedness" was omitted because of the constrained social context of children in residential programs.

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, race, and ethnicity (Cultural Sensitivity); and how well respondents seem to be doing in their daily lives (Functioning). The seventh domain (Interest Items) includes statements regarding client treatment and confidentiality issues, family dynamics/relating skills and client awareness of available community support services. The eighth domain (Psychiatrist/MD) includes statements that relate to the overall satisfaction with the medical doctor at the specific site where care was received. The ninth domain (Medical Practitioner Services) includes statements concerning medical services received and how treatment information as well as options were presented to the youth and parents/caregivers.

Desert Willow Treatment Center's survey instrument was specific to their facility and did not include the same questions as the survey used by the other three programs. The responses in this report correspond with the instrument used by this facility and the data that was collected from parents/caregivers and youth.
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## Survey Population

Parents/caregivers with children receiving residential mental health treatment and the children themselves, when age appropriate (11 years or older), were participants in this survey. The total number of children receiving residential mental health treatment was 394. Responding to the survey were 285 parents/caregivers and 277 youth in program services. Survey participants were solicited at the time of discharge by residential 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. Survey participation was voluntary and survey responses were 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 all

clients served in the respective area's survey. Youth percentages are not reported due to the age eligibility of participants. Only youth aged 11 or older participated in the survey process.

| REGION & SITE | SURVEYS | | | |
|---|---|---|---|---|
| | Parent/Caregiver | | | Youth |
| | Number of Surveys | Number of Clients Discharged | Survey Sample Percent | Number of Surveys |
| **Southern Nevada Child & Adolescent Services** | | | | |
| Desert Willow Treatment Center | 247 | 284 | 87% | 241 |
| Oasis On-Campus Treatment Homes | 6 | 36 | 17% | 7 |
| **SNCAS Total** | 253 | 320 | 79% | 248 |
| **Northern Nevada Child & Adolescent Services** | | | | |
| Adolescent Treatment Center | 14 | 34 | 41% | 13 |
| Family Learning Homes | 18 | 40 | 45% | 16 |
| **NNCAS Total** | 32 | 74 | 43% | 29 |
| **Statewide Total** | 285 | 394 | 72% | 277 |

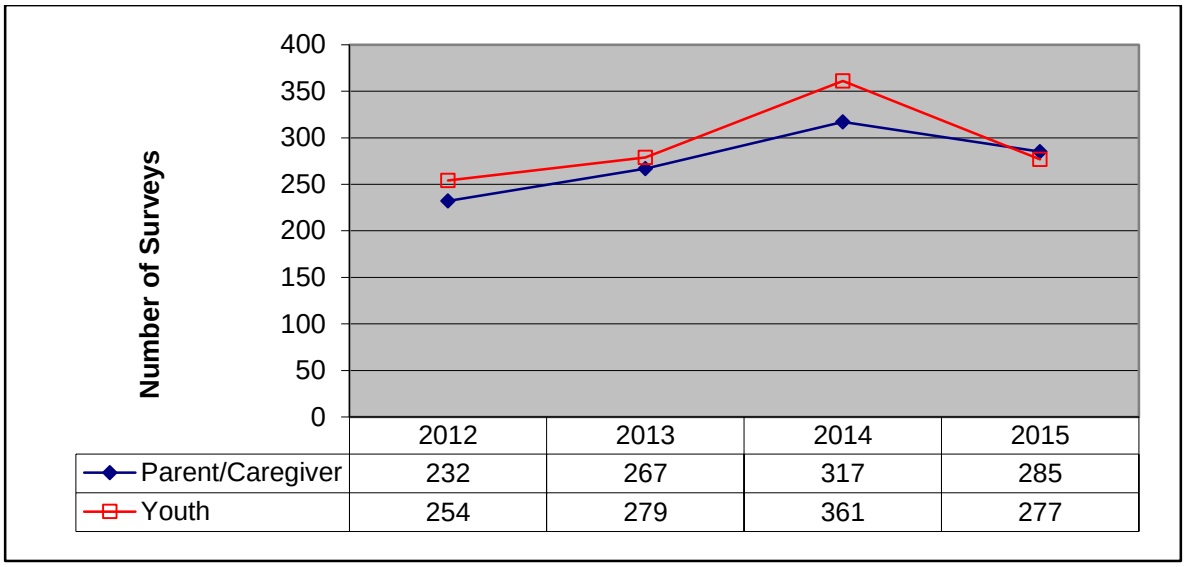
## Survey Demographics

The pie charts within the report represent the demographics of those participating in the 2015 Residential Discharge Survey. Data collected includes both parent/caregiver responses as well as the self-reporting of youth, aged 11 and older. Please note that not every parent/caregiver completing a survey was cross walked to link to a youth survey. Percentages are listed as whole numbers so totals may not always equal 100%.

## Survey Participation

This current survey is the fourth statewide children's Residential Discharge Survey to date conducted by DCFS. The following graph depicts parent/caregiver and youth participation over the past four surveys.

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




| | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| Parent/Caregiver | 232 | 267 | 317 | 285 |
| Youth | 254 | 279 | 361 | 277 |

The current survey shows a statewide decrease (10%) in parent/caregiver participation and a corresponding decrease (23%) in youth participation when compared to the same survey conducted last year. Statewide there were a combined total of 562 agency parent/caregiver and youth survey participants. There was an overall statewide participation decrease of (17%) from the 2014 survey.

## Survey Results Format

For this report, parent/caregiver and youth responses are reported under each domain. Statements listed under each domain are from the parents/caregivers survey instrument. Youth responded to the same statements that had been reworded to apply to them.

The parent/caregiver and youth response numbers appearing under each domain are percentages. Stated percentages represent 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 listed percentages are based upon the actual number of responses to that particular statement.

All statements on the survey with a 60% or less positive response number are "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. Programs should 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. These questions were not part of the survey instrument that Desert Willow Treatment Center utilized are not included as a part of the survey results.

# SNCAS- Desert Willow Treatment Center (DWTC)

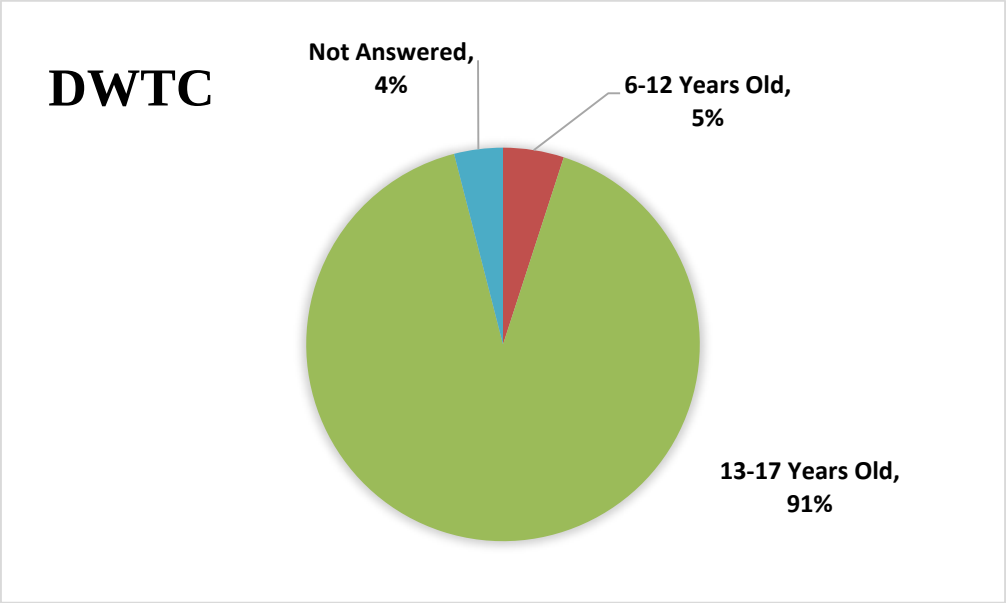
## Demographics

Demographics and data were collected and calculated for youth who were discharged from Desert Willow Treatment Center (DWTC). The survey sample included responses from 216 parents/caregivers and 247 youth participants out of the 284 youth being served by DWTC.

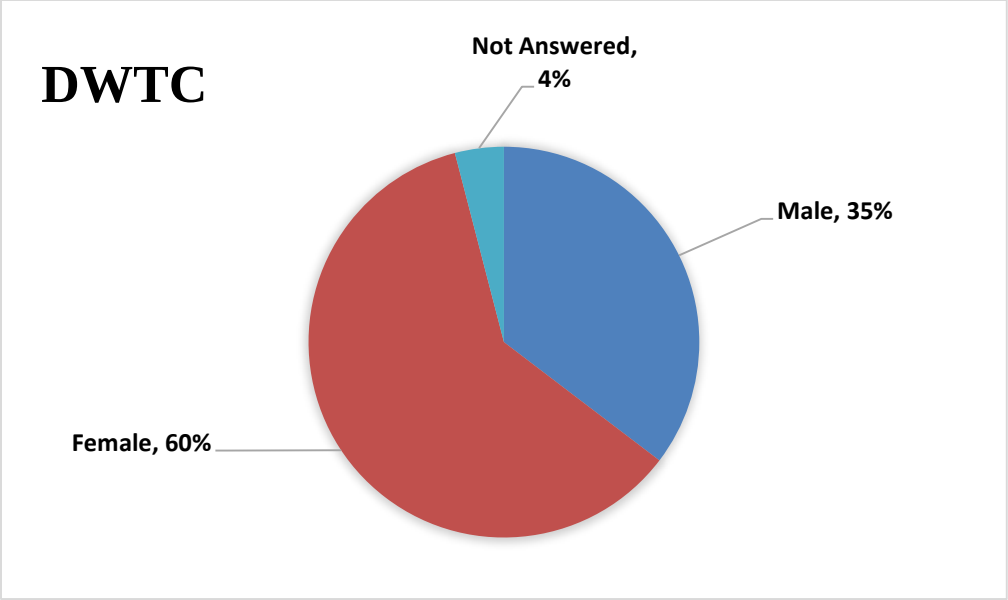
### Age/Gender/Race/Ethnicity of Youth

Results were similar for parents and youth.

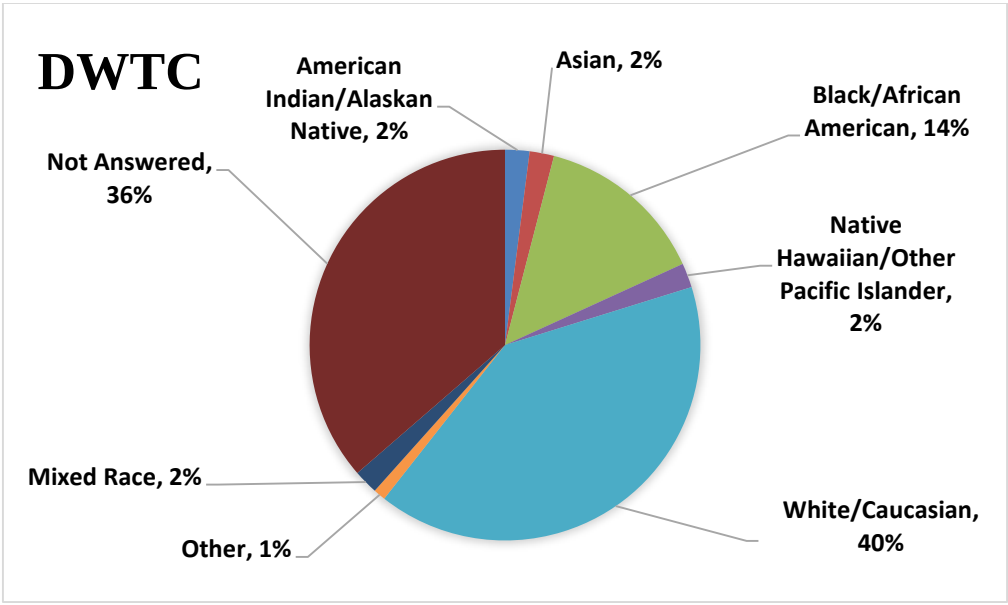
Parents/caregivers reported the youth receiving services at DWTC were between the ages of 13-17 (91%) or 6-12 (5%), and (4%) did not answer the question.



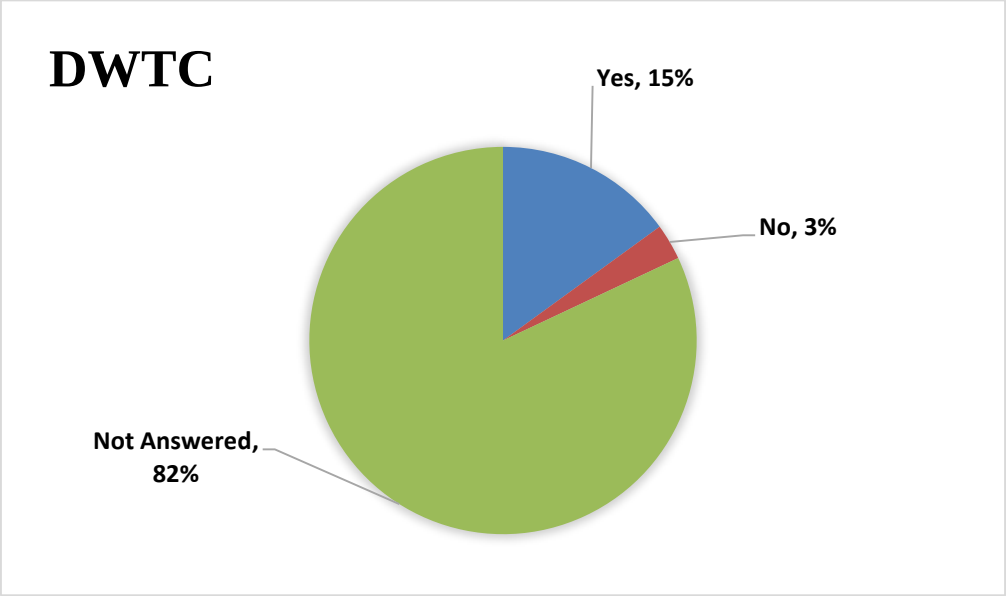
Parents/caregivers reported that the youth receiving services at DWTC were (60%) Female, (35%) Male, and (4%) did not answer the question.




Parents/caregivers reported that (40%) of the youth receiving services at DWTC services were White/Caucasian. Parents/caregivers also listed Black/African American (14%), Native Hawaiian/Other Pacific Islander (2%), Asian (2%), American Indian/Alaskan Native (2%), Mixed Race (2%), and Other (1%) as their child's race, (36%) did not answer the question.

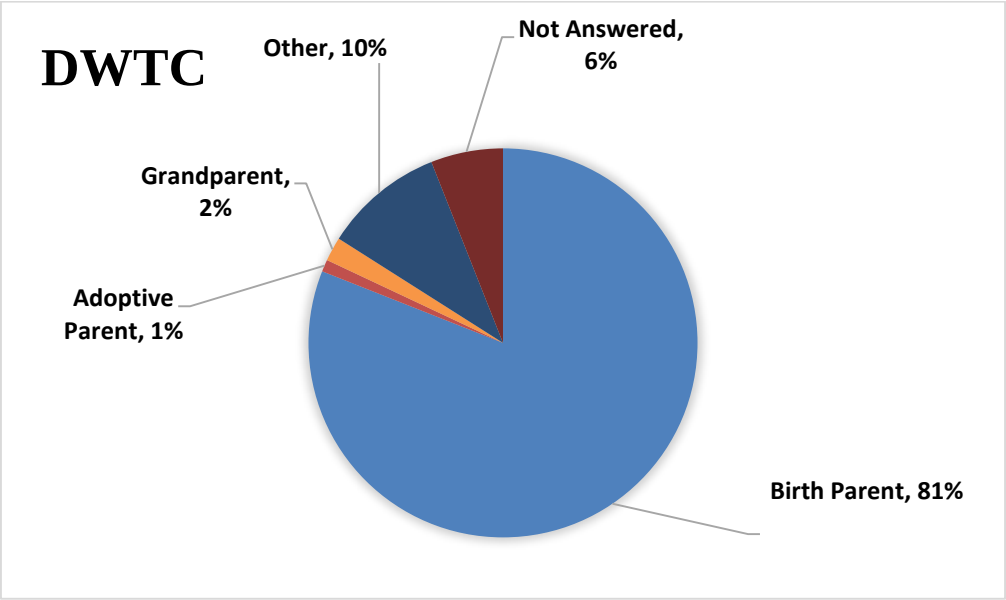


Parents/caregivers reported (15%) of the parents of youth receiving services were of Spanish, Hispanic, Mexican or Latino origin, (3%) were not of Spanish, Hispanic, Mexican or Latino origin, and (82%) did not answer the question.

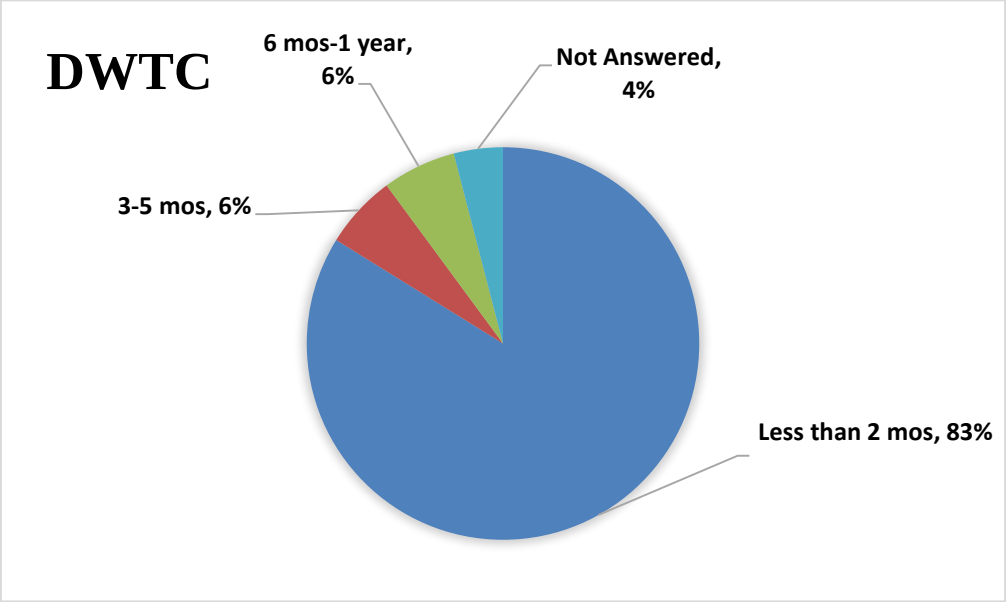



**Survey Completion/Length of Service**

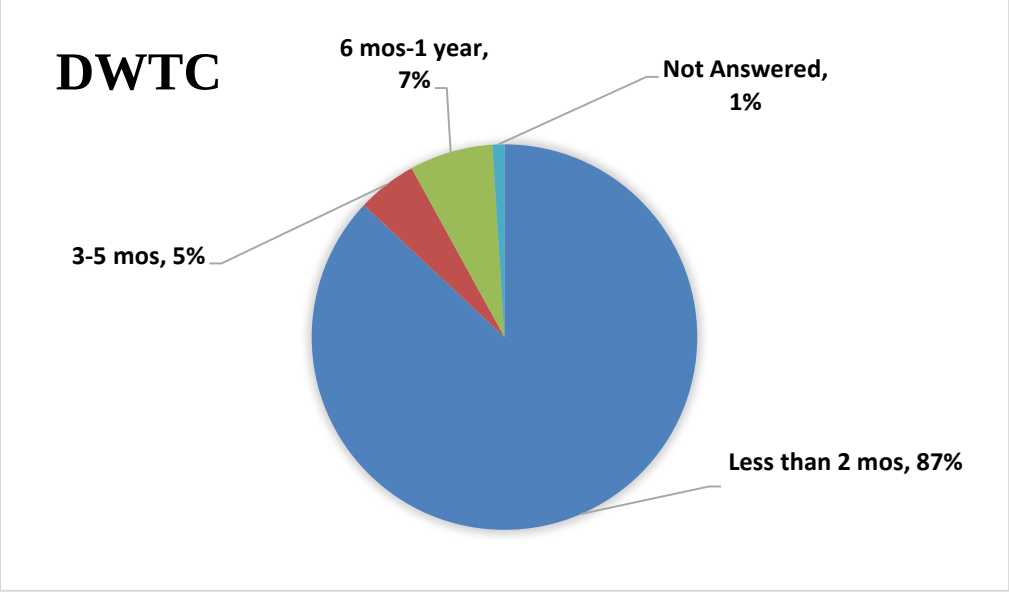
Parents/caregivers reported individuals completing the survey were birth parents (81%), other (10%), grandparents (2%), or adoptive parents (1%) and (6%) did not answer the question.



Both parents/caregivers and youth completed the question regarding the amount of time the youth had been receiving services prior to discharge. The parents/caregivers reported their child had been in services for less than 2 months (83%), 3-5 months (6%), or 6 months to one year (6%), and (4%) did not answer the question.




Youth reported the length of service as less than 2 months (87%), 6 months to one year (7%), or 3-5 months (5%), and (1%) did not answer the question.



**Youth's Immediate Family Serving in Military**

Parents/caregivers with youth receiving services at DWTC were not asked this question on the survey. Data regarding the involvement of immediate family currently serving in the military is not available. The youth were also not asked this question.

**SNCAS- DWTC Survey Results**

Desert Willow Treatment Center's highest positive responses were in the areas of Overall Clinical Evaluations (96%), Staff (96%), and Access (95%). The areas with the lowest positive responses was in the areas of Outcome (90%) and Treatment (90%). Questions with a less than 60% positive response are highlighted below.

| SNCAS- DWTC Survey Results | | |
|---|---|---|
| **Parent/Caregiver N = 216 Youth N = 247<br>Total Discharged = 284 Sample = 76%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
| **NEEDS** | | |
| I got as much help as I needed during the course of treatment (RTC only). | 87 | 97 |
| **EXPECTATIONS** | | |
| The services received met my expectations. | 95 | 86 |
| I got the help I wanted. | 94 | 94 |
| **OVERALL CLINICAL EVALUATION** | | |
| Overall, I am pleased with the services at DWTC. | 98 | 95 |
| **TREATMENT** | | |
| I participated in selecting some activities and services (RTC Only). | 78 | 96 |
| I helped choose treatment goals with the treatment team. | 88 | 87 |
| I participated in treatment planning. | 95 | 89 |
| Staff respected my religious/spiritual beliefs. | 97 | 99 |
| Staff was sensitive to my cultural and ethnic background. | 99 | 94 |
| **ACCESS** | | |
| Staff members were available when there was concerns. | 95 | 97 |
| Services were scheduled at times that were right for us. | 95 | 93 |
| **EDUCATION** | | |
| Educational needs were assessed (RTC Only). | 92 | 95 |
| Staff explained the diagnosis, medication, and treatment services and options. | 98 | 89 |
| Staff explained patient and family rights, safety, and confidentiality issues. | 95 | 97 |
| The patient is doing better in school (RTC Only). | 81 | 98 |
| I am aware of people and services in the community that can help us. | 97 | 97 |
| **STAFF** | | |
| Staff that provided treatment services were caring and professional. | 96 | 94 |
| Staff protected confidentiality. | 97 | 97 |
| Staff protected personal privacy. | 95 | 98 |
| Staff treated me and my family with respect. | 97 | 93 |
| Staff spoke in a way I understood. | 98 | 96 |
| **ENVIRONMENT** | | |
| Buildings in which services were provided are safe and well cared for. | 97 | 96 |
| Buildings in which services were provided are comfortable. | 97 | 90 |

| SNCAS- DWTC Survey Results | | |
|---|---|---|
| **Parent/Caregiver N=216; Youth N=247**<br>**Total Discharged = 284 Sample = 76%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
| **OUTCOME** | | |
| Progress was made on treatment issues (Acute Only.) | 93 | 95 |
| The patient is better at handling life (RTC Only). | 87 | 92 |
| The patient gets along better with family members (RTC Only). | 89 | 77 |
| The patient gets along better with friends and other people (RTC Only). | 80 | 92 |
| The patient is better able to cope when things go wrong (RTC Only). | 92 | 93 |
| My family life is getting better (RTC Only). | 97 | 93 |
| I would recommend DWTC services to others in need of treatment. | 97 | 86 |

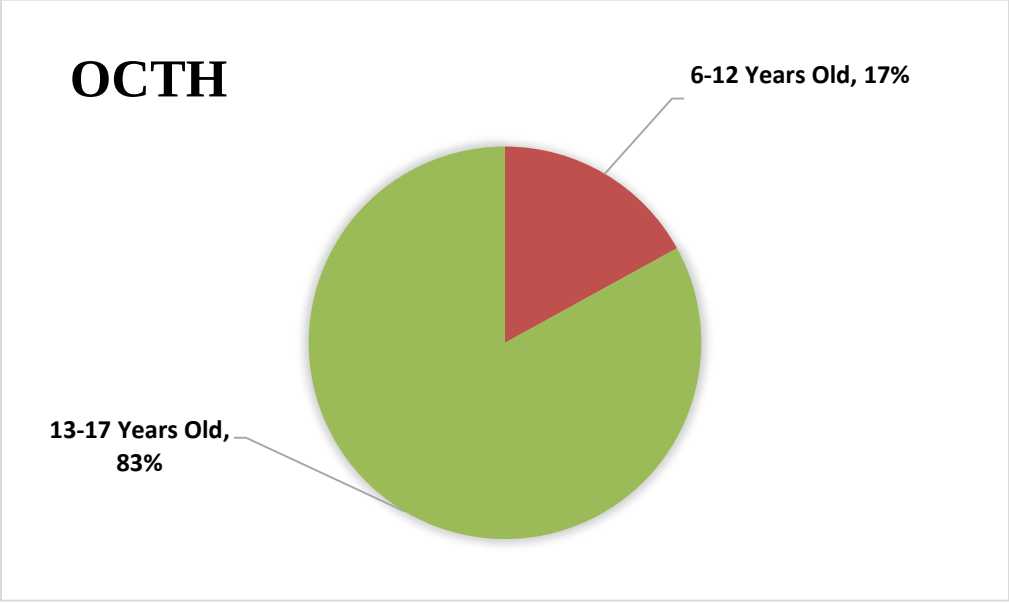
# SNCAS- Oasis On-Campus Treatment Homes

## Demographics

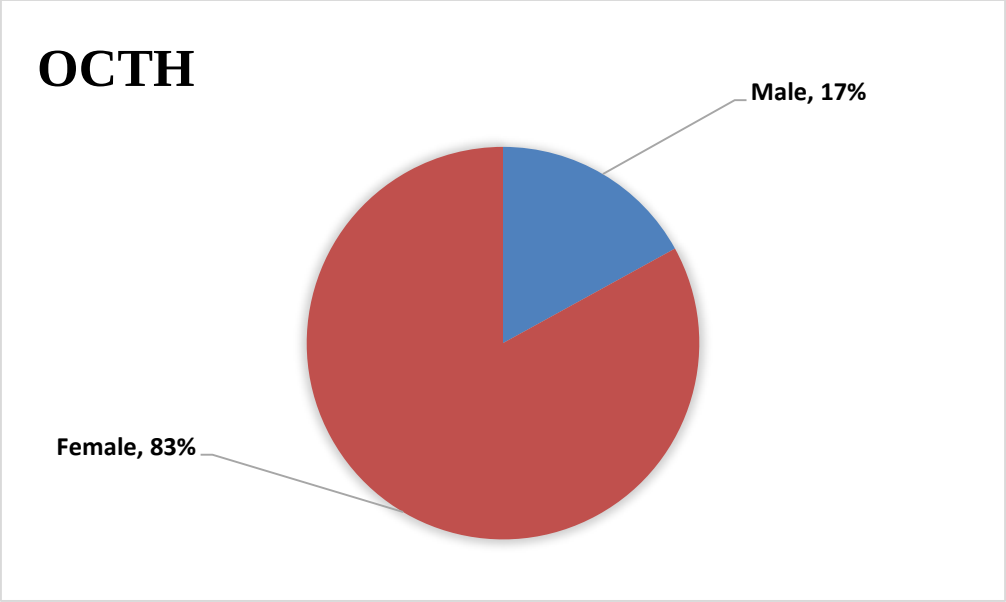
Demographics and data were collected and calculated for youth who were discharged from Oasis On-Campus Treatment Homes (OCTH). The survey sample included responses from 6 parents/caregivers and 7 youth participants out of the 36 youth being served by OCTH.

### Age/Gender/Race/Ethnicity of Youth

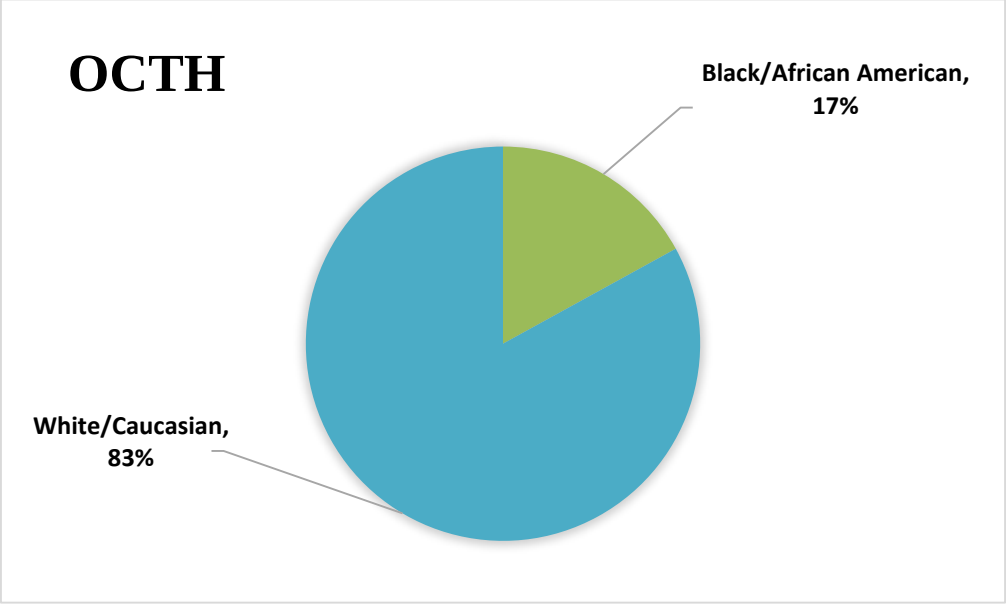
Parents/caregivers reported that youth receiving services at OCTH were between the ages of 13-17 (83%) or 6-12 (17%).



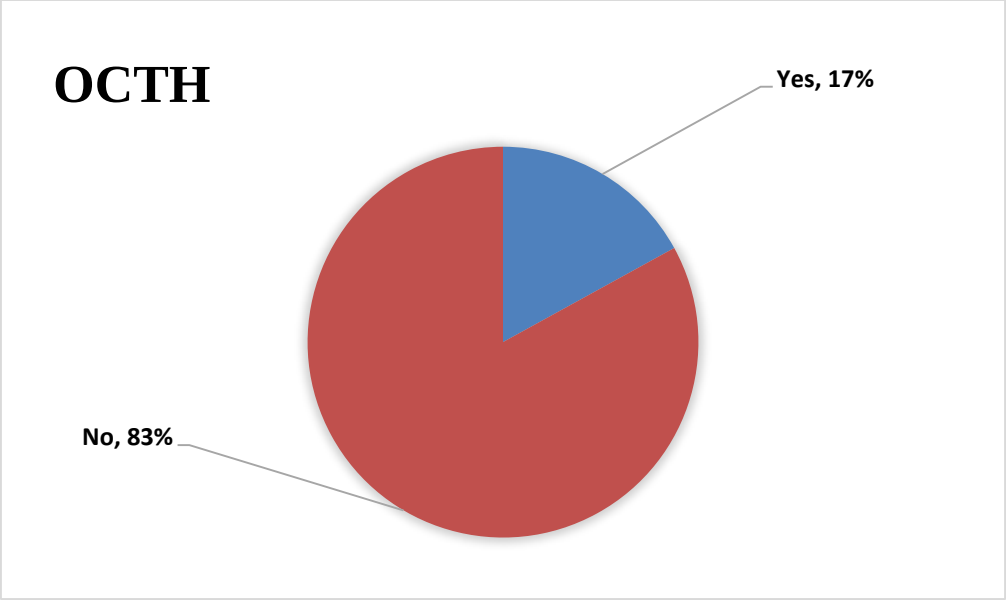
Parents/caregivers reported that the youth receiving services at OCTH were (83%) Female and (17%) Male.



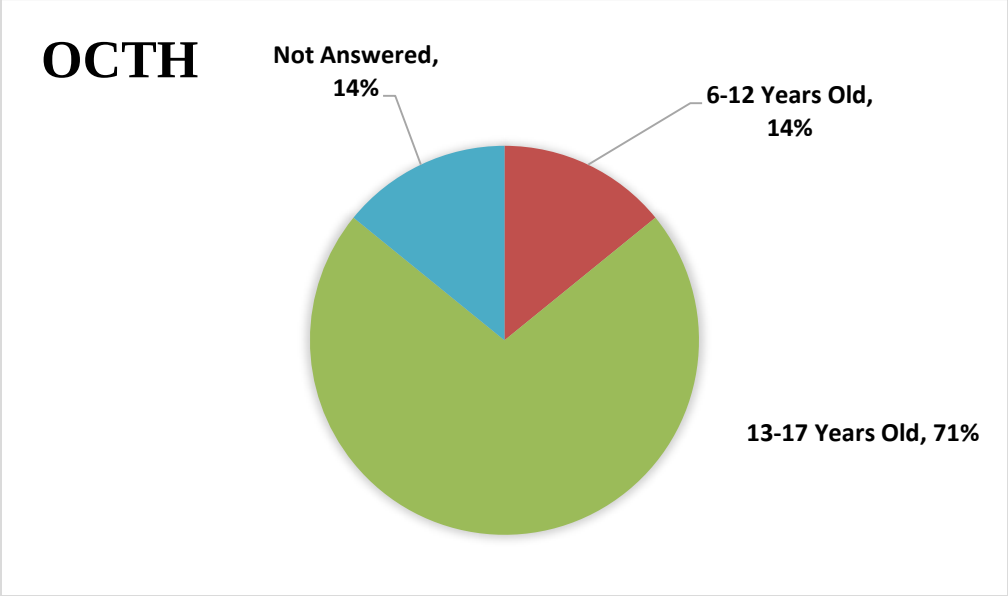

Parents/caregivers reported that (83%) of the youth receiving services at OCTH were White/Caucasian or Black/African American (17%).



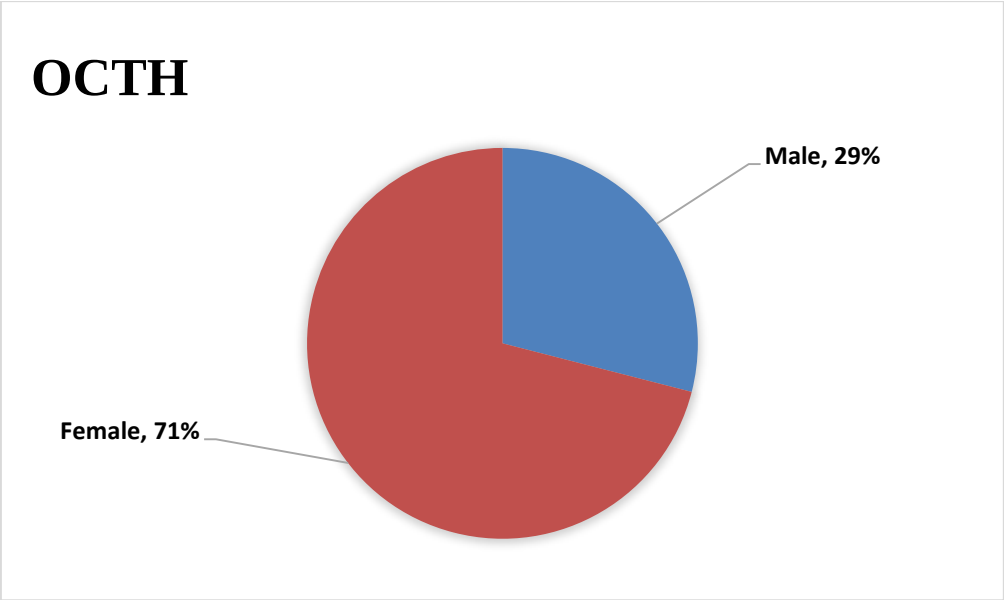
Parents/caregivers reported that (83%) of the parents of youth receiving services at OCTH were not of Spanish, Hispanic, Mexican or Latino origin and (17%) were of Spanish, Hispanic, Mexican or Latino origin.



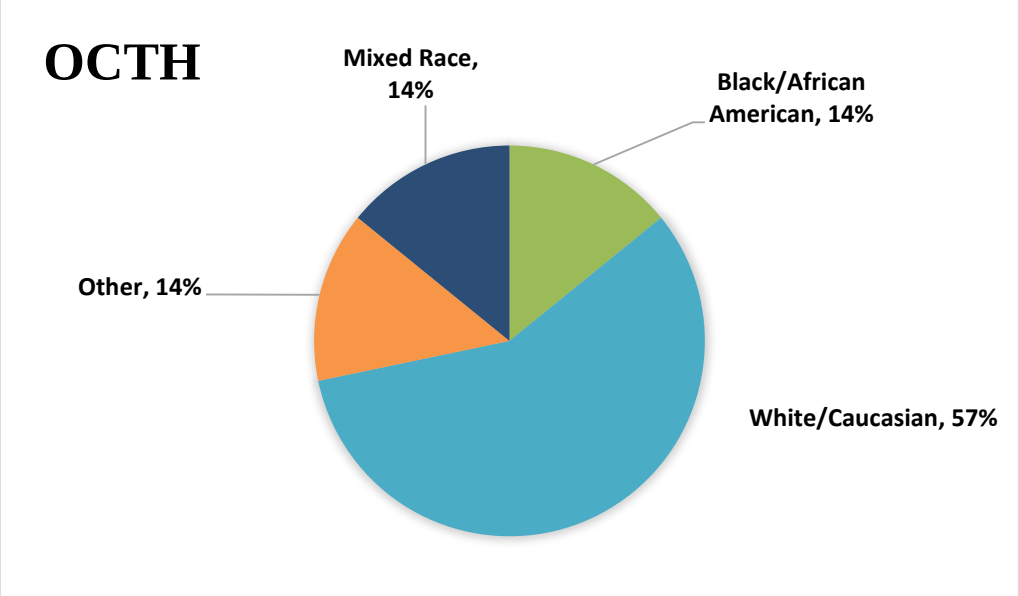

Youth reported their age as 13-17 (71%) or 6-12 (14%), and (14%) did not answer the question. Only youth over the age of 11 were asked to complete surveys.



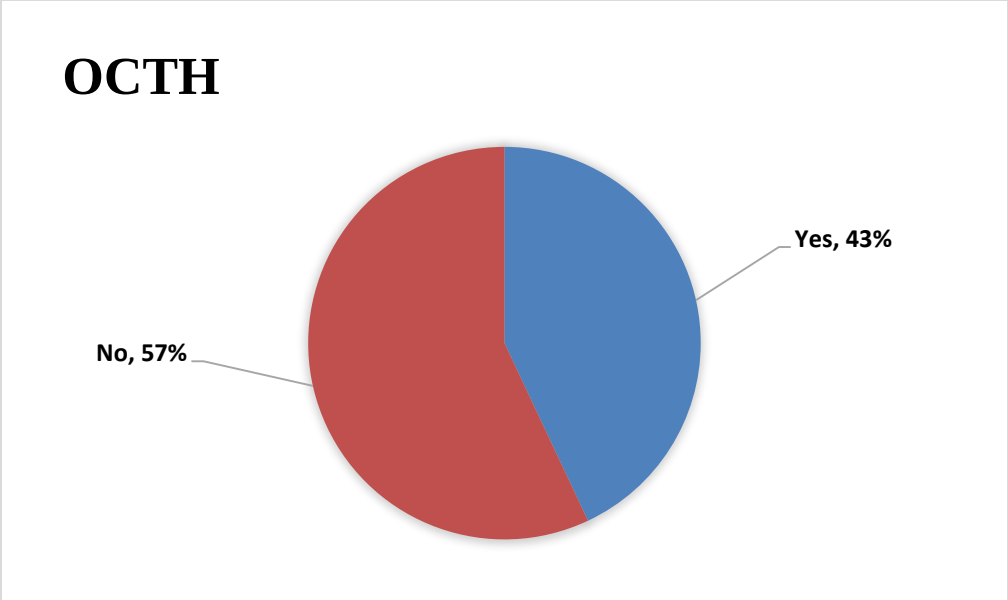
Youth reported their gender as (71%) Female and (29%) Male.




Youth reported their race as (57%) White/Caucasian, Mixed Race (14%), Black/African American (14%), or Other (14%).

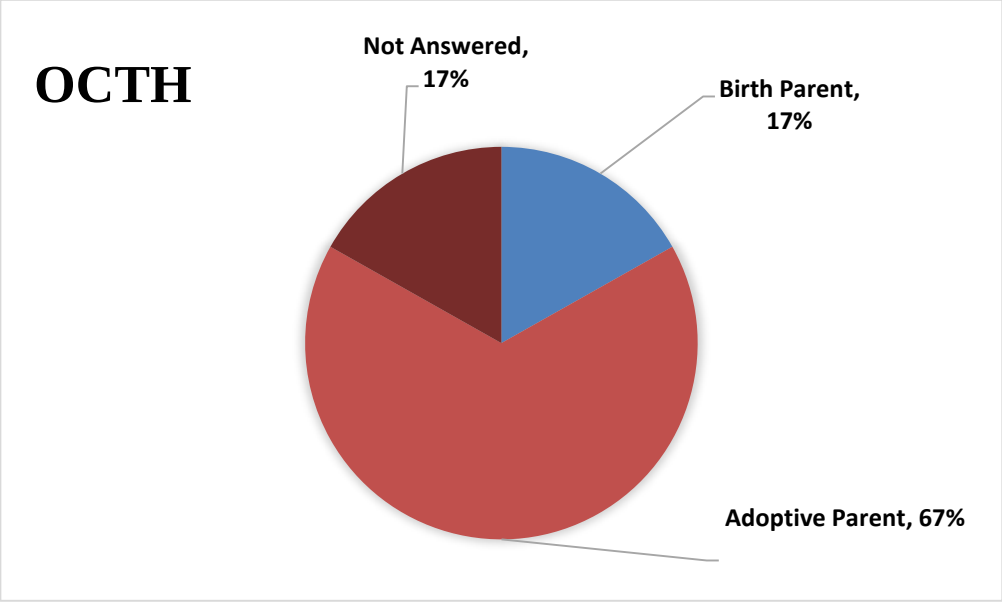


Youth reported (57%) of their parents were not of Spanish, Hispanic, Mexican or Latino origin and (43%) were of Spanish, Hispanic, Mexican or Latino origin.




**Survey Completion/Length of Service**

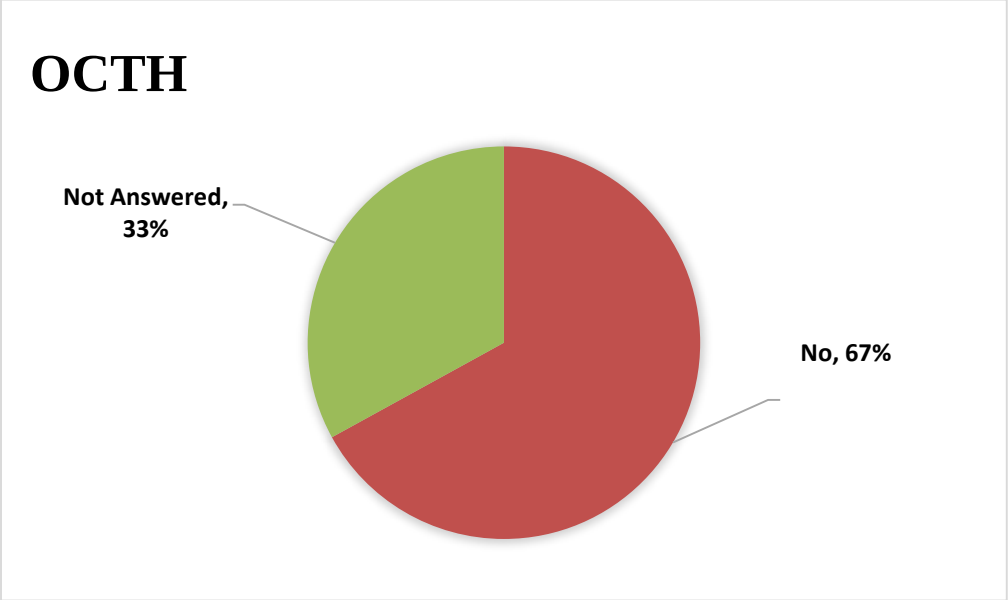
Parents/caregivers reported individuals completing the parent/caregiver survey were adoptive parents (67%) or birth parent (17%) and (17%) did not answer this question.



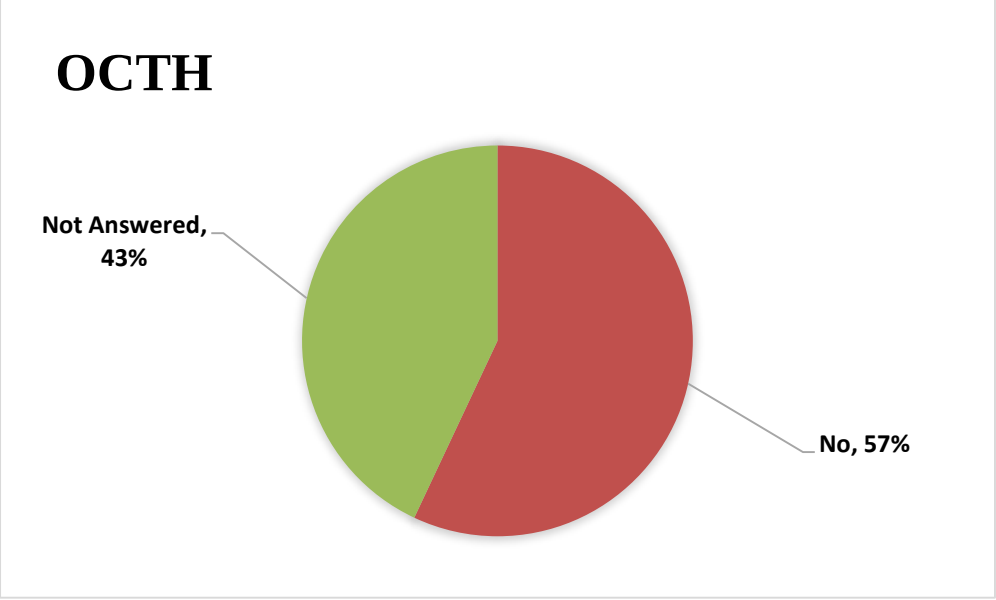

Both parents/caregivers and youth completed the question regarding duration of youth services prior to discharge. The parents/caregivers reported that (100%) of the children had been in services for 6 months to one year. Youth surveyed reported the length of service as being 6 months to one year (86%) or more than one year (14%).

**Youth's Immediate Family Serving in Military**

Parents/caregivers reported that of youth receiving services at OCTH, (67%) do not have immediate family currently serving in the military and (33%) did not answer the question.




Youth reported that (57%) do not have immediate family currently serving in the military and (43%) did not answer the question.



## SNCAS-OCTH Survey Results

Oasis On-Campus Treatment Homes' highest positive responses were in the areas of Access to Services (100%), Cultural Sensitivity (100%), and Participation in Treatment (97%). The areas with the lowest responses were Positive Outcomes (84%) and Psychiatrist (87%). Questions with less than 60% positive response are highlighted below.

| SNCAS-OCTH Survey Results | | |
|---|---|---|
| **Parent/Caregiver N = 6 Youth N = 7<br>Total Discharged = 36 Sample = 17%** | **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 | 100 |
| **GENERAL SATISFACTION** | | |
| Overall, I am pleased with the services my child and/or family received. | 100 | 100 |
| The people helping my child and family stuck with us no matter what. | 83 | 100 |
| I felt my child and family had someone to talk to when troubled. | 100 | 100 |
| The services my child and family received were right for us. | 83 | 100 |
| My family got the help we wanted for my child. | 83 | 100 |
| My family got as much help as we needed for my child. | 100 | 100 |
| **POSITIVE OUTCOMES** | | |
| My child's educational needs were met during residential services. | 83 | 71 |
| My child is better at handling daily life. | 50 | 100 |
| My child gets along better with family members. | 100 | 100 |
| My child gets along better with friends and other people. | 83 | 100 |
| My child is doing better in school and/or work. | 80 | 100 |
| My child is better able to cope when things go wrong. | 67 | 100 |
| I am satisfied with our family life right now. | 80 | 67 |
| **PARTICIPATION IN TREATMENT** | | |
| I helped to choose my child and family's services. | 100 | 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 | 100 |
| **CULTURAL SENSITIVITY** | | |
| Staff treated our family with respect. | 100 | 100 |
| Staff respected our family's religious/spiritual beliefs. | 100 | 100 |
| Staff spoke with me in a way that I understood. | 100 | 100 |
| Staff was sensitive to my family's cultural and ethnic background. | 100 | 100 |
| **FUNCTIONING** | | |
| My child is better at handling daily life. | 50 | 100 |
| My child gets along better with family members. | 100 | 100 |
| My child gets along better with friends and other people. | 83 | 100 |
| My child is doing better in school. | 80 | 100 |
| My child is better able to cope when things go wrong. | 67 | 100 |
| **INTEREST ITEMS** | | |
| Staff explained my child's diagnosis, medication and treatment options. | 100 | 100 |
| Staff explained my child and family's rights, safety and confidentiality issues. | 100 | 86 |
| Our family is aware of people and services in the community that support us. | 100 | 100 |
| I am better able to handle our family issues. | 60 | N/A |
| I am learning helpful parenting skills while in services. | 80 | N/A |
| I have information about my child's developmental expectations and needs. | 100 | N/A |

# SNCAS-OCTH Survey Results

| Parent/Caregiver N = 6 Youth N = 7<br>Total Discharged = 36 Sample = 17% | Parent/Caregiver Positive Response % | Youth Positive Response % |
|---|---|---|
| **PSYCHIATRIST/MD** | | |
| My child's Psychiatrist/MD was respectful and helpful. | 100 | 75 |
| My child's Psychiatrist/MD answered my questions. | 100 | 75 |
| My child's Psychiatrist/MD spends enough time with him/her. | 100 | 75 |
| My child's Psychiatrist/MD provides guidance and support to his/her treatment. | 100 | 75 |
| My child's Psychiatrist/MD understood his/her problems and feelings. | 100 | 75 |
| My child's meetings with his/her Psychiatrist/MD were helpful. | 100 | 75 |
| The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her. | 100 | 75 |
| Overall-I am pleased with the services my child has received from his/her Psychiatrist MD. | 100 | 75 |

| MEDICAL PRACTITIONER SERVICES | Parent/Caregiver Response % | | | | | Youth Response % | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered |
| In the last twelve months, my child did see a medical doctor (or nurse) for a health checkup or because he/she was sick. | 50 | 0 | 17 | 0 | 33 | 57 | 0 | 0 | 0 | 43 |

| | Parent/Caregiver Positive Response % | Youth Positive Response % |
|---|---|---|
| My child is on medication for emotional/behavioral problems. | 100 | 100 |
| My child's doctor or nurse did tell me and/or my child what side effects to watch for. | 100 | 75 |

| Parent/Caregiver comments | Youth comments |
|---|---|
| 1. What has been the most helpful thing about the services your child received?<br>• My daughter learned to identify and express her feelings better. The staff was supportive during CFT's.<br>• For the most part I was very pleased with staff/support at Oasis. There was open communication/consistency of meetings and family therapy was helpful.<br>• The patience they show to my family.<br>• UNK - foster parent.<br>• The complete dedication of Mr. [NAME], Miss [NAME], Mr [NAME] and Miss [NAME]. | 1. What has been the most helpful thing about the services you received?<br>• ILP Classes.<br>• I have become a better person. I have better self-esteem and can deal with my problems.<br>• My target skills.<br>• That it was helpful to me.<br>• The staff.<br>• Helping me with my Self Control Strategy.<br>• The way I act in school. |

| Parent/Caregiver comments | Youth comments |
|---|---|
| 2. What would improve services your child and the family received?<br>• Better communication among staff at OASIS.<br>• Client was very patient to move into independent building but nothing happened that was supposed to. I was asked to get her a bike (never used), we were told she would learn how to use the bus and she would be able to check herself in and out. When I asked [NAME] why this didn't happen she said it was because she [Client] was moving to Ohio so the bus schedule would be different - ? but the goal was to teach her independence in general. I know she got in trouble a few times for Facebook but there didn't seem to be a goal to | 2. What would improve services you received?<br>• Nothing.<br>• Getting off my IEP and be trusted to do school on my own.<br>• Nothing.<br>• I improve by my skills.<br>• IL Program should be more IL than constantly having to reward behavior wise.<br>• I don't think they need to improve. |

# SNCAS-OCTH Survey Results

| **Parent/Caregiver N = 6 Youth N = 7**<br>**Total Discharged = 36 Sample = 17%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
|---|---|---|
| advance to next step. Everything I was told would happen in new home did not.<br>• Have more family and staff gatherings.<br>• UNK -foster parent.<br>• I am not sure, this was our last resource. | | |
| 3. What would improve client safety?<br>• I believe my child was safe.<br>• No feedback here - I felt she was safe.<br>• I can't think of anything, they always were awesome.<br>• I am unsure. | | 3. What would improve client safety?<br>• There is none.<br>• None I am a safe person.<br>• Nothing.<br>• My Skills - My Relationships.<br>• They were good, they don't need to improve. |
| 4. Additional Comments?<br>• The staff was amazing until recently I had to run in with Tiara. I came to pick Client up and she started talking to me about education. She said I should have never had her [Client] in the math class she was in as if to say I set her up for failure.<br>• I'm glad you have this place. My family and I feel this place saved our family.<br>• Thank you. I hope my daughter applies what she learned here. | | 4. Additional comments?<br>• Thank you guys for everything. Mr. [NAME] is a great teacher.<br>• Thank you for helping me.<br>• The program could be more than just groups about independent living. The staff were amazing for me.<br>• I had a good time. |

# NNCAS- Adolescent Treatment Center (ATC)

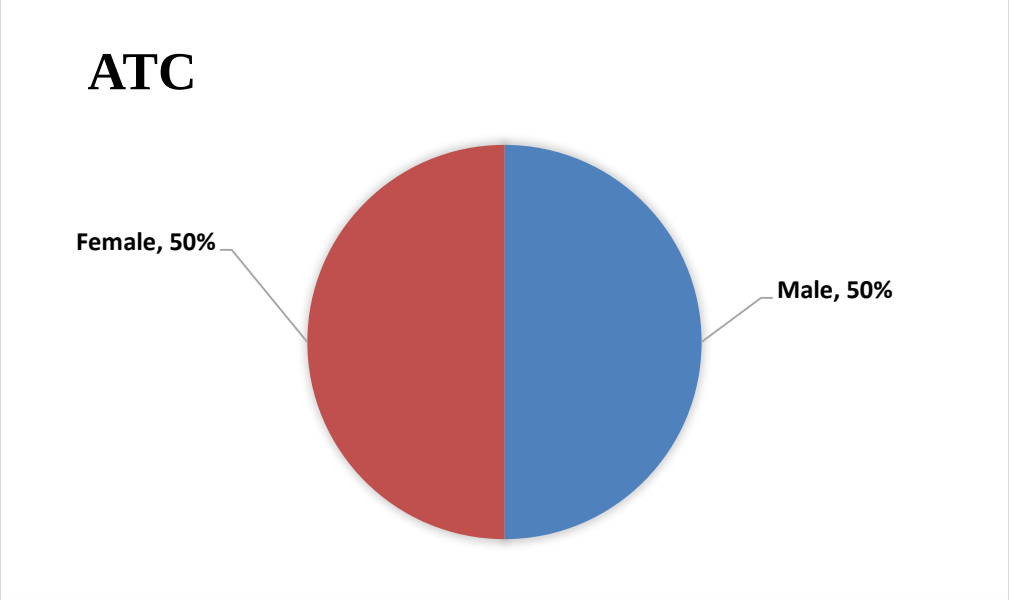
## Demographics

Demographics and data were collected and calculated for youth who were discharged from the Adolescent Treatment Center (ATC). The survey sample included responses from 14 parents/caregivers and 13 youth participants out of the 34 youth being served by ATC.

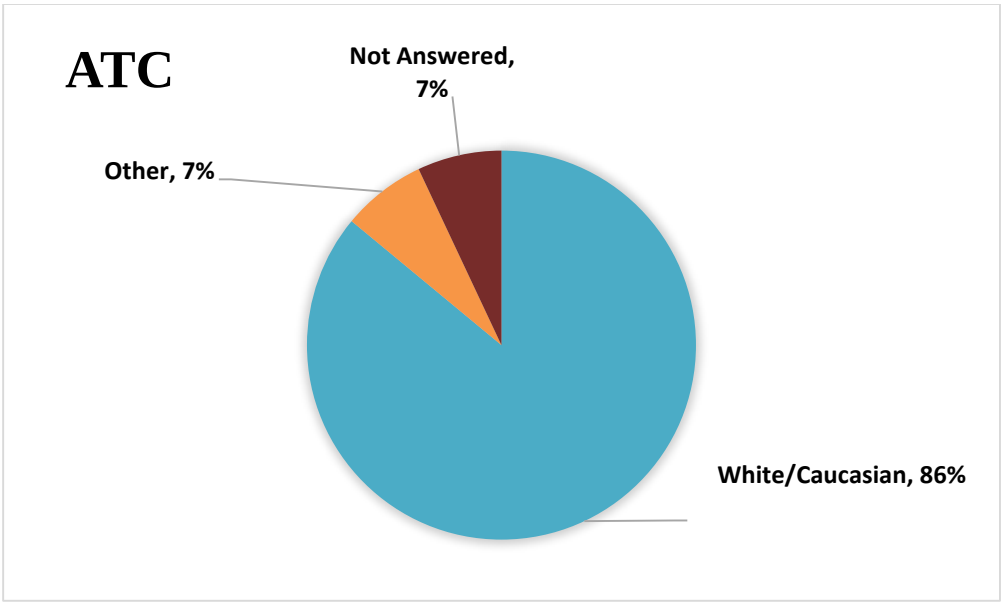
### Age/Gender/Race/Ethnicity of Youth

Parents/caregivers reported that youth receiving services at ATC were between the ages of 13-17 (100%).

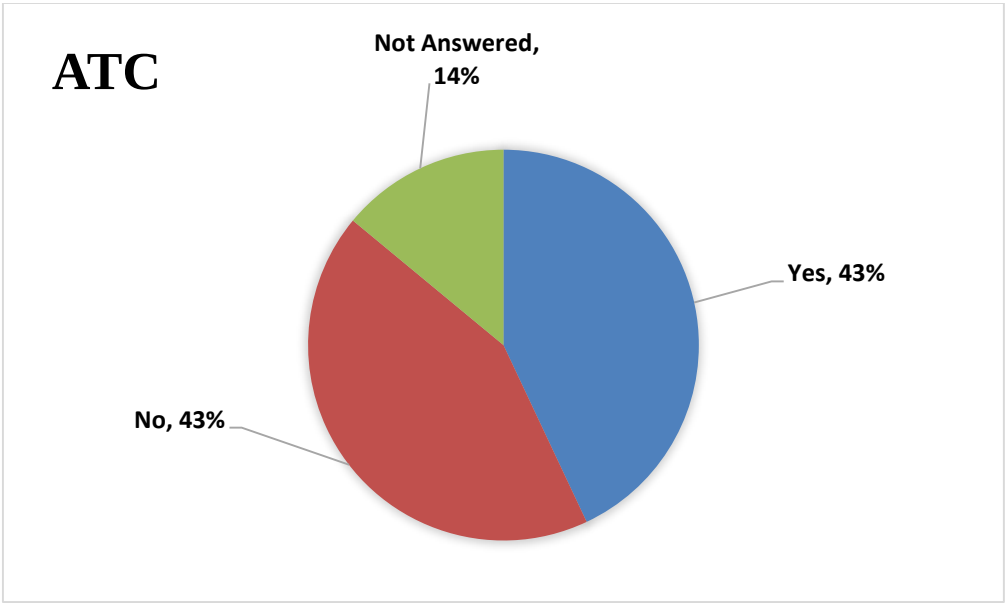
Parents/caregivers reported that the youth receiving services at ATC were (50%) Female and (50%) Male.



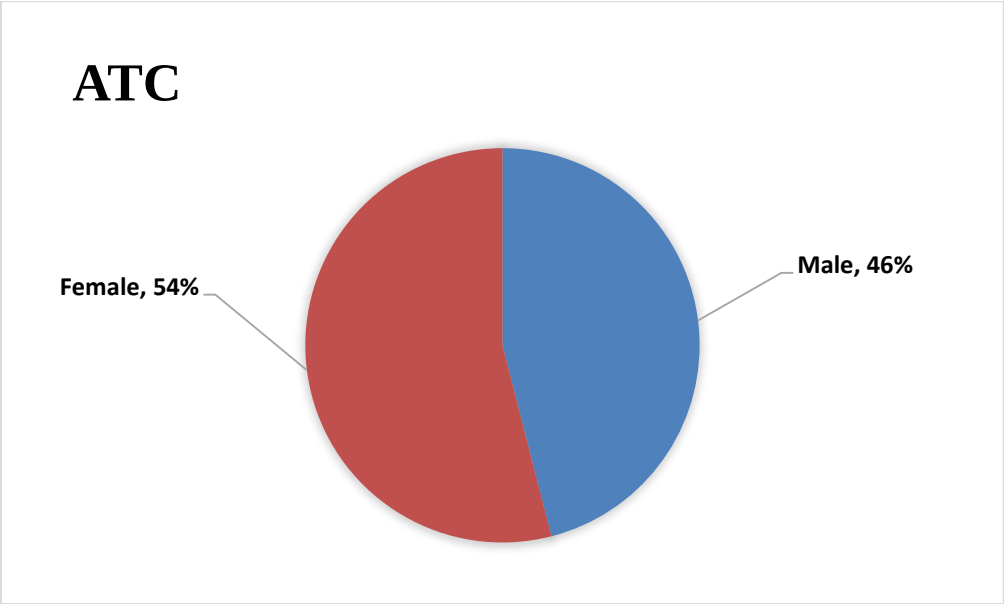
Parents/caregivers reported that of the youth receiving services at ATC, (86%) were White/Caucasian. Parents/caregivers also listed Other (7%) as the child's race or did not answer (7%).



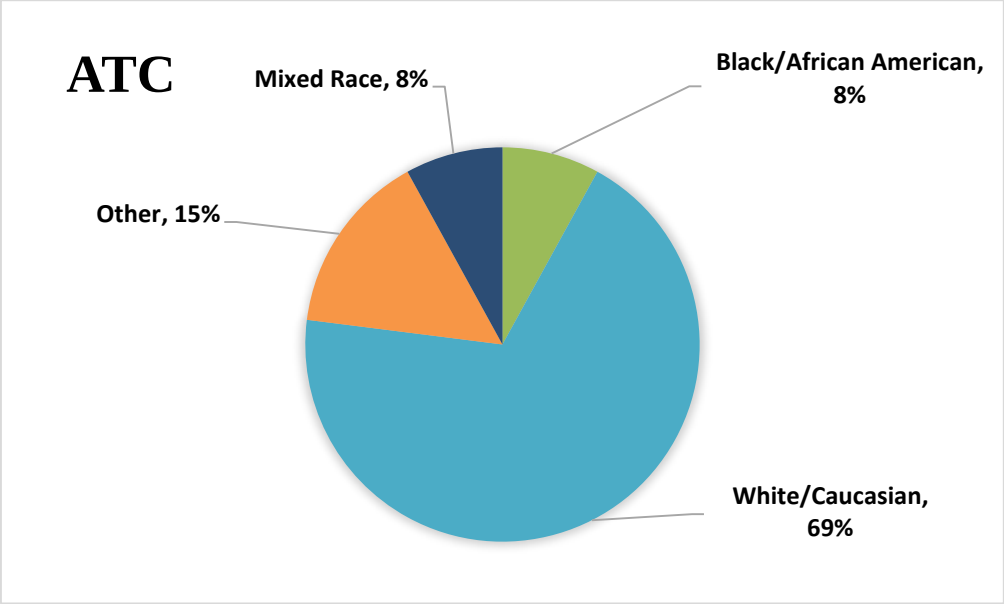

Parents/caregivers reported (43%) of the parents of youth receiving services at ATC were not of Spanish, Hispanic, Mexican or Latino origin and (43%) were of Spanish, Hispanic, Mexican or Latino origin, (14%) did not answer the question.



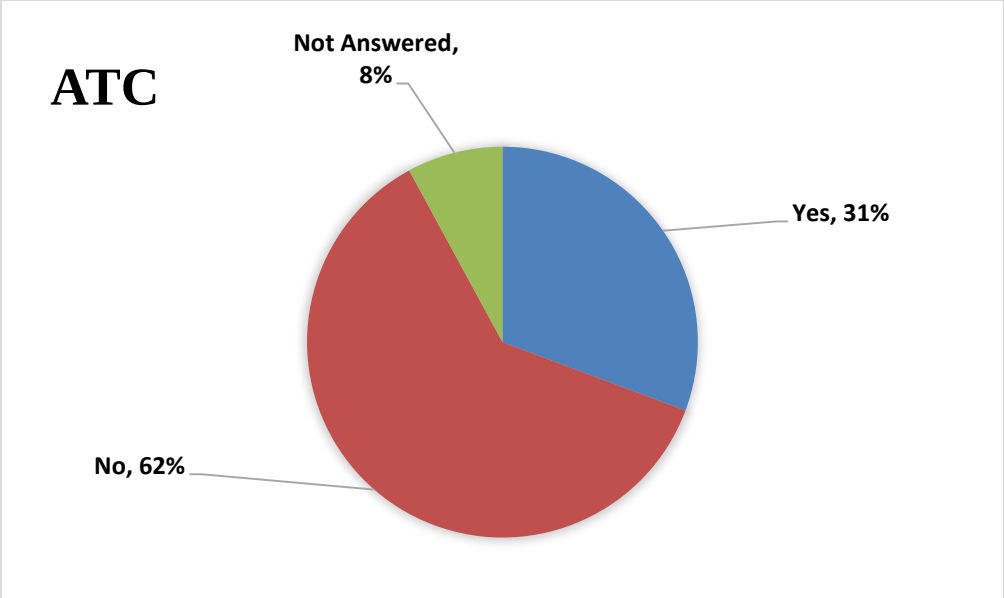
Youth reported their age as between the ages of 13-17 (100%) and their gender as (54%) Female and (46%) Male.




Youth reported their race as (69%) White/Caucasian. They also listed Other (15%), Mixed Race (8%), or Black/African American (8%) as their race.

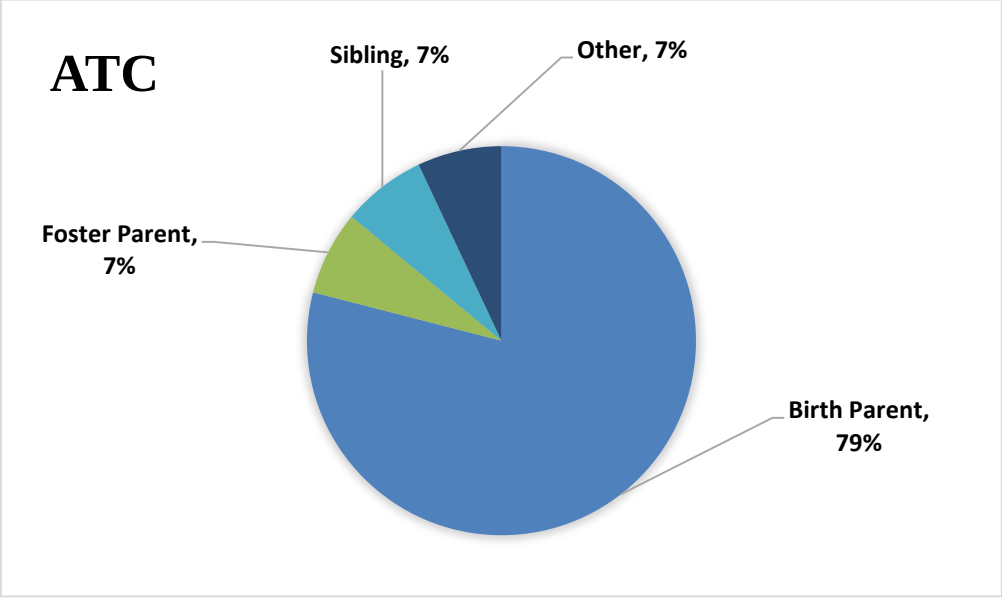


Youth reported that (62%) of their parents were not of Spanish, Hispanic, Mexican or Latino origin and (31%) were of Spanish, Hispanic, Mexican or Latino origin, (8%) did not answer the question.

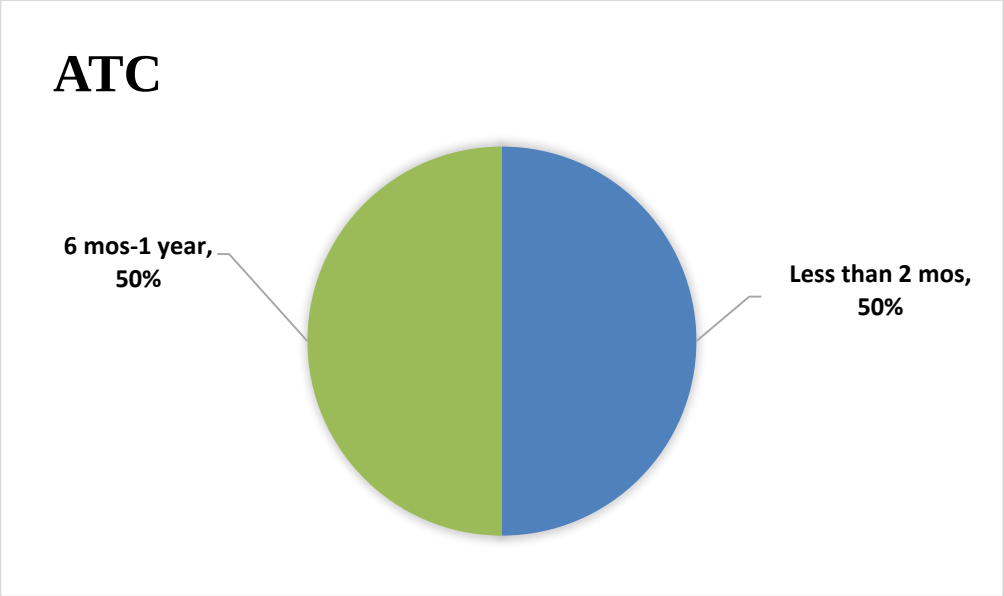



**Survey Completion/Length of Service**

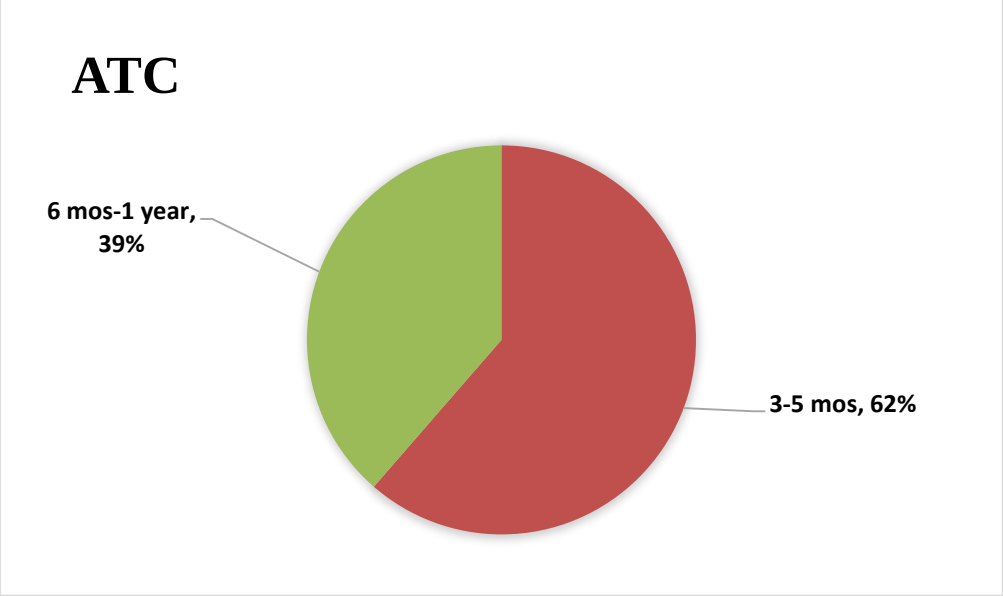
Parents/caregivers reported individuals completing the parent/caregiver survey were birth parents (79%), foster parent (7%), or a sibling (7%), and (7%) did not answer this question.



Both parents/caregivers and youth completed the question regarding the duration of services prior to discharge. The parents/caregivers reported their child had been receiving services at ATC for 6 months to one year (50%) or for less than 2 months (50%).

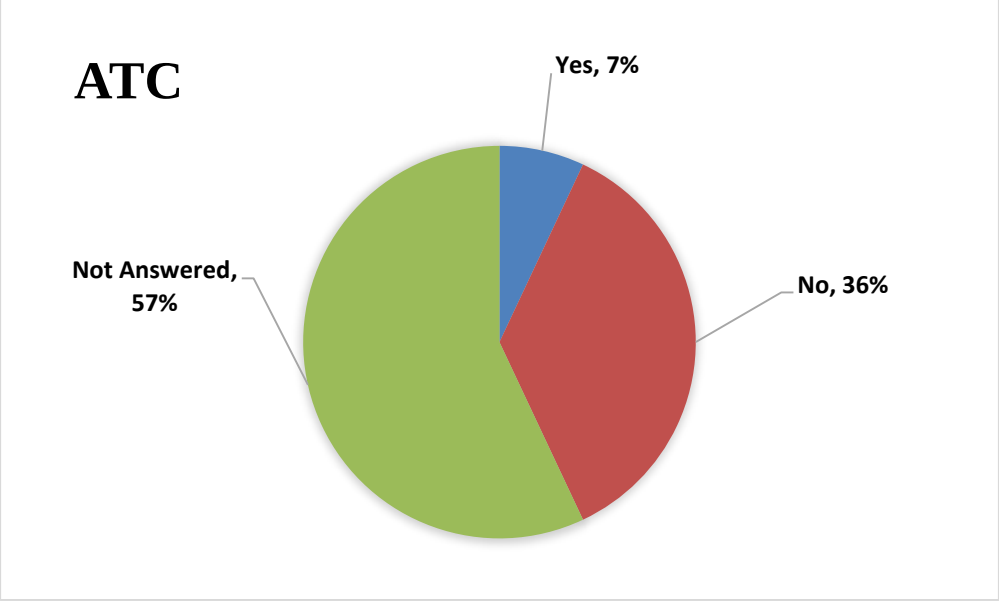



Youth reported the length of service as 3-5 months (62%) or 6 months to one year (39%).

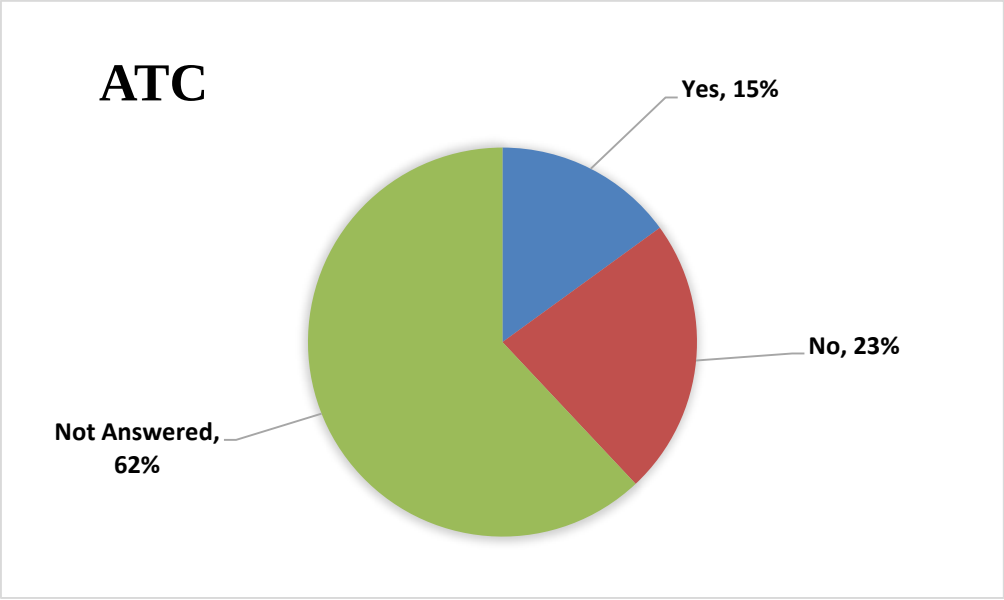


**Youth's Immediate Family Serving in Military**

Parents/caregivers reported that of youth receiving services at ATC, (57%) do not have immediate family currently serving in the military and (7%) did have family serving, (36%) did not answer the question.




Youth reported that (15%) have immediate family currently serving in the military, (23%) did not have family serving and (62%) did not answer the question.



## NNCAS-ATC Survey Results

Adolescent Treatment Center's highest positive responses were in the areas of Psychiatrist/MD (98%), Cultural Sensitivity (92%), and Interest Items (89%). The areas with the lowest positive response were in the areas of Functioning (74%) and Positive Outcomes (75%). Questions with less than 60% positive response are highlighted below.

| NNCAS-ATC Survey Results | | |
|---|---|---|
| **Parent/Caregiver N = 14 Youth N = 13<br>Total Discharged = 34 Sample = 34%** | **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. | 83 | 69 |
| Services were scheduled at times that were right for us. | 93 | 85 |
| **GENERAL SATISFACTION** | | |
| Overall, I am pleased with the services my child and/or family received. | 93 | 77 |
| The people helping my child and family stuck with us no matter what. | 100 | 62 |
| I felt my child and family had someone to talk to when troubled. | 86 | 92 |
| The services my child and family received were right for us. | 86 | 69 |
| My family got the help we wanted for my child. | 71 | 77 |
| My family got as much help as we needed for my child. | 64 | 69 |
| **POSITIVE OUTCOMES** | | |
| My child's educational needs were met during his/her stay. | 93 | 62 |
| My child is better at handling daily life. | 71 | 85 |
| My child gets along better with family members. | 79 | 69 |
| My child gets along better with friends and other people. | 57 | 77 |
| My child is doing better in school and/or work. | 77 | 75 |
| My child is better able to cope when things go wrong. | 71 | 85 |
| I am satisfied with our family life right now. | 85 | 62 |
| **PARTICIPATION IN TREATMENT** | | |
| I helped to choose my child and family's services. | 73 | 77 |
| I helped to choose my child and/or family's treatment goals. | 83 | 92 |
| I participated in my child's and family's treatment. | 93 | 92 |
| **CULTURAL SENSITIVITY** | | |
| Staff treated our family with respect. | 100 | 77 |
| Staff respected our family's religious/spiritual beliefs. | 100 | 100 |
| Staff spoke with me in a way that I understood. | 100 | 92 |
| Staff was sensitive to my family's cultural and ethnic background. | 100 | 67 |
| **FUNCTIONING** | | |
| My child is better at handling daily life. | 71 | 85 |
| My child gets along better with family members. | 79 | 69 |
| My child gets along better with friends and other people. | 57 | 77 |
| My child is doing better in school. | 77 | 75 |
| My child is better able to cope when things go wrong. | 71 | 85 |
| **INTEREST ITEMS** | | |
| Staff explained my child's diagnosis, medication and treatment options. | 92 | 85 |
| Staff explained my child and family's rights, safety and confidentiality issues. | 100 | 85 |
| Our family is aware of people and services in the community that support us. | 92 | 85 |
| I am better able to handle our family issues. | 93 | N/A |
| I am learning helpful parenting skills while in services. | 79 | N/A |

# NNCAS-ATC Survey Results

| **Parent/Caregiver N = 14 Youth N = 13<br>Total Discharged = 34 Sample = 34%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
|---|---|---|
| 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. | 100 | 100 |
| My child's Psychiatrist/MD answered my questions. | 100 | 100 |
| My child's Psychiatrist/MD spends enough time with him/her. | 100 | 100 |
| My child's Psychiatrist/MD provides guidance and support to his/her treatment. | 100 | 100 |
| My child's Psychiatrist/MD understood his/her problems and feelings. | 100 | 100 |
| My child's meetings with his/her Psychiatrist/MD were helpful. | 83 | 100 |

| **MEDICAL PRACTITIONER SERVICES** | **Parent/Caregiver Response %** | | | | | **Youth Response %** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered |
| In the last twelve months, my child did see a medical doctor (or nurse) for a health checkup or because he/she was sick. | 29 | 0 | 14 | 0 | 57 | 8 | 0 | 8 | 8 | 77 |

| | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
|---|---|---|
| My child is on medication for emotional/behavioral problems. | 50 | 100 |
| My child's doctor or nurse did tell me and/or my child what side effects to watch for. | 100 | 100 |

| **Parent/Caregiver comments** | **Youth comments** |
|---|---|
| 1. What has been the most helpful thing about the services your child received?<br>• Took over treatment where I couldn't.<br>• More communication between family.<br>• Family Therapy.<br>• My son has become more confident and has the ability to use his words and avoids most confrontation.<br>• Learning a better way to control his anger.<br>• Services from Dr.[NAME] .<br>• Therapist / been supervised.<br>• Therapy.<br>• We talk a lot. It is good.<br>• Better behavior and grades.<br>• My son has learned a lot of new coping skills.<br>• Learning to talk things out as a family. Having strategies to help with anger problems.<br>• [NAME] | 1. What has been the most helpful thing about the services you received?<br>• I had someone to talk to.<br>• My peers helped me stay on task and staff made me feel stronger than I was.<br>• Art Skill Streaming.<br>• The individual therapy.<br>• I believe the most helpful thing would be therapy.<br>• The support I had was most helpful emotionally and I learned better coping skills.<br>• Family therapy.<br>• I can cope with my feelings without doing negative things.<br>• ART.<br>• The skill TX.<br>• The most helpful thing about the services received was coping skills and how to communicate with people calmly and how to calm myself down. |
| 2. What would improve services your child and the family received?<br>• Teach the child to know the difference between respect and standing up for herself. Time and Place. Who and What.<br>• More respect.<br>• I was satisfied with the services received.<br>• Dealing with "Real" issues that bother my son.<br>• That both sides of the family should be involved equally in | 2. What would improve services you received?<br>• Nothing, it was perfect.<br>• To treat everyone equally fair.<br>• Food Services.<br>• More family sessions, different groups, more team work.<br>• Staff's tone and respect towards clients.<br>• Food that is good.. i.e. fish is widely unliked so no fish. |

| | |
|---|---|
| meetings and therapy sessions.<br>• Therapy more objective. A lot of times the family sessions seemed to just be us, [NAME] & myself catching up, not getting to the real problems.<br>• More intense therapy.<br>• Support.<br>• Nothing, everything is fine. | • More P.E. Equipment.<br>• None! Did a good job!<br>• Self-Control, Coping Skills.<br>• Better activities for skills.<br>• More groups, less self-structure. |
| 3. What would improve client safety?<br>• Transportation to other facilities.<br>• Be responsible.<br>• None at this time.<br>• I feel ATC did the best they could.<br>• Things are good.<br>• More privacy; maybe room individually. | 3. What would improve client safety?<br>• Put a cage on the windows.<br>• Treat all genders equally.<br>• Everyone have their own room.<br>• Actually act when people make threats.<br>• More therapy.<br>• None! Did a good job!<br>• Restrain the kids that were causing a major milieu when they got upset or just to stop them before it got worse. |
| 4. Additional Comments?<br>• No comments.<br>• The family therapist was very easy to talk to, I was comfortable talking about anything with her. | 4. Additional comments?<br>• Nope.<br>• I am glad that I came here.<br>• None! Thank You.<br>• I enjoyed the treatment I had received while I was there. Umm maybe just cut back on all the healthy food all the time. |

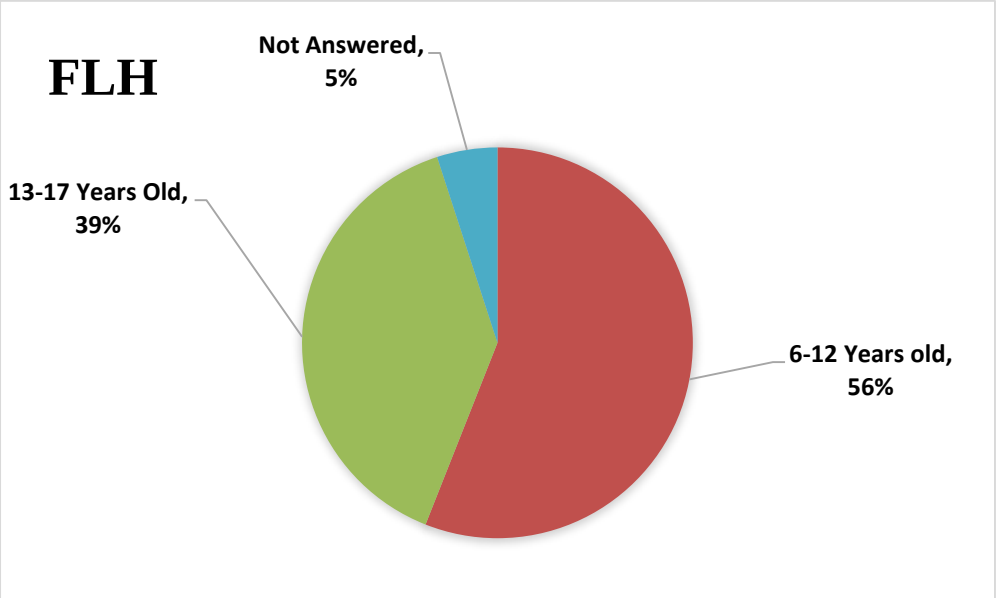
# NNCAS- Family Learning Homes (FLH)

## Demographics

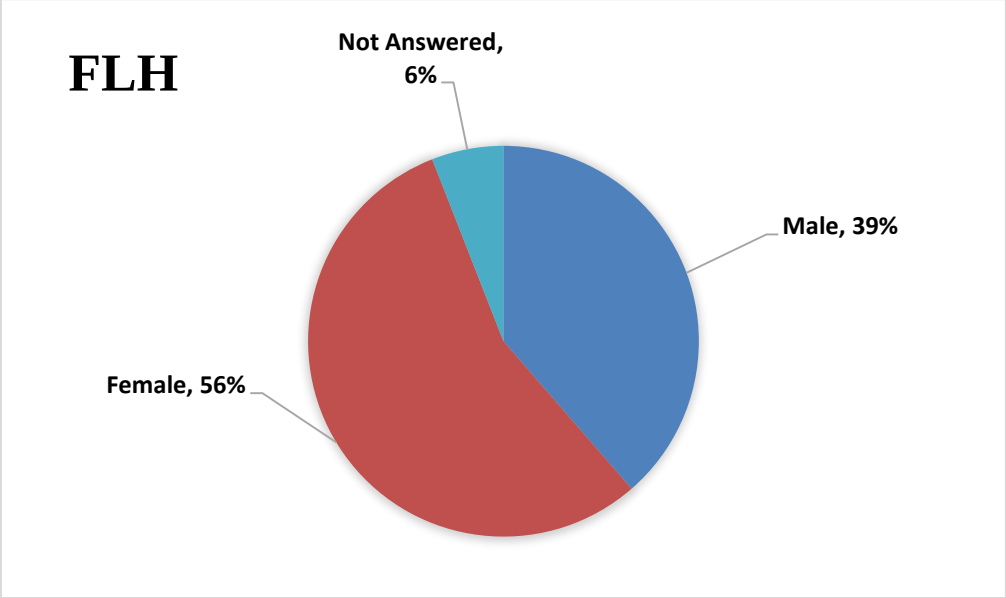
Demographics and data were collected and calculated for youth who were discharged from Family Learning Homes (FLH). The survey sample included responses from 18 parents/caregivers and 16 youth participants out of the 45 youth being served by the FLH.

### Age/Gender/Race/Ethnicity of Youth

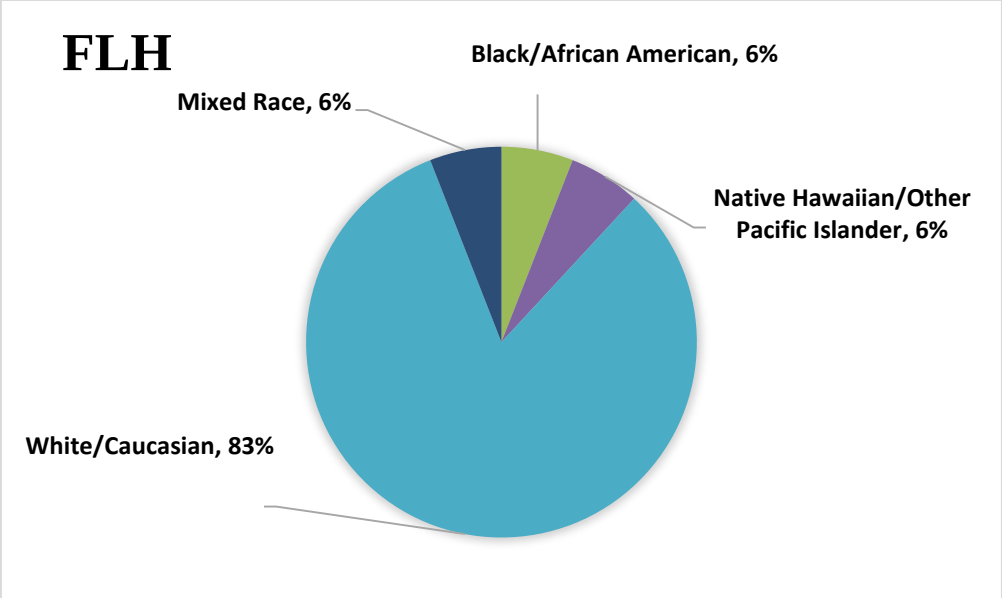
Parents/caregivers reported that youth receiving services at the FLH were between the ages of 6-12 (56%) or 13-17 (39%), and (5%) did not answer the question.



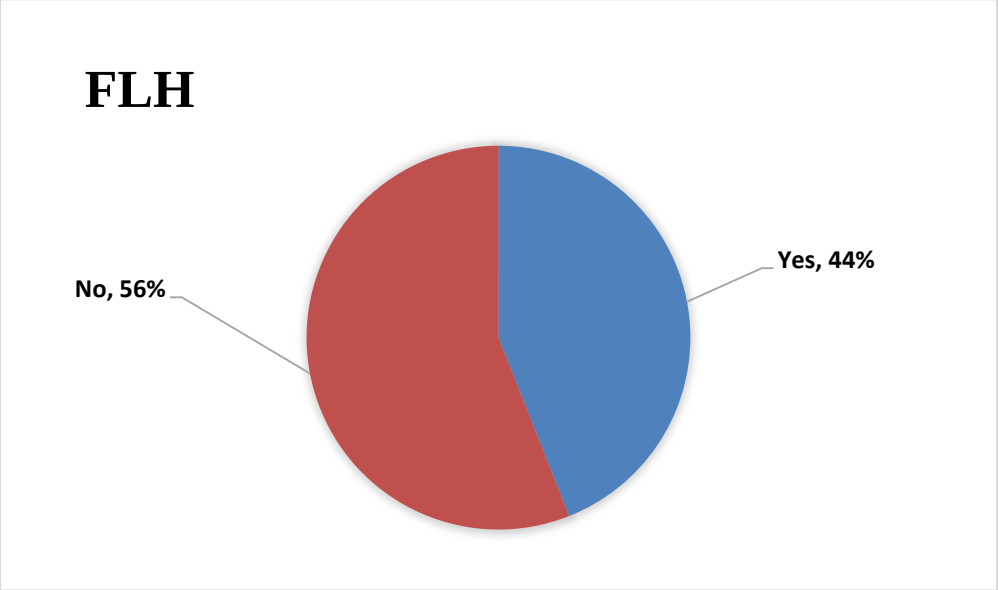

Parents/caregivers reported that the youth receiving services at the FLH were (56%) Female or (39%) Male, and (6%) did not answer the question.



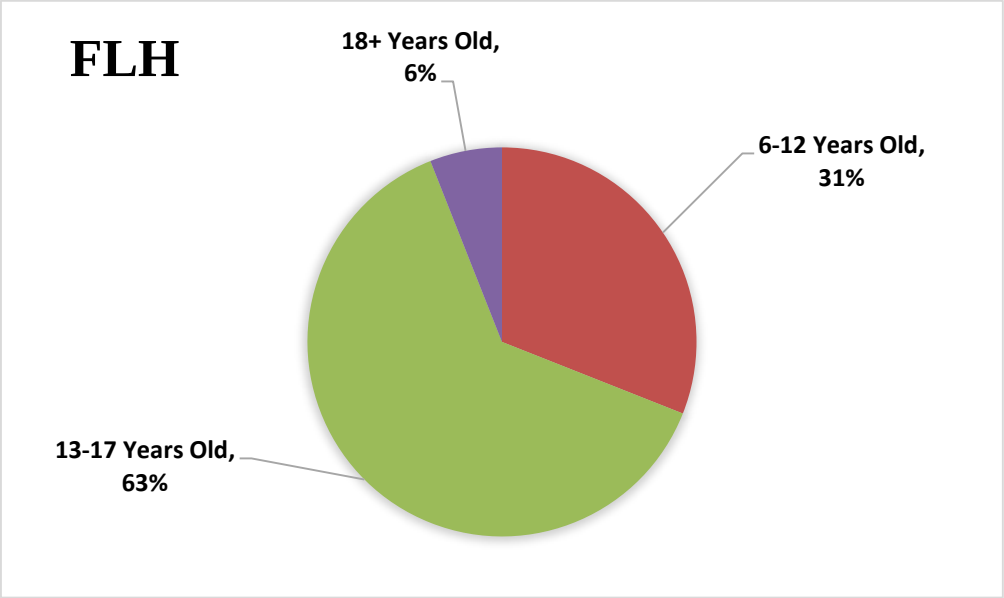
Parents/caregivers reported that (83%) of the youth in the FLH were White/Caucasian. Parents/caregivers also listed Black/African American (6%), Mixed Race (6%), or Native Hawaiian/Other Pacific Islander (6%) as the child's race.



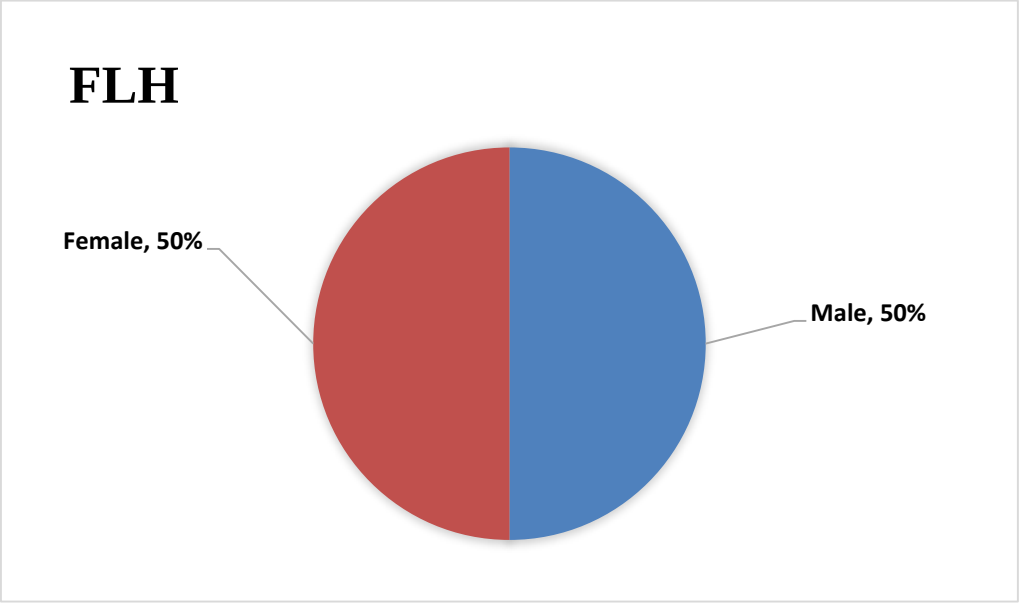

Parents/caregivers reported (44%) of the parents of youth receiving services at the FLH were of Spanish, Hispanic, Mexican or Latino origin and (56%) were not of Spanish, Hispanic, Mexican or Latino origin.



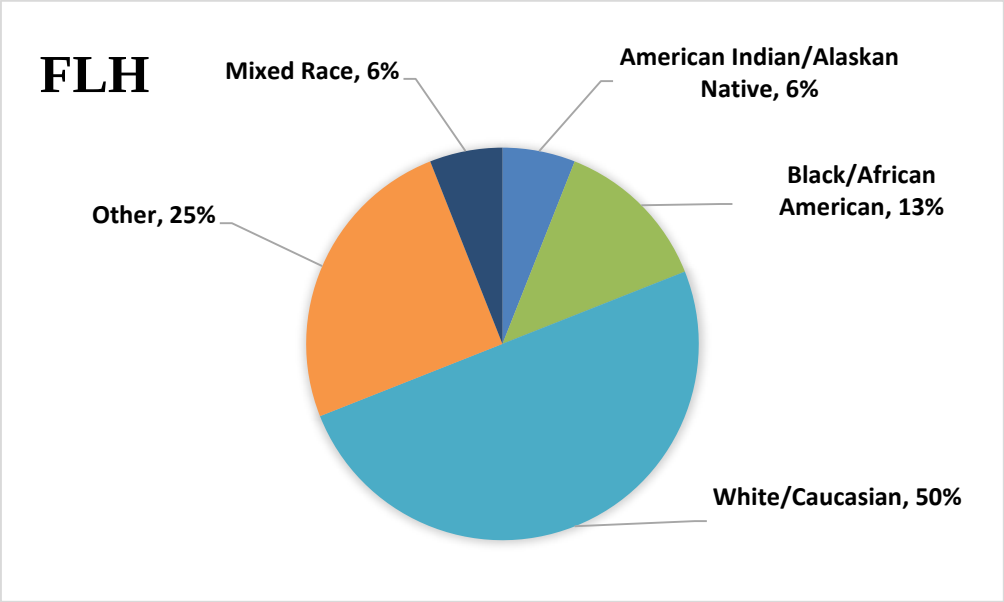
Youth reported their age as 13-17 (63%), 6-12 (31%), or over 18 (6%). Only youth over the age of 11 were asked to complete surveys.



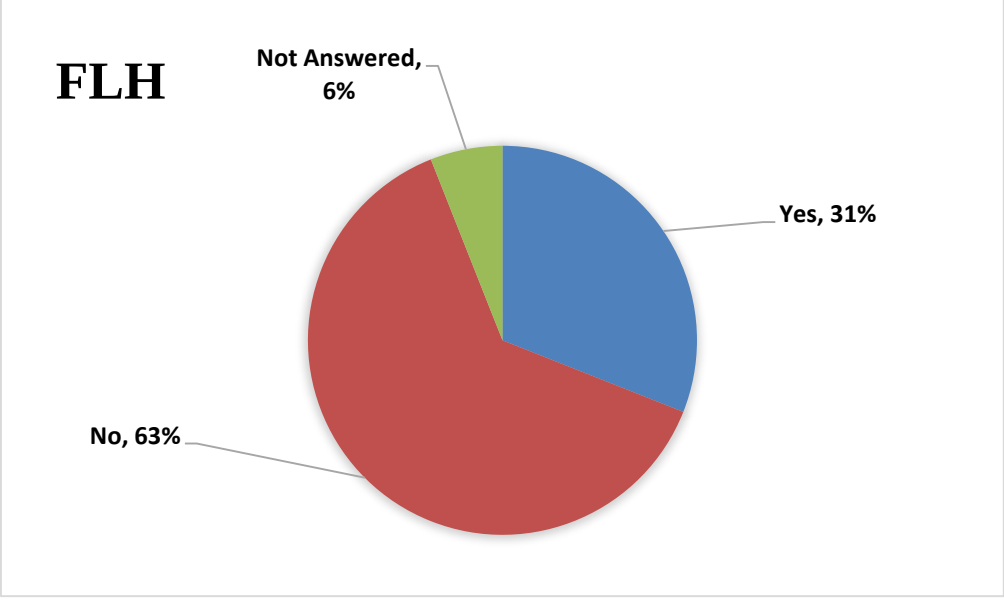

Youth reported their gender as (50%) Female and (50%) Male.



Youth reported their race as White/Caucasian (50%), Other (25%), Black/African American (13%), Mixed Race (6%), or American Indian/Alaskan Native (6%).

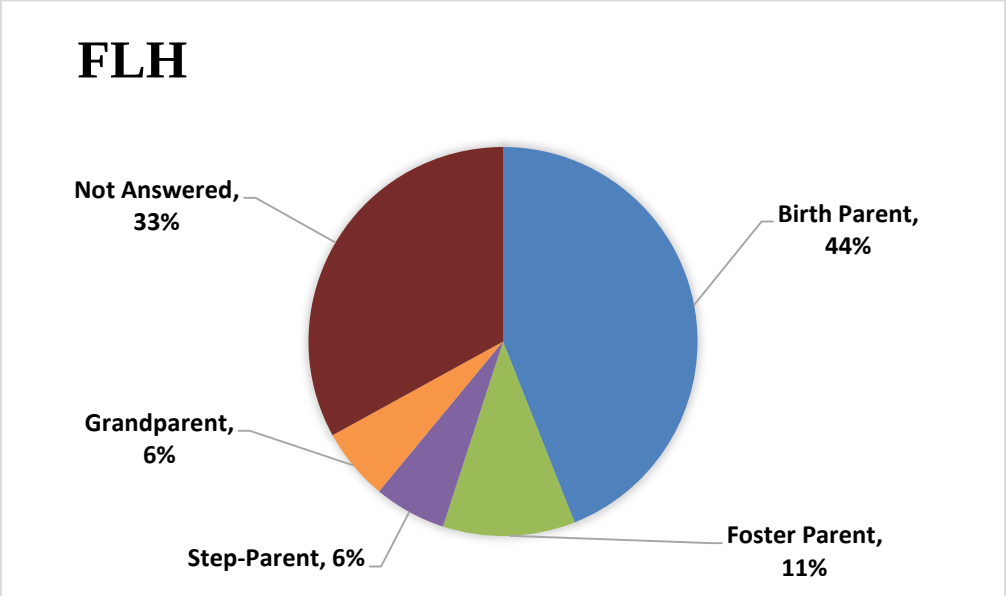



Youth reported (63%) their parents were not of Spanish, Hispanic, Mexican or Latino origin, (31%) reported that their parents were of Spanish, Hispanic, Mexican or Latino origin and (6%) did not answer the question.

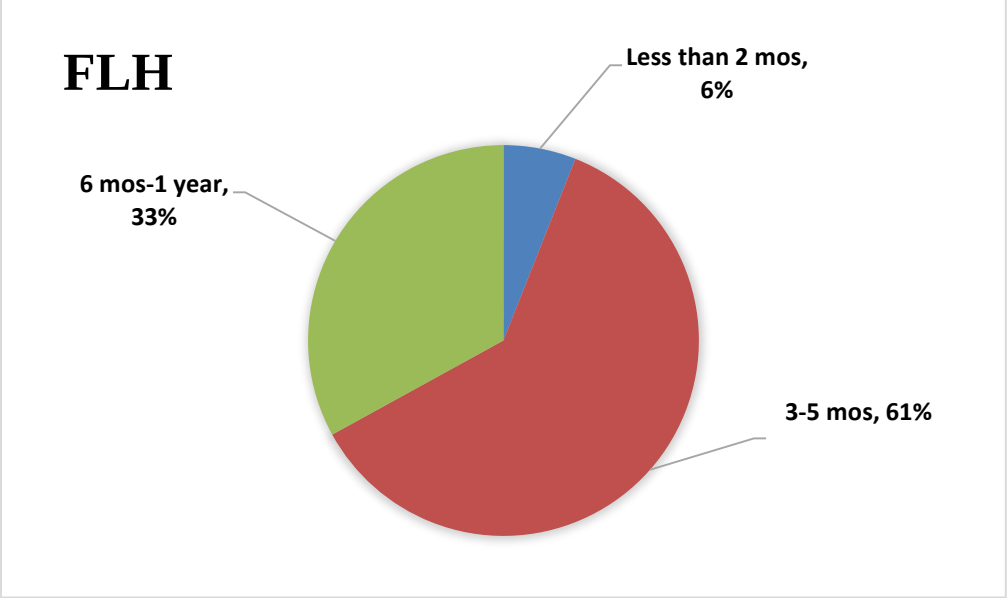


**Survey Completion/Length of Service**

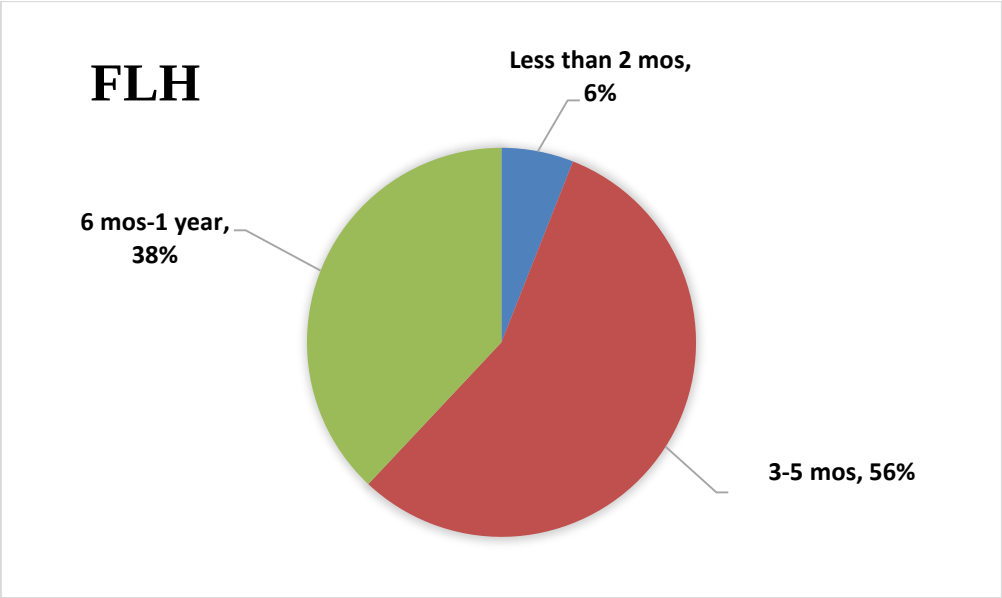
Parents/caregivers reported individuals completing the parent/caregiver survey were birth parents (44%), foster parents (11%), grandparents (6%), or step-parents (6%), (33%) did not answer this question.




Both parents/caregivers and youth completed the question regarding the duration of youth services. The parents/caregivers reported their child had been receiving services for 3-5 months (61%), 6 months to one year (33%), and less than 2 months (6%).

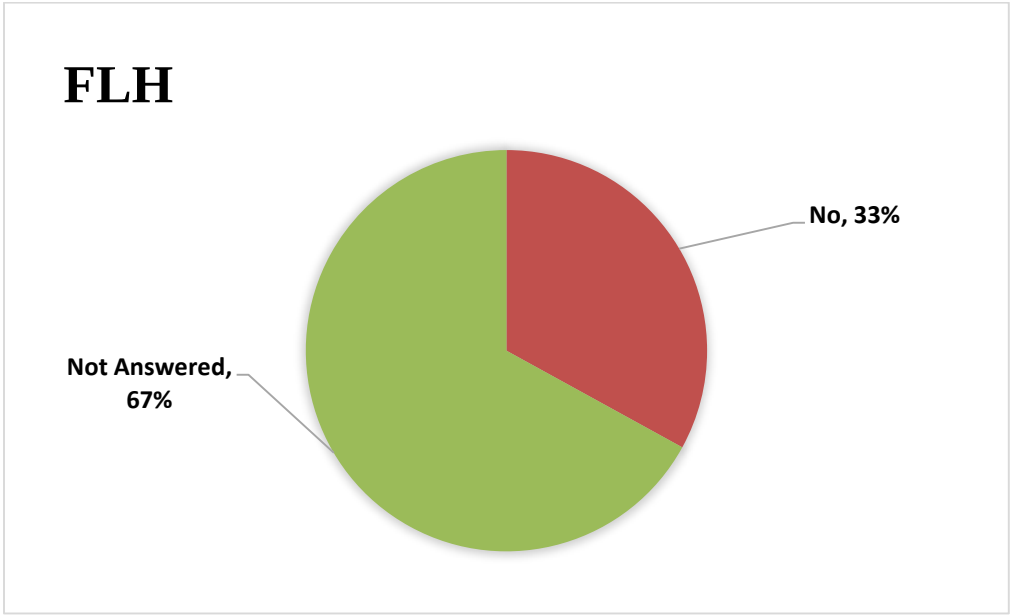


Youth reported the length of service as 3-5 months (56%), 6 months to one year (38%), or less than 2 months (6%).

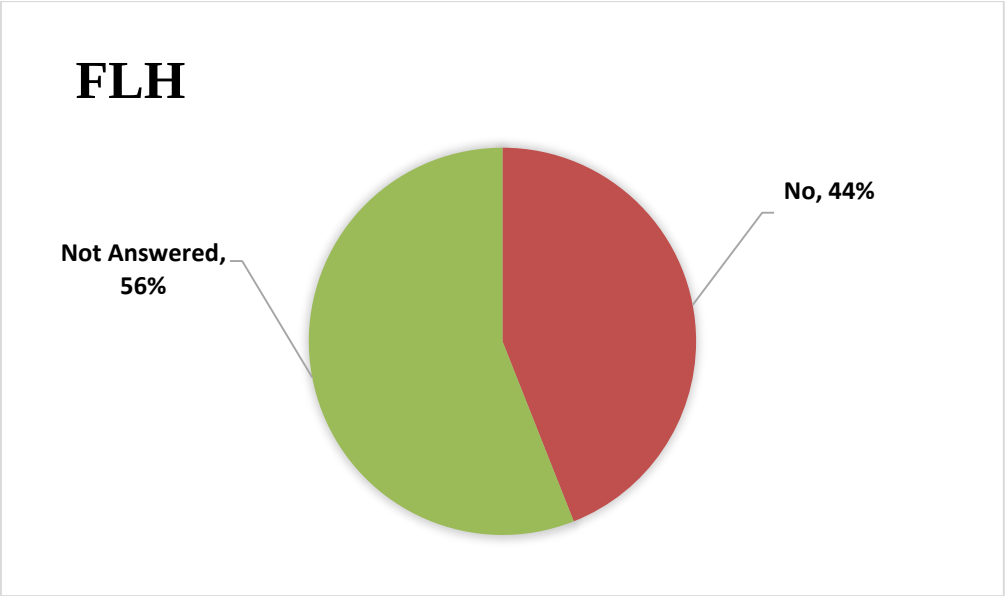



**Youth's Immediate Family Serving in Military**

Parents/caregivers reported that of youth receiving services at the FLH, (33%) did not have immediate family serving in the military and (67%) did not answer this question.



Youth reported that (44%) did not have immediate family currently serving in the military and (56%) did not answer this question.




**NNCAS-FLH Survey Results**

The Family Learning Home's highest positive responses were in the areas of Participation in Treatment (87%), Access to Services (85%), and Cultural Sensitivity (84%). The areas with the lowest responses were General Satisfaction (80%) and Positive Outcomes (82%). Questions with a less than 60% positive response are highlighted below.

| NNCAS-FLH Survey Results | | |
|---|---|---|
| **Parent/Caregiver N = 18 Youth N = 16<br>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. | 88 | 100 |
| Visitation rooms were comfortable and provided privacy with my child. | 64 | 92 |
| Services were scheduled at times that were right for us. | 72 | 94 |
| **GENERAL SATISFACTION** | | |
| Overall, I am pleased with the services my child and/or family received. | 72 | 94 |
| The people helping my child and family stuck with us no matter what. | 67 | 88 |
| I felt my child and family had someone to talk to when he/she was troubled. | 78 | 81 |
| The services my child and family received were right for us. | 72 | 81 |
| My family got the help we wanted for my child. | 72 | 88 |
| My family got as much help as we needed for my child. | 72 | 94 |
| **POSITIVE OUTCOMES** | | |
| My child's educational needs were met during his/her stay. | 88 | 93 |
| My child is better at handling daily life. | 78 | 94 |
| My child gets along better with family members. | 82 | 81 |
| My child gets along better with friends and other people. | 72 | 100 |
| My child is doing better in school and/or work. | 61 | 87 |
| My child is better able to cope when things go wrong. | 78 | 94 |

# NNCAS-FLH Survey Results

| Parent/Caregiver N = 18 Youth N = 16<br>Total Discharged = 45 Sample = 38% | Parent/Caregiver Positive Response % | Youth Positive Response % |
|---|---|---|
| I am satisfied with our family life right now. | 59 | 88 |
| **PARTICIPATION IN TREATMENT** | | |
| I helped to choose my child and family's services. | 77 | 94 |
| I helped to choose my child and/or family's treatment goals. | 81 | 94 |
| I participated in my child's and family's treatment. | 83 | 94 |
| **CULTURAL SENSITIVITY** | | |
| Staff treated our family with respect. | 78 | 88 |
| Staff respected our family's religious/spiritual beliefs. | 73 | 92 |
| Staff spoke with me in a way that I understood. | 78 | 93 |
| Staff was sensitive to my family's cultural and ethnic background. | 73 | 100 |
| **FUNCTIONING** | | |
| My child is better at handling daily life. | 78 | 94 |
| My child gets along better with family members. | 82 | 81 |
| My child gets along better with friends and other people. | 72 | 100 |
| My child is doing better in school. | 61 | 87 |
| My child is better able to cope when things go wrong. | 78 | 94 |
| **INTEREST ITEMS** | | |
| Staff explained my child's diagnosis, medication and treatment options. | 83 | 100 |
| Staff explained my child and family's rights, safety and confidentiality issues. | 78 | 94 |
| Our family is aware of people and services in the community that support us. | 78 | 94 |
| I am better able to handle our family issues. | 71 | N/A |
| I am learning helpful parenting skills while in services. | 72 | N/A |
| I have information about my child's developmental expectations and needs. | 78 | N/A |
| **PSYCHIATRIST/MD** | | |
| My child's Psychiatrist/MD was respectful and helpful. | 83 | 100 |
| My child's Psychiatrist/MD answered my questions. | 83 | 75 |
| My child's Psychiatrist/MD spends enough time with him/her. | 83 | 88 |
| My child's Psychiatrist/MD provides guidance and support to his/her treatment. | 83 | 88 |
| My child's Psychiatrist/MD understood his/her problems and feelings. | 83 | 88 |
| My child's meetings with his/her Psychiatrist/MD were helpful. | 83 | 88 |
| The medications that my child's Psychiatrist/MD prescribed (if applicable) were explained to him/her. | 83 | 100 |
| Overall-I am pleased with the services my child has received from his/her Psychiatrist MD. | 100 | 100 |

| MEDICAL PRACTITIONER SERVICES | Parent/Caregiver Response % | | | | | Youth Response % | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered | Yes, in clinic | Yes, in ER | No | Don't remember | Not answered |
| In the last twelve months, my child did see a medical doctor (or nurse) for a health checkup or because he/she was sick. | 33 | 0 | 0 | 0 | 67 | 25 | 6 | 0 | 19 | 50 |

| | Parent/Caregiver Positive Response % | Youth Positive Response % |
|---|---|---|
| My child is on medication for emotional/behavioral problems. | 83 | 50 |
| My child's doctor or nurse did tell me and/or my child what side effects to watch for. | 100 | 75 |

| Parent/Caregiver comments | Youth comments |
|---|---|

# NNCAS-FLH Survey Results

| **Parent/Caregiver N = 18 Youth N = 16**<br>**Total Discharged = 45 Sample = 38%** | **Parent/Caregiver Positive Response %** | **Youth Positive Response %** |
|---|---|---|

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

- The whole program and Parenting Classes.
- Communication.
- The dedication of everyone involved of my family's case.
- Skills of everyday life and coping mechanisms.
- Self-control and social skill.
- Psycho/education, constant guidance for child and mother too
- Self-control and social skill.
- Coping skills at school. Organization.
- How to make rules in the home and how to keep them and to make my yes stronger and my no too when it comes to decisions.
- The staff put 110% into my kid. My kid still needs to make the right decision.
- Making him communicate and a little better being responsible.
- Working with my son on everything he was going threw in ways I could not.
- Made him want to be home.
- The one on one communication with Shelly & Kelly.
- Learning behavioral boundaries and listening skills.
- Dealing with behavioral issues and parent training.

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

- They teach new skills to me.
- [NAME] and [NAME] were excellent help and support towards me.
- I learned how to endure my emotion and anger.
- Going on passes with my mom.
- I now know how to use my coping skills when I'm in time of need.
- The chore circle we have.
- I learned how to have a good relationship with my family.
- Well to be honest I can't really explain how good it was for me. Well I say you guys have helped me with coping skills.
- The help to a good and healthy life.
- Having a Staff present during visits.
- Having structure.
- I felt I could trust some people.
- Learned to treat others with respect, follow rules, and handle my anger.
- They have been gentle when I was upset.
- Getting all the things I needed to succeed.

| **Parent/Caregiver comments** | **Youth comments** |
|---|---|

2. What would improve services your child and the family received?

- Willingness to overcome issues.
- No known recommendations.
- More family meetings.
- You guys are doing good.
- Making meetings easier to attend same day instead of multiple trips.
- After 5pm appointments.
- For this program only to be for children transition to independent living.
- On sight family therapy.
- Not sure.

2. What would improve services you received?

- A little less strict on the food because I was starving most of the time.
- Bring back MP3 so when we are angry we can listen to our music.
- More respect from staff.
- What would have improved the services received is letting me go to more of my CFTs'.
- Nothing that I can think of.
- I don't think there needs to be improvements.
- Well-being more aware what is happening around.
- To get my family back and to see my sisters again.
- Keep the good food.
- A bit more open to different suggestions for breakfast, lunch and snack like at dinner.
- Personal rooms.
- One on One time with staff.
- Being able to express my feelings.

3. What would improve client safety?

- No known recommendations.
- The staff were all great but maybe in the future you could get some bilingual staff to help the language barriers.
- Can't think of any.
- It's been great, nothing to complain about.

3. What would improve client safety?

- None. I felt pretty safe here.
- Staff being more respectful.
- Nothing because their safety was good.
- There is nothing that I can think of.
- 1. Being aware 2. Telling clients to not reach to my side of room. 3. Telling clients to keep their boundaries.
- My safety was fine.

| | |
|---|---|
| | • Seating arrangements so everybody is comfortable. |
| 4. Additional Comments?<br><br>• Thank you to everyone who has helped me and my family.<br>• Staff is Excellent - Thank You.<br>• Enjoyed the relationships I formed with staff. Very knowledgeable and speaks in a friendly easy way I understand.<br>• Staff was great with the kids. Always trying to help no matter what the situation.<br>• Thanks [NAME}, [NAME] and [NAME]. Good people who care.<br>• Have a great day! And thank you guys for all your help.<br>• A voice mail tree for each client.<br>• Thank you for all your support and help. | 4. Additional comments?<br><br>• This place was a life changing experience and I'm very thankful for having [Name} and [Name] in this short period of my life.<br>• Thank God I'm leaving, Hope I never see any of you ever again.<br>• This is a great learning home with great people and I hope to visit soon.<br>• I think you guys should let kids have seconds.<br>• I liked it here.<br>• I enjoyed my time here and like the staff and I appreciate their help. Thank you.<br>• Thanks for improving my life's care!<br>• Thanks for all the help you did for me.<br>• In 3 weeks I learned a lot and am a lot happier.<br>• Thanks for everything.<br>• Thank You.<br>• If I could start again I would not personalize feedback. |

# ATTACHMENT E

Risk Measures / Departure Conditions Report:
Oasis

# Division of Child and Family Services
# Risk Measures and Departure Conditions
# 2015 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 2015 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 departure conditions collected from January 2015 through December 2015. Oasis submitted a timely and complete data set in 2015. 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 2015 through December 2015. 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 | |
|---|---|---|---|
| 2015 | 29<br>Range: no range | 2015 | 18.67<br>Range: 13 to 23 |
| 2014 | 28.75<br>Range: 28 to 29 | 2014 | 14.75<br>Range: 12 to 18 |
| 2013 | 27.17<br>Range: 26 to 28 | 2013 | 14.83<br>Range: 10 to 17 |
| 2012 | 25.83<br>Range: 22 to 27 | 2012 | 16.67<br>Range: 10 to 25 |
| 2011 | 25.75<br>Range: 22 to 27 | 2011 | 24.83<br>Range: 21 to 28 |

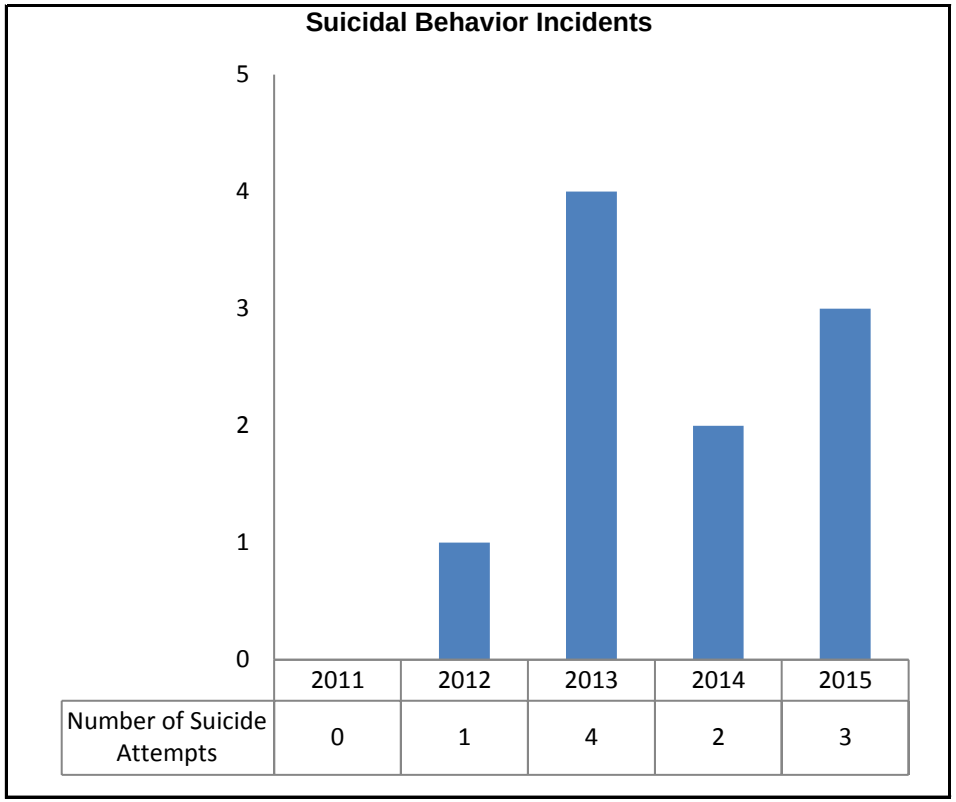
# Suicidal Behavior

**Descriptive Information:**

- All were female.
- Average age was 154.33(range: 14 - 15 years)
- Race
  1 was African American and 2 w
- Custody Status
  1 of the youth was in DCFS Youth Parole
  2 of the youth was in Parental Custody on Probation
- 1 of the youth is Hispanic

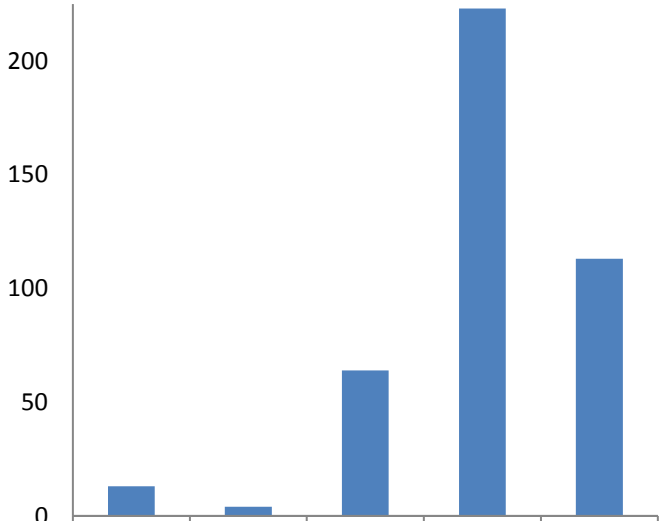
**Clinical and Suicide Attempt Information:**

- Bipolar Disorder NOS and Mood Disorder NOS were the diagnoses for the youth.
- All of the youth had a history of suicide attempt.
- All 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
  Ongoing interactions with youth to encourage her to make safe choices, manual guidance when she was unsafe
  Attempted to verbally de-escalate youth, physical restraint needed for safety
- Suicide Outcome
  youth was admitted to a psychiatric hospital



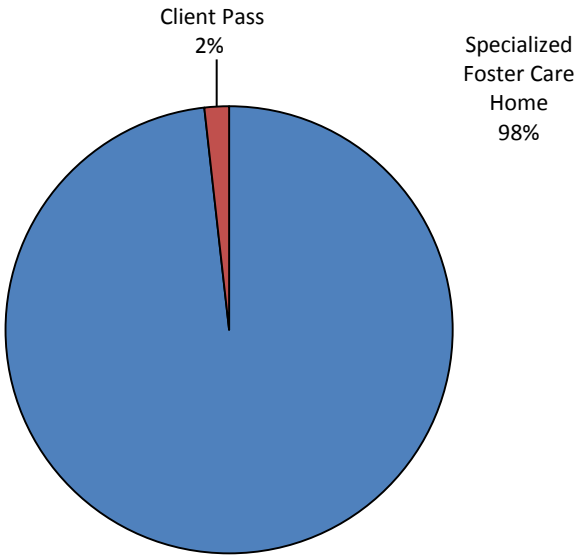
# Medication Errors

## Medication Error Incidents

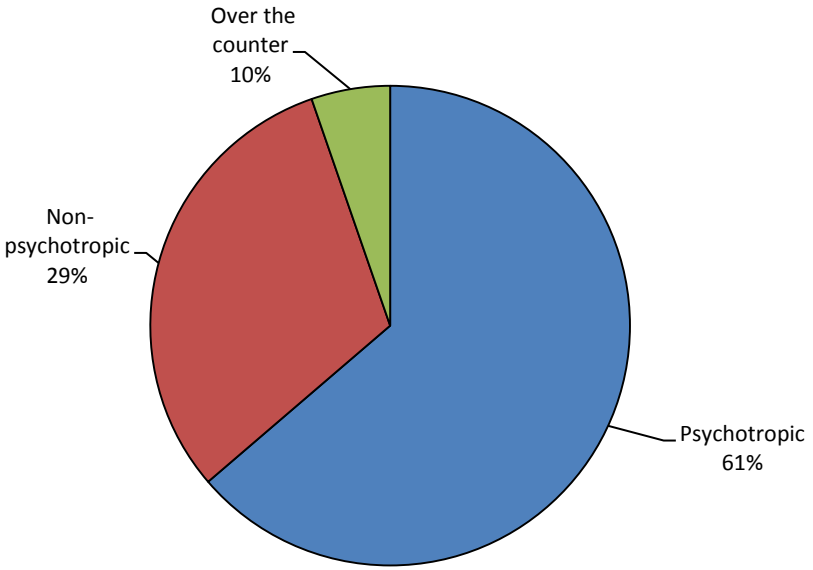



| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Number of Medication Errors | 13 | 4 | 64 | 223 | 113 |

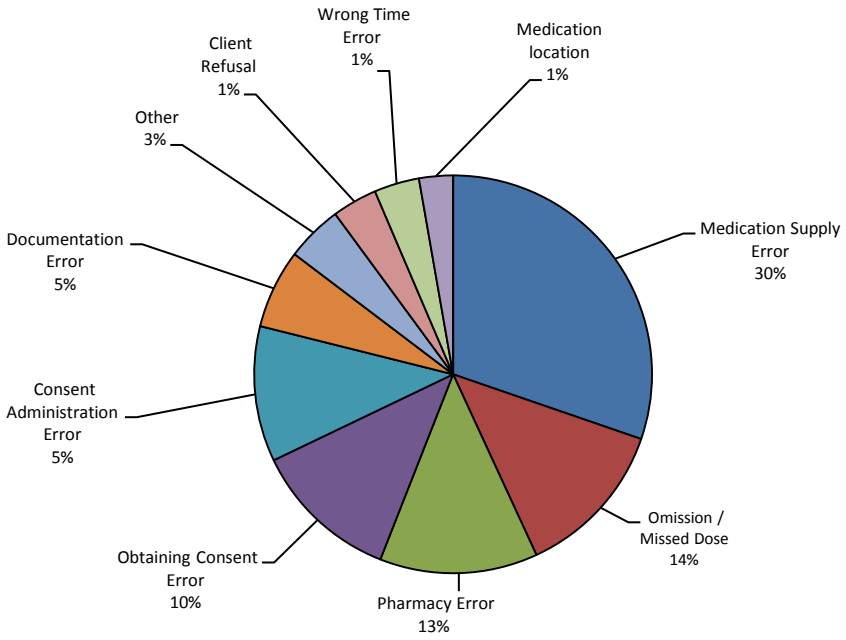
## Location of Medication Error



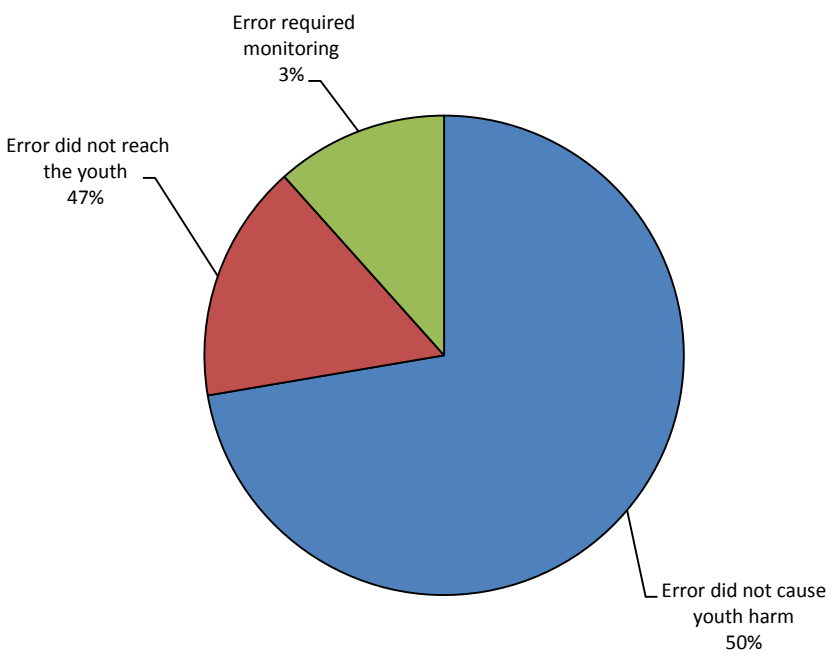

## Type of Medication

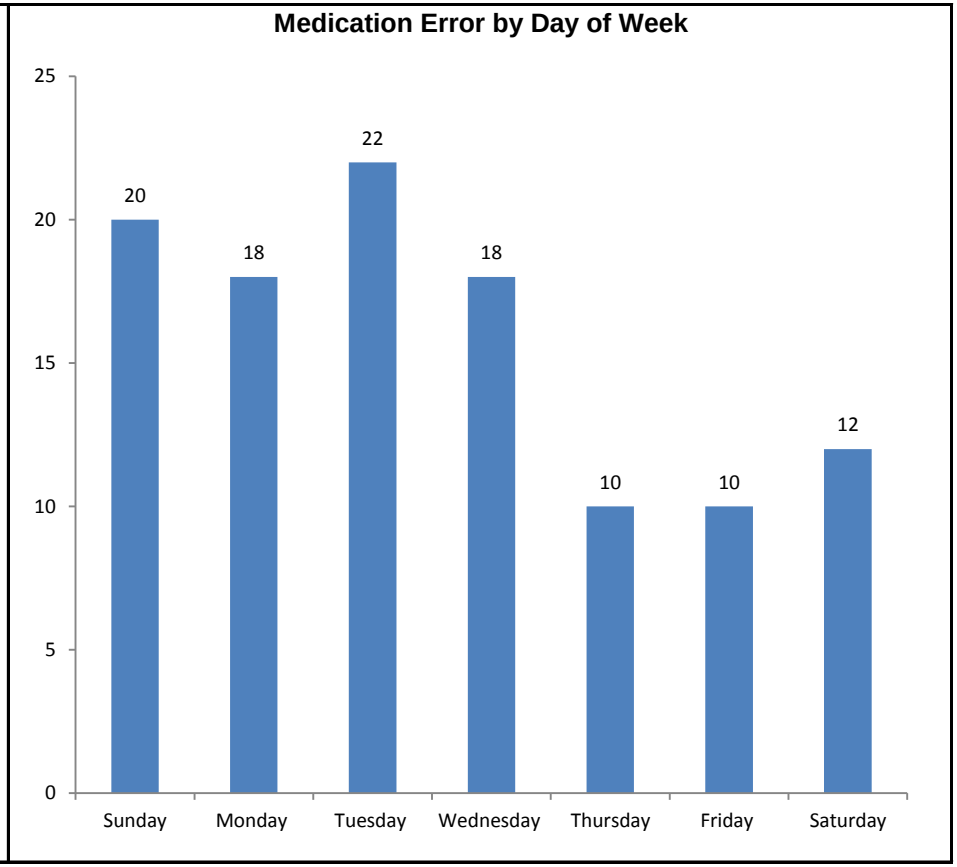



## Type of Medication Error



# Medication Errors (Continued)



# AWOL

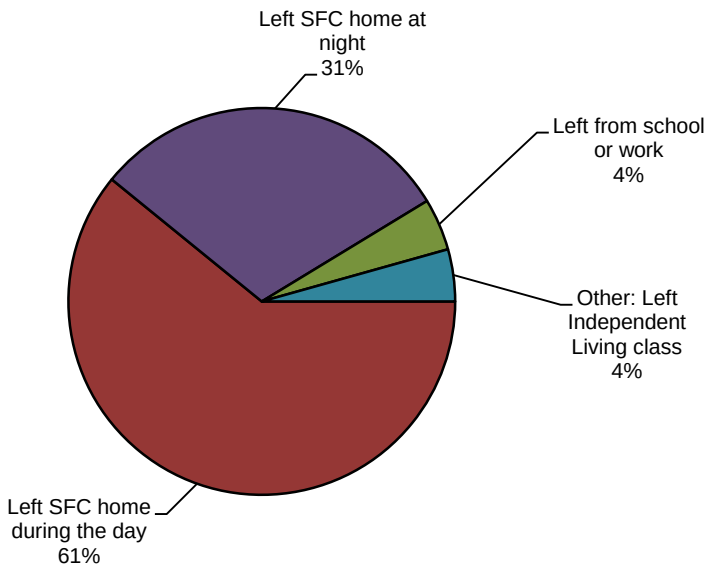
**Descriptive Information:**

- 7 (30.43%) were female and 16 (69.57%) were male.
- Average age was 14.91 (range: 9 - 17 years)
- Race
  13 (56.52%) Caucasian
  2 (8.70%) American Indian/Alaskan Native
  2 (8.70%) Asian
  5 (21.74%) Mixed
  1 (4.34%) Unknown
- None were Hispanic.
- Custody Status
  11 (48.83%) Child Welfare Custody
  6 (26.09%) Parental Custody no Probation
  5 (21.74%) DCFS Youth Parole Custody/Supervision
  1 (4.34%) Parental Custody on Probation

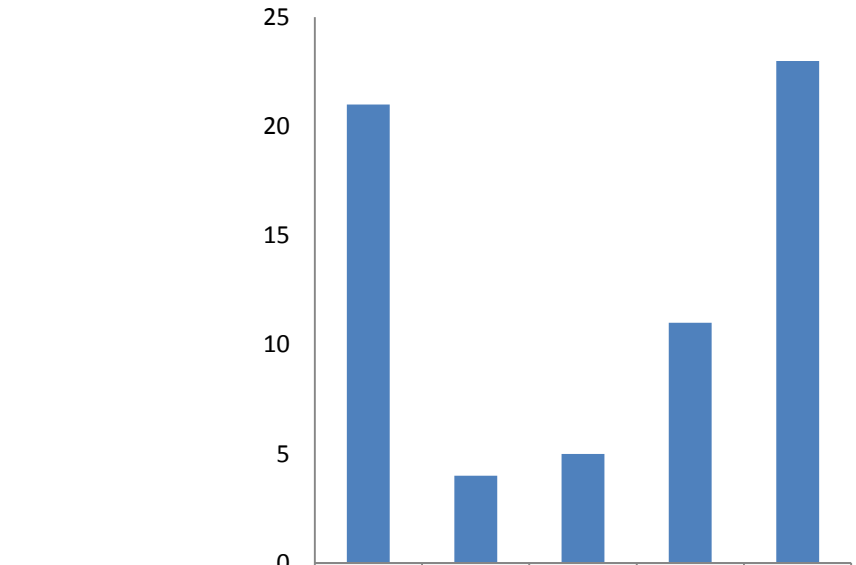
**Clinical and AWOL Information:**

- PTSD Disorder (5 or 45.45% of youth) was the most frequent diagnosis.
- 5.22 (range: 1 - 13) of days AWOL
- 22 of the youth had a history of AWOL.

**Type of Supervision at AWOL**

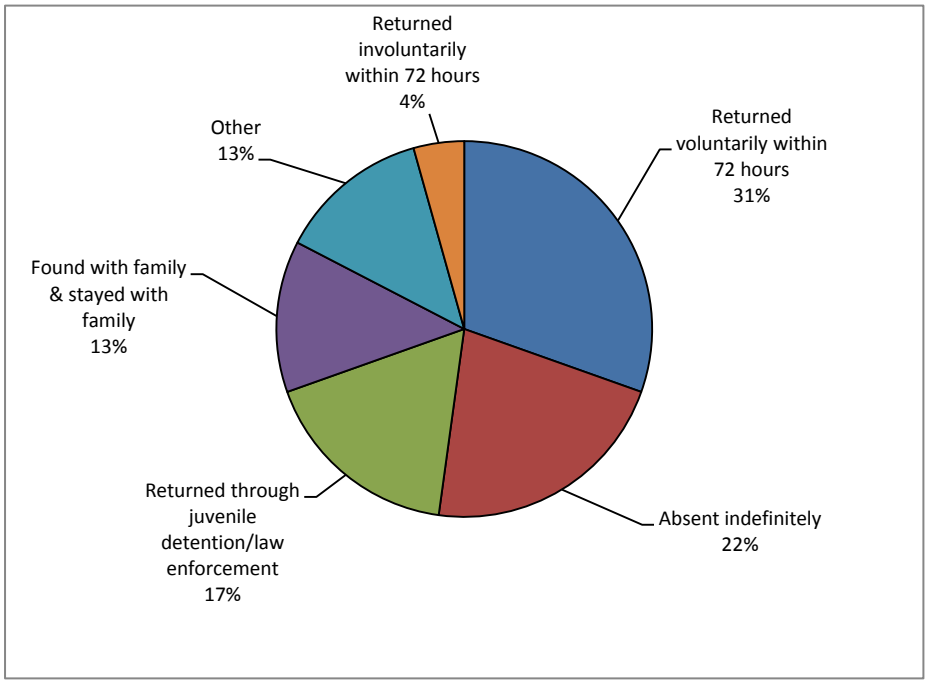



**AWOL Incidents**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Number of AWOL Incidents | 21 | 4 | 5 | 11 | 23 |

**Outcome of AWOL**



# Restraint and Manual Guidance

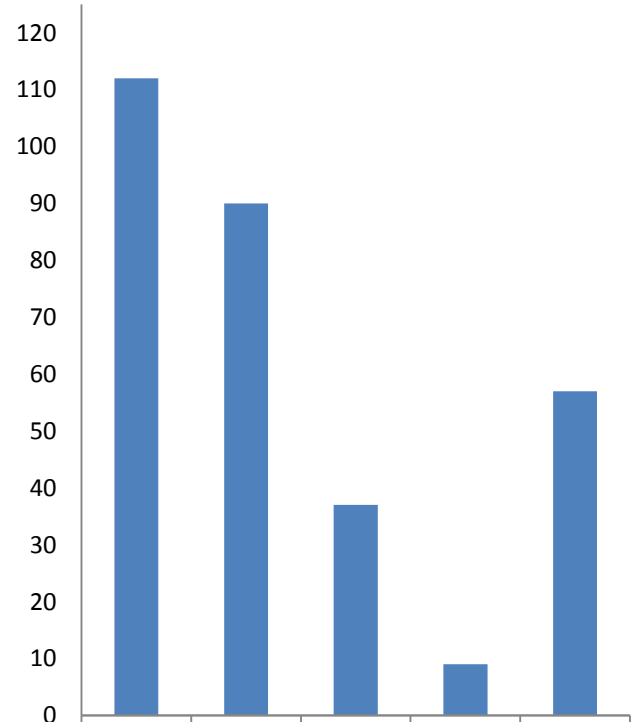
**Descriptive Information:**

- 24 (42.11%) were female and 33 (57.89%) were male.
- Average age was 6.49 (range: 6 - 14 years)
- Race
  32 (56.14%) were Caucasian
  25 (43.86%) were African Amer
- 1 (1.75%) were Hispanic.
- Custody Status
  31 (54.39%) Parental Custody and no Juvenile Probation involvement
  26 (45.61%) Parental Custody on Probation

**Clinical and Restraint and Manual Guidance Information:**

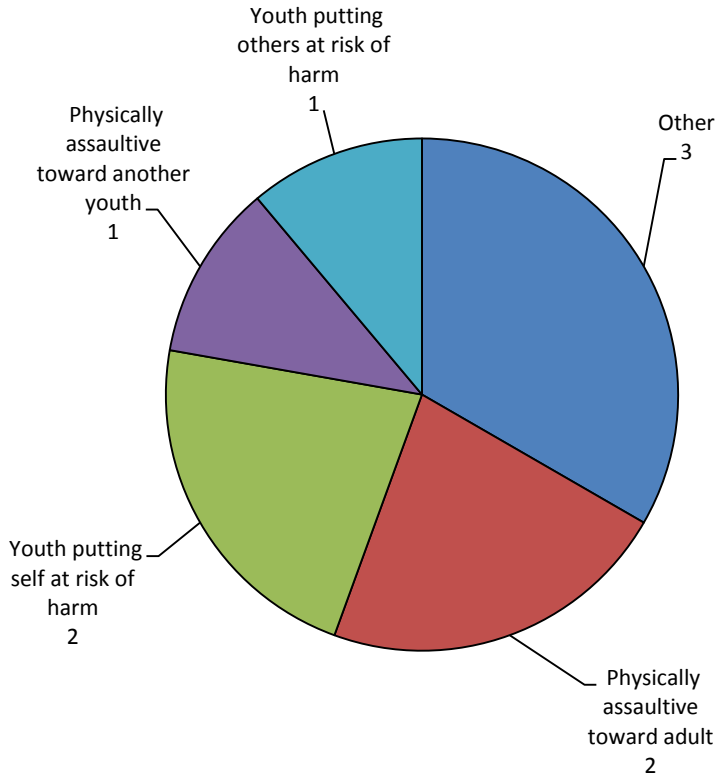
- Mood Disorder was the most frequent diagnosis.
- 53 (92.98%) of the youth had a history of restraint and manual guidance
- A manual guidance was used during each restraint.
- 1 was the average number of times a restraint used per incident
- 11.20 (range: 1 - 50) was average length of restraint in minutes
- None of the restraints had a debriefing held after the incident.
- The most common intervention used was verbal redirection.
- On average, 4.28 interventions were used in each incident.

**Restraint and Manual Guidance Incidents**



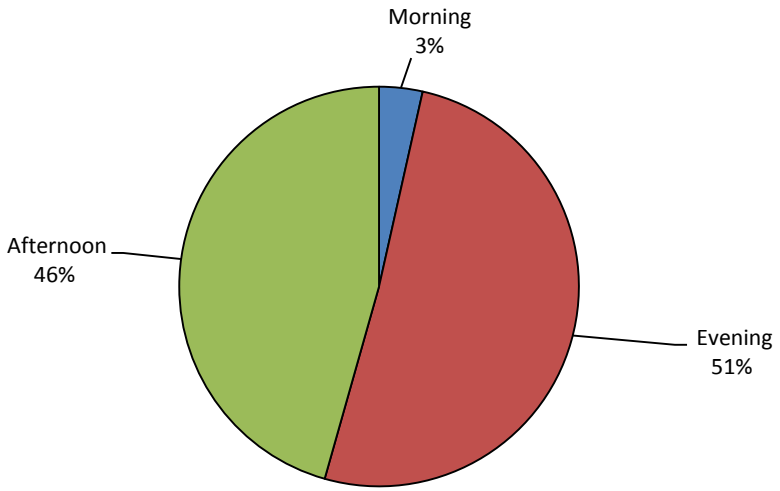

| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Number of restraint and manual guidance incidents | 112 | 90 | 37 | 9 | 57 |

**Restraint and Manual Guidance Event**

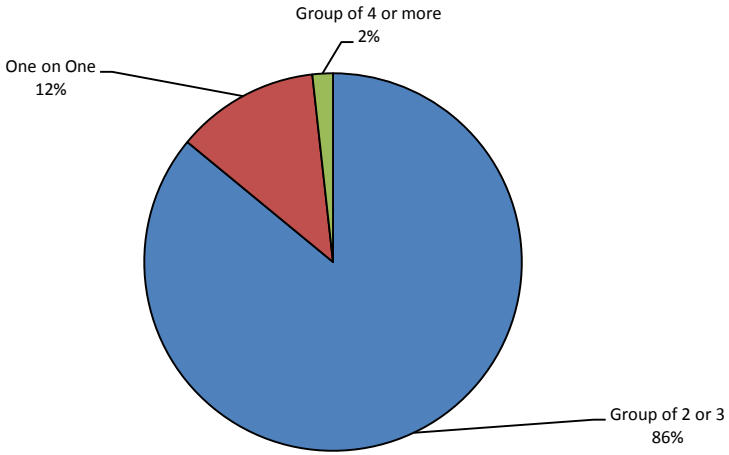


# Restraint and Manual Guidance (Continued)

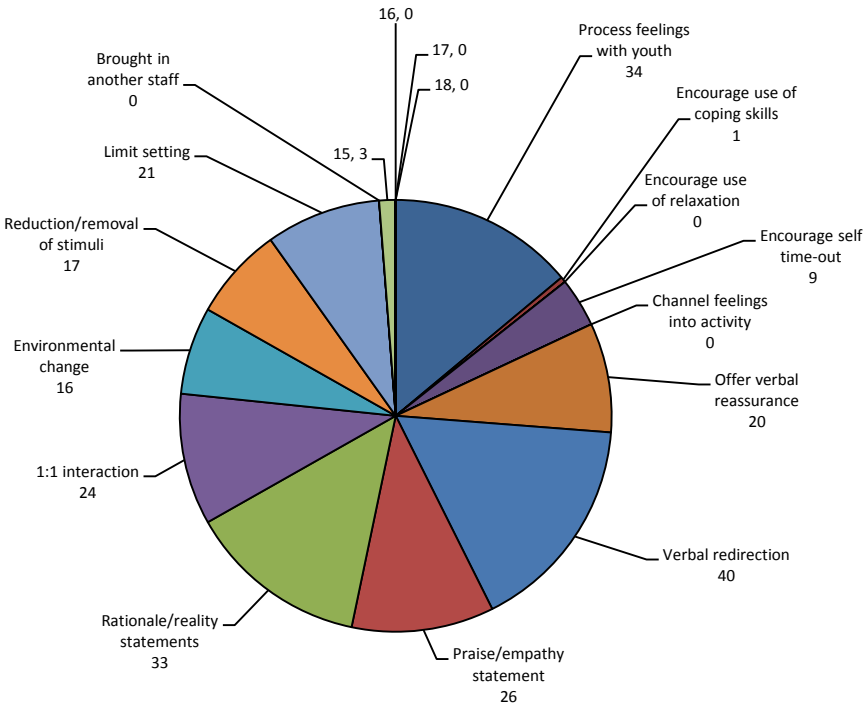
## Incident Time of Day



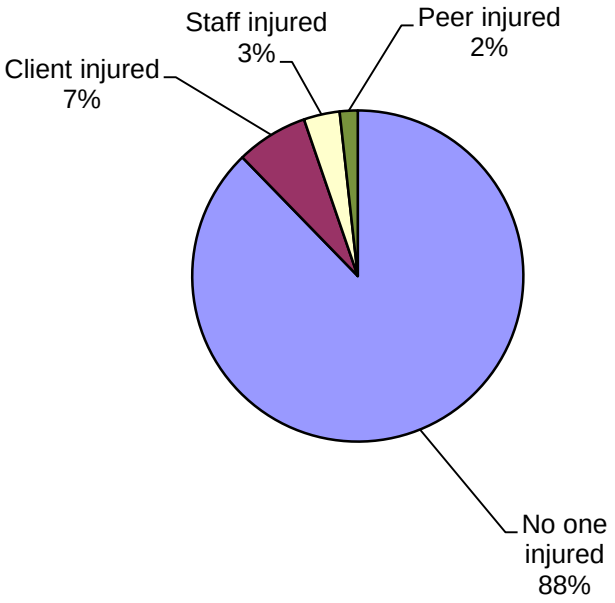

## Type of Supervision for Restraint and Manual Guidance




## Interventions Used Prior to Incident




## Restraint and Manual Guidance Injury



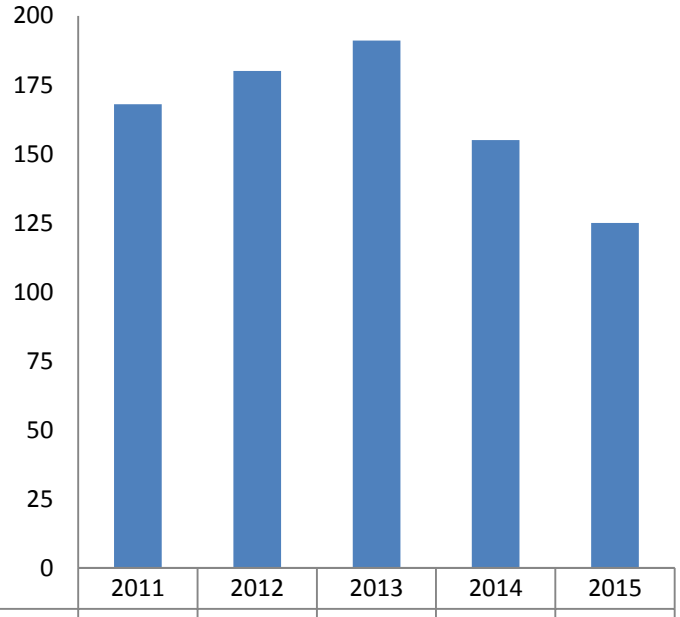
## Departure Conditions

Oasis reported 30 discharges in the 2015 reporting period.

**Descriptive Information:**

- 15 (50%) were female and 15 (50%) were male.
- Average age was 14.86 (range: 9 - 17 years)
- Race
  19 (63.33%) Caucasian
  8 (26.67%) African American
  2 (6.67%) Asian
  2 (3.33%) Mixed
- 3 (10%) were Hispanic.
- Custody Status
  15 (50%) Child Welfare Custody
  3 (10%) Parental Custody on Probation
  3 (10%) DCFS Youth Parole Custody/Supervision
  9 (30%) Parental Custody and no Juvenile Probation involvement
- 27 (90%) of the youth were Medicaid recipients.
- The average length of stay at Oasis was 124.83 days, ranging from 3 days to 324 days.

**AVERAGE LENGTH OF STAY**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Average length of stay (days) | 168 | 180 | 191 | 155 | 125 |

**Clinical and Departure Information:**

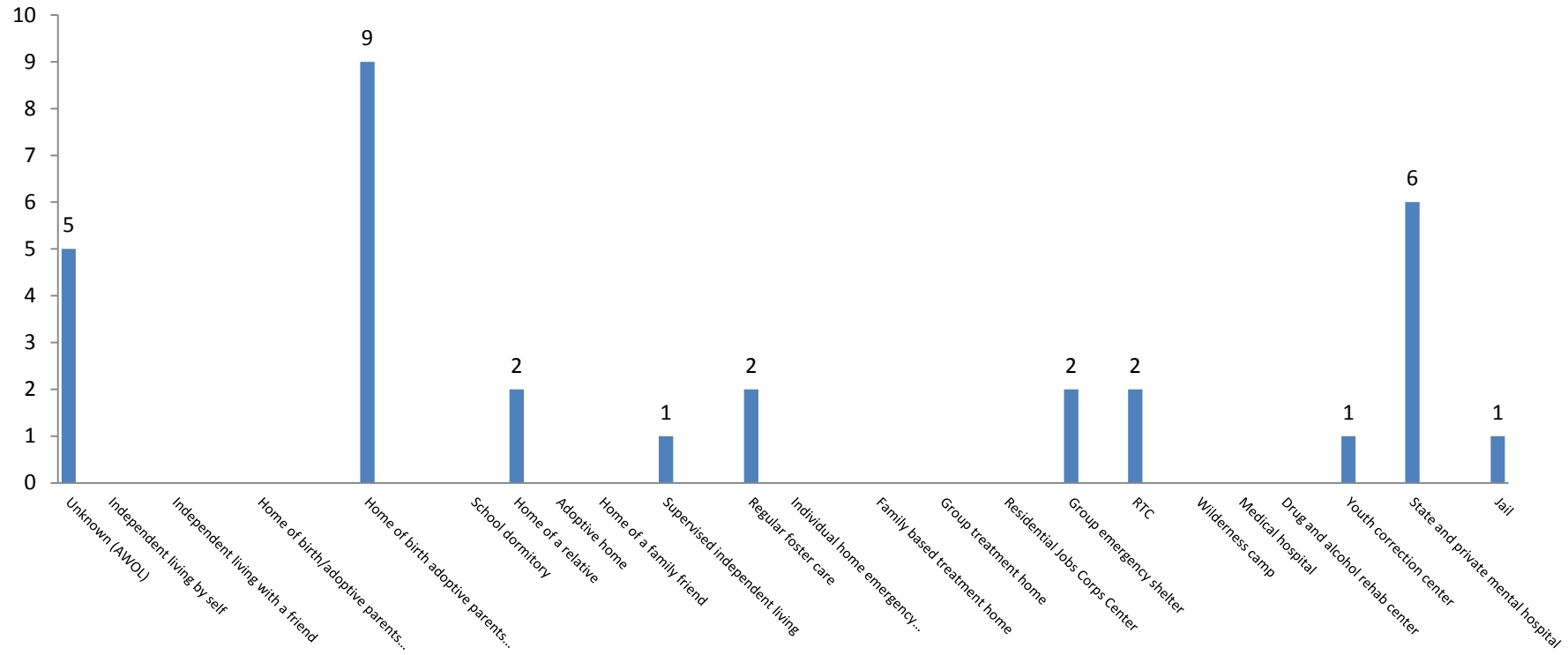
- PTSD (5 or 16.67% of youth) was the most frequent diagnosis at admission followed by Bipolar Disorder NOS (5 or 16.67% of youth).
- Mood Disorder (6 or 20% of youth) was the most frequent diagnosis at discharge followed by Major Depressive Disorder (3 or 10% of youth).
- The average CASII composite score at admission was 21.33.
- The average CASII composite score at discharge was 21.46.
- 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 |
| 2015 | 15 | Residential Job Corps Center |
| 2014 | 14 | Group treatment home |
| 2013 | 13 | Family based treatment home |
| 2012 | 13 | Family based treatment home |
| 2011 | 11 | Specialized foster care |

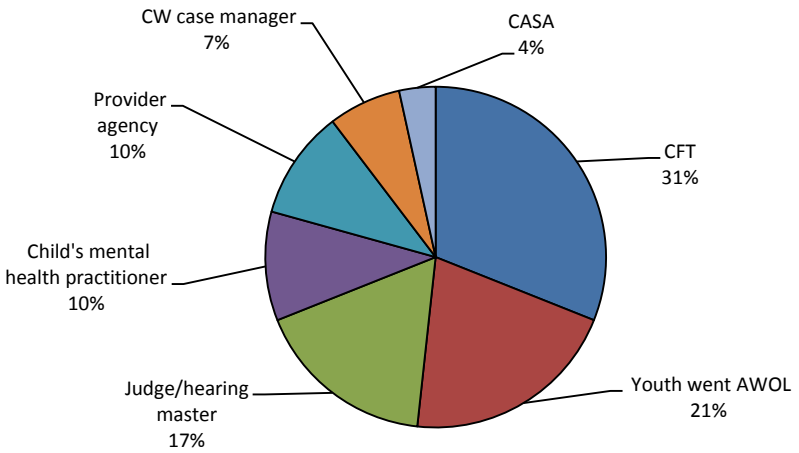
- In 2015, the ROLES score resulted in an average of 15, which equals the restrictiveness score of residential job corps center.

## Departure Conditions (Continued)

### RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)




### WHO RECOMMENDED DEPARTURE



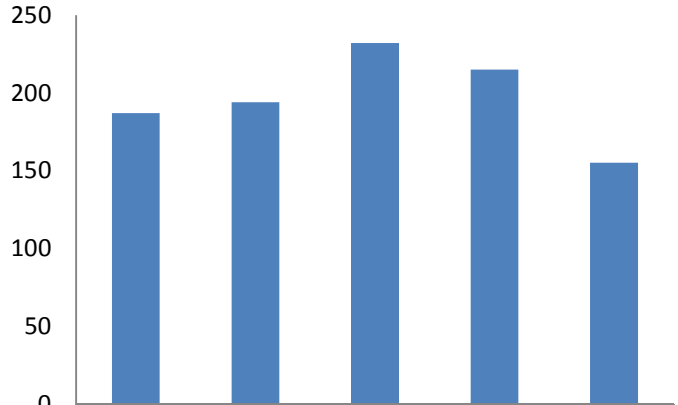
## Departure Conditions - Youth in Child Welfare Custody

Of the 30 discharges reported by Oasis in the 2015 reporting period, 15 (50%) were in the custody of a public child welfare agency.

**Descriptive Information:**

- 9 (60%) were female and 6 (40%) were male.
- Average age was 14.80 (range: 9-17 years)
- Race
  6 (40%) Caucasian
  5 (33.33%) African American
  1 (6.67%) Asian
  2 (13.33%) Mixed
  1 (6.67%) American Indian
- 1 (6.67%) were Hispanic.
- The average length of stay at Oasis was 154.67 days, ranging from 0 days to 324 days.

**AVERAGE LENGTH OF STAY**




| | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| Average length of stay (days) | 187 | 194 | 232 | 215 | 155 |

**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 21.14.
- The average CASII composite score at discharge was 22.67.

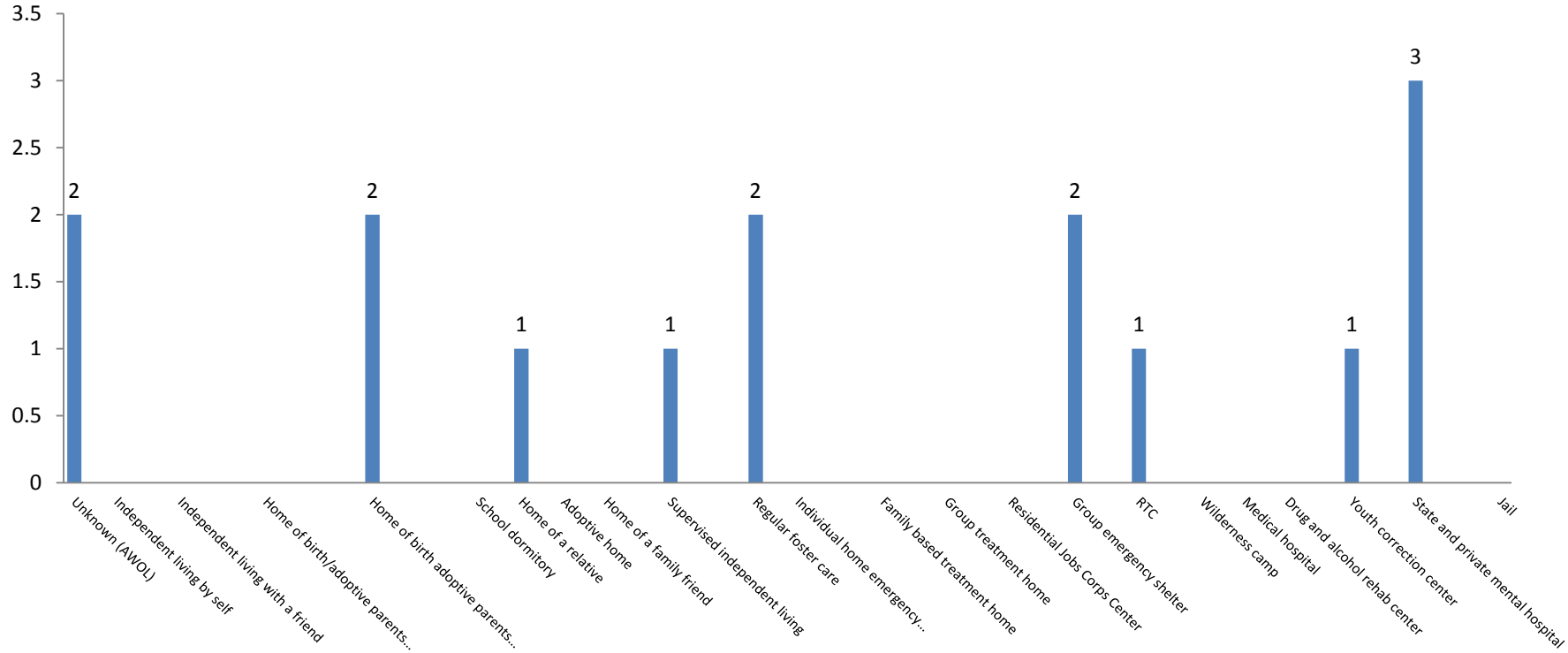
- Setting child/adolescent will live - The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Rieitz, 1992) resulted in the following restrictiveness score and setting.

| RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES) | | |
|---|---|---|
| Reporting Period | Restrictiveness Score | Setting |
| 2015 | 14 | Group Treatment Home |
| 2014 | 15 | Residential Job Corps Center |
| 2013 | 12 | Individual home emergency shelter |
| 2012 | 13 | Family based treatment home |
| 2011 | 12 | Individual home emergency shelter |

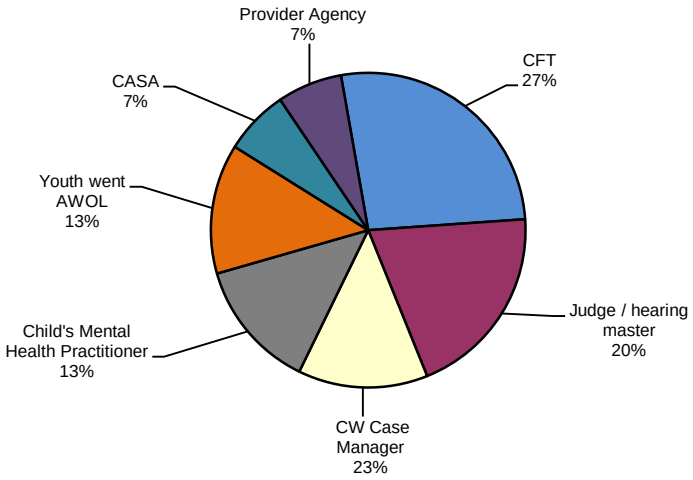
- In 2015, the ROLES score resulted in an average of 14.31, which equals the restrictiveness score of group treatment home.

## 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:**

- 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 2015, Oasis continued to work with a part-time nurse to work with staff on Medication training, documentation, and reduction of medication errors.
- In 2015, changes to the NAC 424 required Provider Agencies to document and report medication refusals by a youth.
- 97% of the medication errors either did not reach the youth or cause the youth harm.

**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.
- 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:**

- 12 (52%) of the youth returned to Oasis.

**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,4.28 interventions were used for each restraint and manual guidance incident. The three most used interventions were: process feelings with youth, rationale / reality statements, and verbal redirection.
- Over the past five reporting periods, Oasis continues to show reduction in the use of restraint and manual guidance.

**Practice Guidelines and Opportunities for Improvement:**

- At the time of admission, an assessment of relevant risk factors and the youth's history with restraint should be explored as this will inform the treatment planning and services provided; therefore, the provider should focus on obtaining a complete restraint history of each child and adolescent as early in the pre-placement process as possible (GAO, 1999).
- Each child who is identified as having behavior management problems or a history with restraint should have an individualized behavior management plan that is evaluated on a regular basis for efficacy (Council on Children and Families, 2007).
- Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation (Council on Children and Families, 2007).
- Ensure debriefing occurs with those staff involved in the restraint to explore and address the events leading to the use of restraint, to explore alternatives to restraint which may have been more useful or effective, potential strategies to avoid the use of restraint, and to evaluate the physical/psychological/emotional effects on both the youth and the staff (GAO, 1999).
- Ensure staff has effective alternative methods for handling those youth who may have a history with restraint or whose behavior plan indicates they are at risk for being restrained.

**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, 19 (63.33%) of the youth were placed in less restrictive settings.
- Upon discharge, 4 (13.33%) of the youth continued to receive services from the Division of Child and Family Services.

**Children in Child Welfare Custody Highlights:**

- Upon discharge,8%(53.33) of youth returned to a less restrictive environment.
- Upon discharge, 2 (13.33%) of the youth continued to receive services from the Division of Child and Family Services.

**Practice Guidelines and Opportunities for Improvement:**

- Only 9 (30%) 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 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 2015, Oasis had 3 support staff complete the Trauma Informed Care training.

## Summary

Oasis submitted all of its 2015 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 2015 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of Medication errors, AWOLs, and Child and Family 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 2015 risk measures data submission. The PEU is also available to offer technical assistance in any of these areas if so requested by the provider.

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# ATTACHMENT F

Risk Measures / Departure Conditions Report:
Adolescent Treatment Center

# Division of Child and Family Services
# Risk Measures and Departure Conditions
# 2015 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 2015 report is the eighth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2015 through December 2015. Adolescent Treatment Center (ATC) submitted a timely and complete data set in 2015. 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

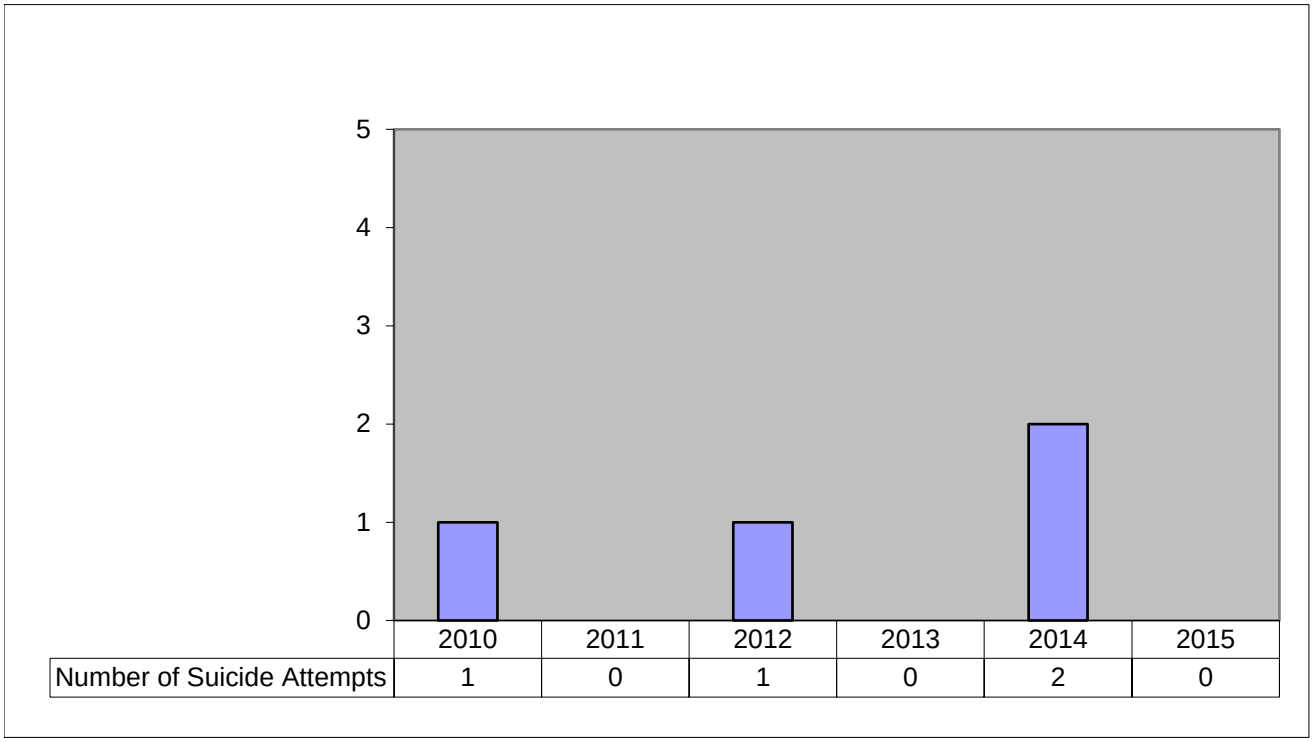
This report for ATC is the analysis of risk measure and departure conditions data collected from January 2015 through December 2015. Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number of youth served for 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 | |
|---|---|---|---|
| 2015 | 16<br>Range: 16 to 16 | 2015 | 18.33<br>Range: 16 to 24 |
| 2014 | 16<br>Range: 16 to 16 | 2014 | 18.33<br>Range: 16 to 20 |
| 2013 | 16<br>Range: 16 to 16 | 2013 | 19.42<br>Range: 17 to 22 |
| 2012 | 15.5<br>Range: 14 to 16 | 2012 | 18.92<br>Range: 16 to 22 |
| 2011 | 15.6<br>Range: 14 to 18 | 2011 | 19.2<br>Range: 17 to 23 |

## Suicidal Behavior

There were no attempted or completed suicides during the 2015 reporting period.




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Number of Suicide Attempts | 1 | 0 | 1 | 0 | 2 | 0 |

# Medication Errors

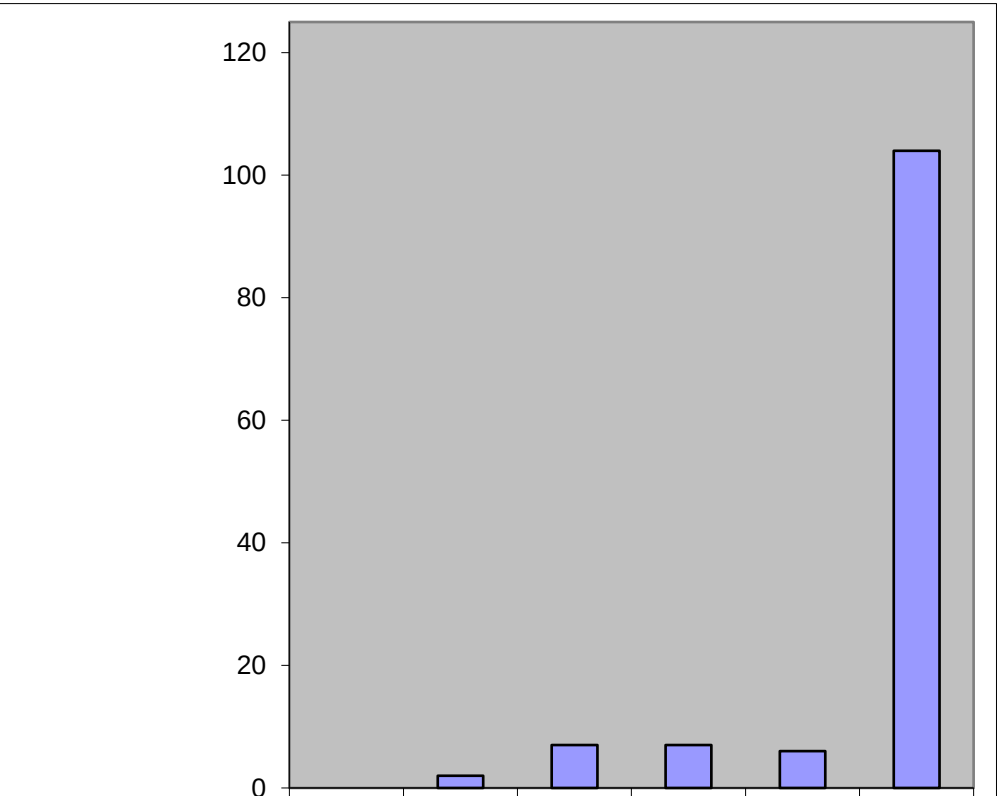
**Medication Error Location**

- 103 (99.04%) of the errors occurred in the home
- 1(0.96%) of the errors occurred on a client pass

**Medication Error Type Information:**

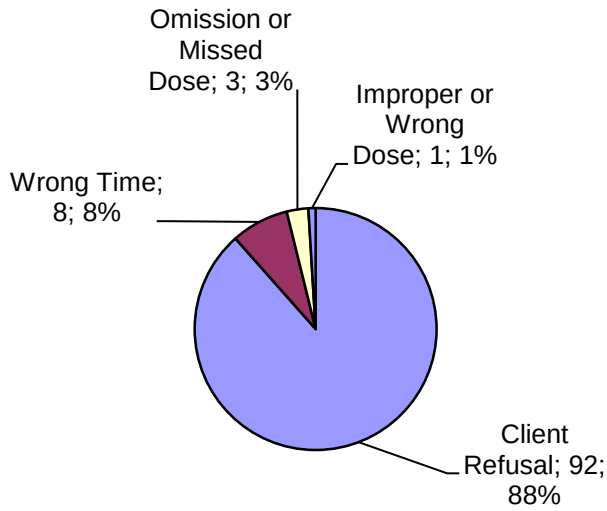
- 99 (95.19%) of the medication errors were psychotropic medication
- 5 (4.81%) of the medication errors were non-psychotropic medication

**Medication Error Incidents**




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Number of Medication Errors | 0 | 2 | 7 | 7 | 6 | 104 |

**Type of Medication Error**



# AWOL

**Descriptive Information:**

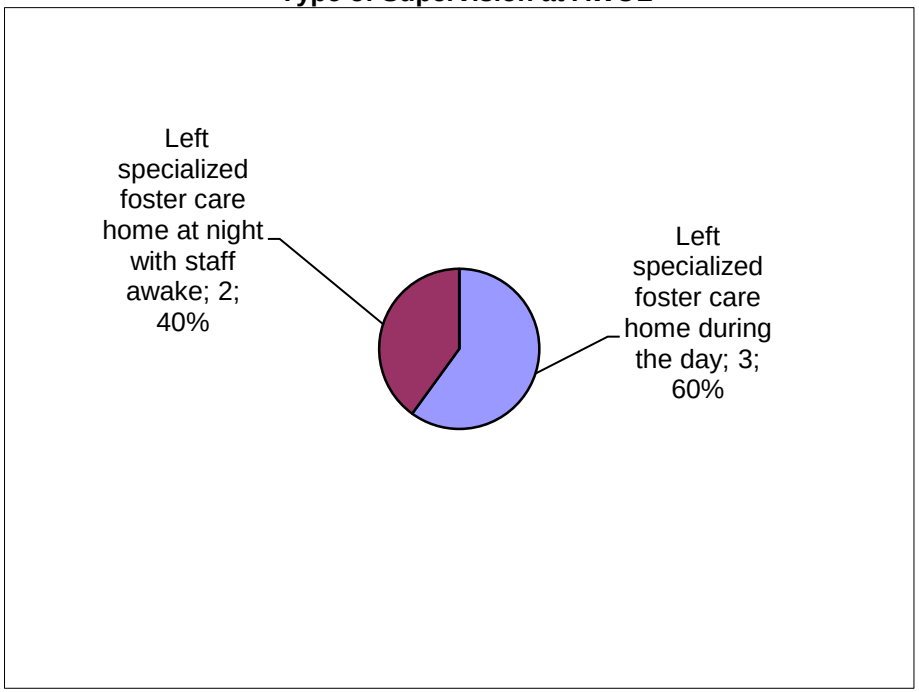
- 5 (100%) were male.
- Average age was 14.08 (range: 13 - 17 years)
- Race
  4 (80.0%) Caucasian
  1 (20.0%) Mixed Race

- Custody Status
  3 (60%) Parental Custody on Probation
  1 (20%) Child Welfare Custody
  1 (20%) DCFS Youth Parole

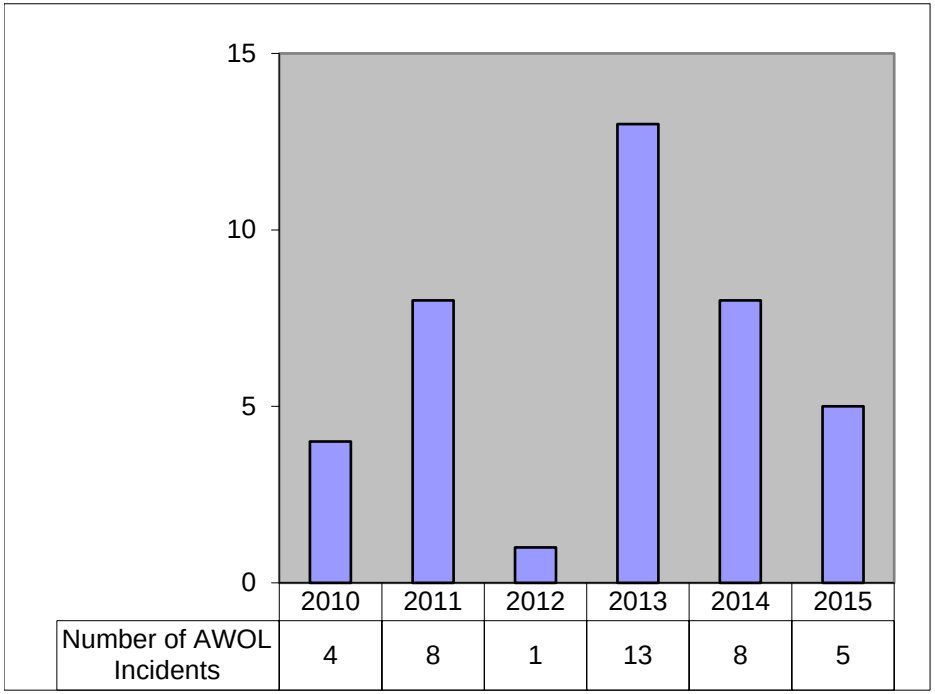
**Clinical and AWOL Information:**

- Major Depressive Disorder (80%) was the most frequent diagnosis.
- 4.2(range: 3-5) was the average number of days AWOL
- 4 (80%) of the youth had a history of AWOL.

**Type of Supervision at AWOL**

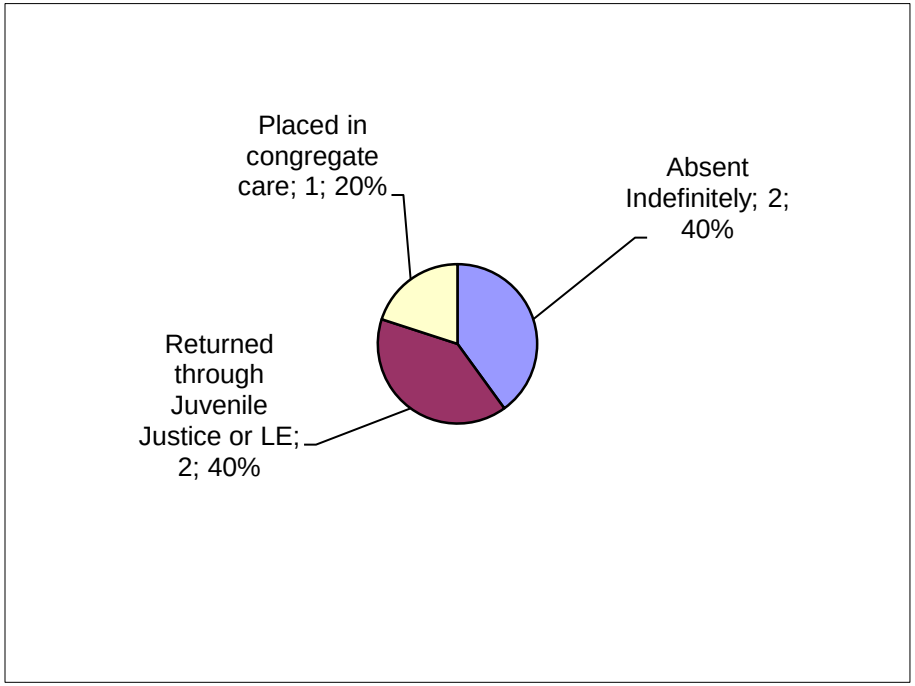



**AWOL Incidents**




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Number of AWOL Incidents | 4 | 8 | 1 | 13 | 8 | 5 |

**Outcome of AWOL**



## Restraint and Manual Guidance

**Descriptive Information:**

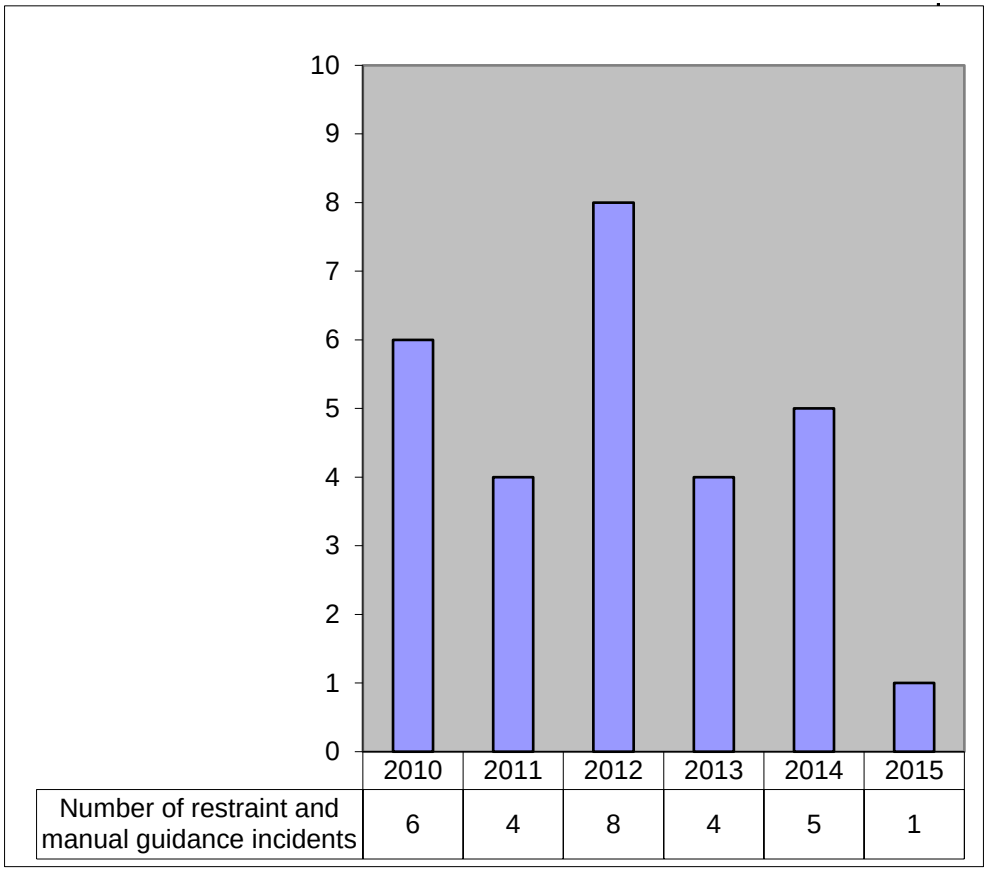
- 1 male
- Average age was 17 years+A224
- Race
  1 Caucasian

- Custody Status
  1 Parental Custody on Probation

**Clinical and Restraint and Manual Guidance Information:**

- Bipolar Disorder (100% of youth) was the most frequent diagnosis.
- 100% did not have 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 not used during a restraint.
- 1 was 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.
- 6 interventions was used in the incident.

**Restraint and Manual Guidance Incidents**




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Number of restraint and manual guidance incidents | 6 | 4 | 8 | 4 | 5 | 1 |

**Restraint and Manual Guidance Event**

The one incident involved physical assualt toward an adult.

**Type of Supervision for Restraint and Manual Guidance**

The one incidents invovled a group of 4 or more youth.

**Restraint Outcome**

The outcome of the incident involved the client needing time out.

## Departure Conditions

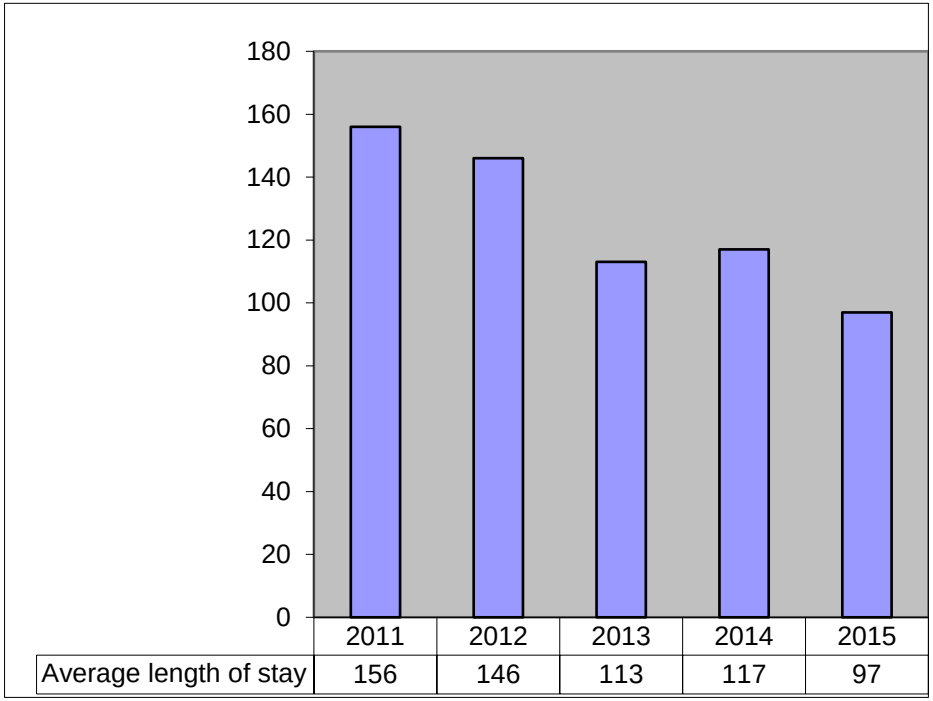
ATC reported 36 discharges in the 2015 reporting period.

**Descriptive Information:**

- 14 (38.89%) were female and 22 (61.11%) were male.
- Average age was 15.9 (range: 13 - 17 years)
- Race
  29 (80.56%) Caucasian
  5 (13.89%) African American
  1 (2.78%) Mixed Race  1 (2.78%) Other Race
- 13 (36.11%) were Hispanic.
- Custody Status
  21 (58.33%) Parental Custody on Probation
  10 (27.78%) Child Welfare Custody
  5 (13.89%) DCFS Youth Parole Custody/Supervision

- 36 (100%) were Medicaid recipients.
- The average length of stay at ATC was 138.19 days, ranging from 1 days to 335 days.
- 28 (77.78%) stayed more than 90 days.
- None continued services after discharge.

**Average length of stay**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Average length of stay | 156 | 146 | 113 | 117 | 97 |

**Clinical and Departure Information:**

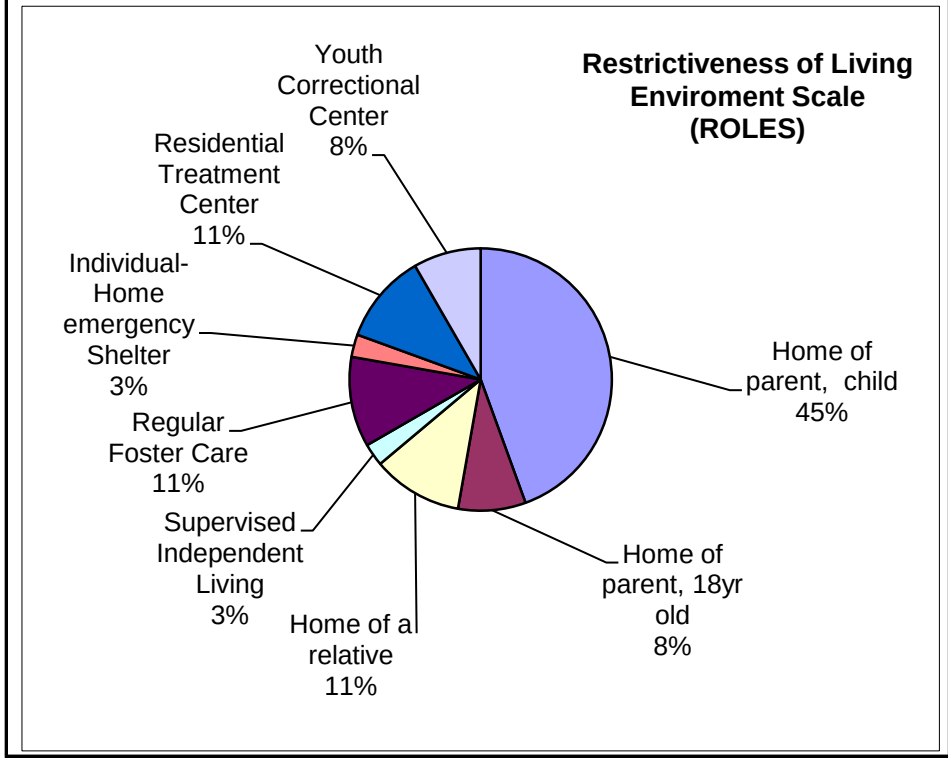
- Major Depressive Disorder (9 or 25 % of youth) was the most frequent diagnosis at admission followed by Posttraumatic Disorder (3 or 8.33%) and Bipolar Disorder (3 or 8.33%) of youth).
- Missing (8 or 22.22% of youth) was the most frequent diagnosis at discharge followed by Posttraumatic Stress Disorder (3 or 8.33% of youth ).
- The average CASII composite score at admission was 23.06
- The average CASII composite score at discharge was 20.96.
- 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 |
| 2015 | 13.42 | Family-based treatment home |
| 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 |

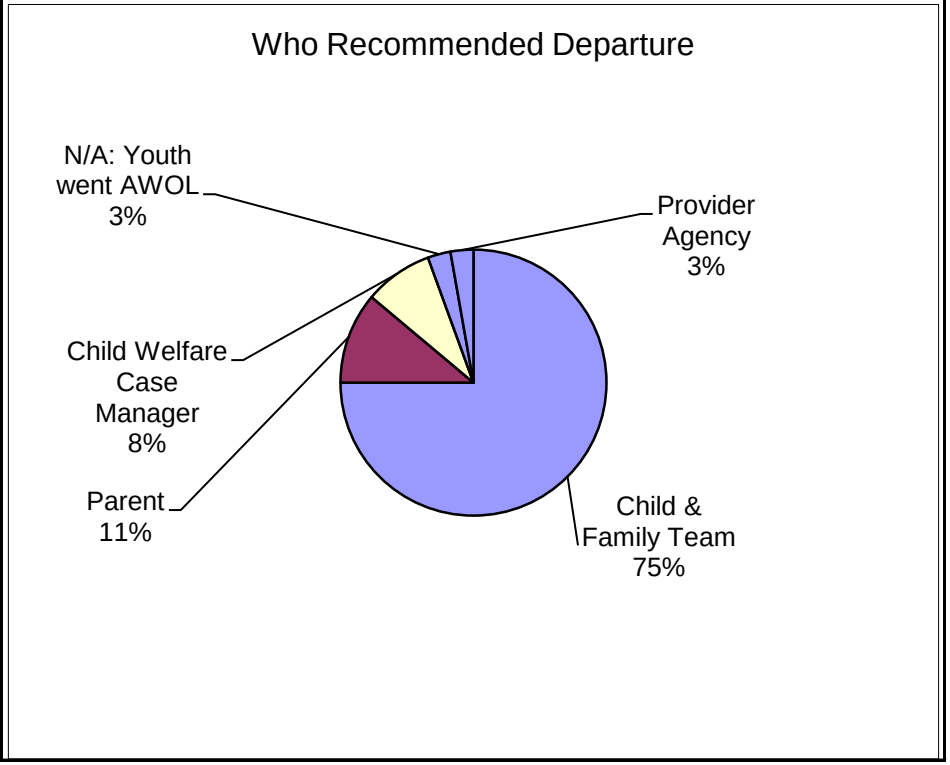
- In 2015, the ROLES score resulted in an average of 13.42 which equals the restrictiveness score of family-based treatment home.

## Departure Conditions (Continued)

### RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES)




### WHO RECOMMENDED DEPARTURE



## Departure Conditions - Youth in Child Welfare Custody

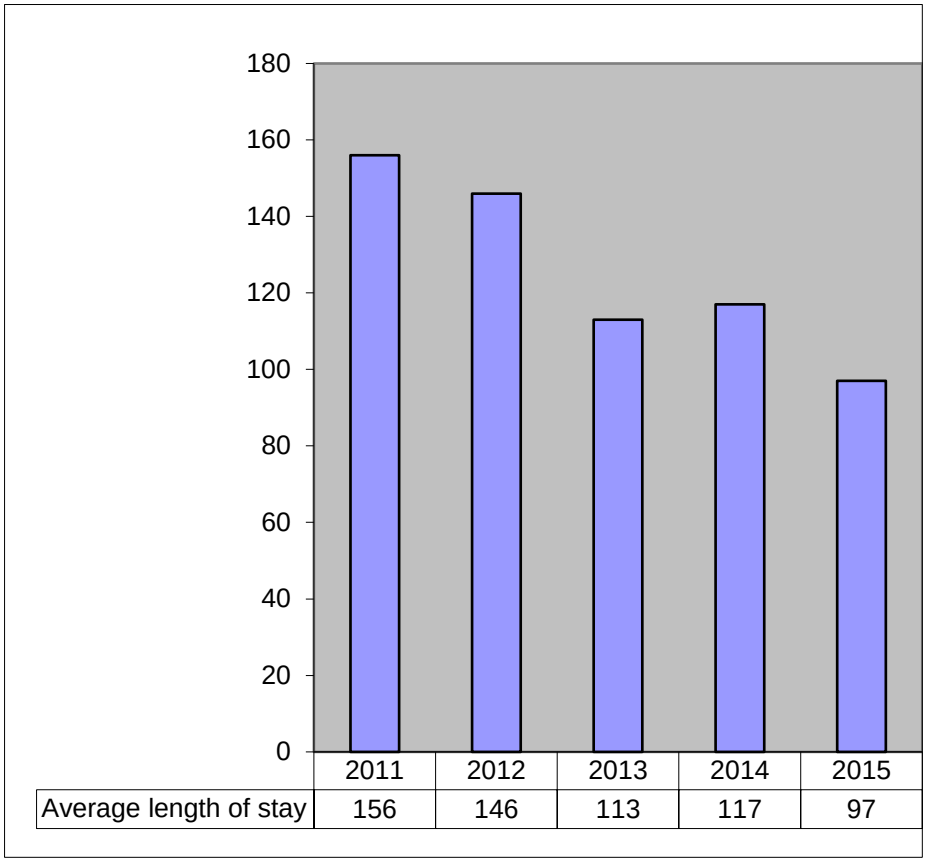
Of the 36 discharges reported by ATC in the 2015 reporting period, 10 were in the custody of a public child welfare agency.

**Descriptive Information:**

- 7 (70%) were female and 3 (30%) were male.
- Average age was 15.30 (range: 14 - 17 years)
- Race
  8 (80%) Caucasian
  2 (20%) African American

- 2 (20%) was Hispanic.
- The average length of stay at ATC was 96.80 days, ranging from 6 days to 179 days.

**AVERAGE LENGTH OF STAY**




| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Average length of stay | 156 | 146 | 113 | 117 | 97 |

| RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES) | | |
|---|---|---|
| Reporting Period | ictiveness Score | Setting |
| 2015 | 11.5 | Regular Foster Care |
| 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 |

- In 2015, the ROLES score resulted in an average of 11.5 which equals the restrictiveness score of Regular Foster Home.
- Departure was determined by the child and family team in 7 (70%) of cases and by Child Welfare Case Manager 3 (30%) of cases.

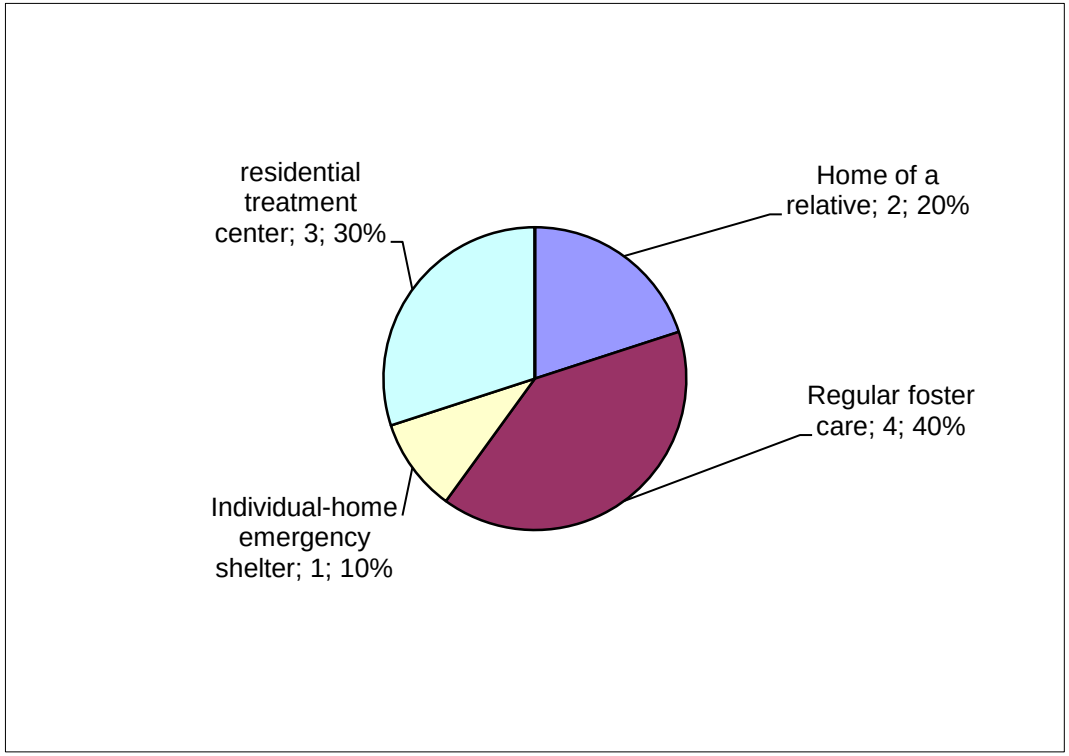
**Clinical and Departure Information:**

- Major Depressive Disorder (5 or 50% of youth) was the most frequent diagnosis at admission followed by PTSD (2 or 20% of youth).
- Major Depressive Disorder (3 or 30% of youth) was the most frequent diagnosis at discharge followed by Missing (4 or 40% of youth).

- The average CASII composite score at admission was 23.90.
- The average CASII composite score at discharge was 20.67.
- 6 (60%) 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 ENVIRONMENT SCALE (ROLES)**



## Suicidal Behavior

Attempted suicide was defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill

**Highlights:**

- There were no attempted or completed suicides in the 2015 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 were few errors that reached the patient.
- There was an increase in the number of medication errors in 2015.

**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
- 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:**

- There were 5 youth who went AWOL during 2015, this is down from the 8 in 2014.

**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
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior. Discuss his/her
- 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 the 1 restraint incident in 2015.

**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 of 36 youth, 28 of these youth were placed in less restrictive settings.
- Most of the (27) discharges were recommended by the Child and Family Team (CFT).

**Children in Child Welfare Custody Highlights:**

- Upon discharge, 6 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 10 departures for children in the custody of a child welfare agency all 7 or 70% were recommended by a CFT. In 2014, 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 2015, ATC did not complete any Trauma Informed Care training.

## Summary

ATC submitted all of its 2015 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 2015 Risk Measures and Departure Conditions report reflects opportunities for improvement in the areas of medication errors, and AWOLs.

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 2015 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:
Family Learning Homes

# Division of Child and Family Services
# Risk Measures and Departure Conditions
# 2015 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 2015 report is the sixth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2015 through December 2015. Family Learning homes submitted a timely and complete data set in 2015. 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

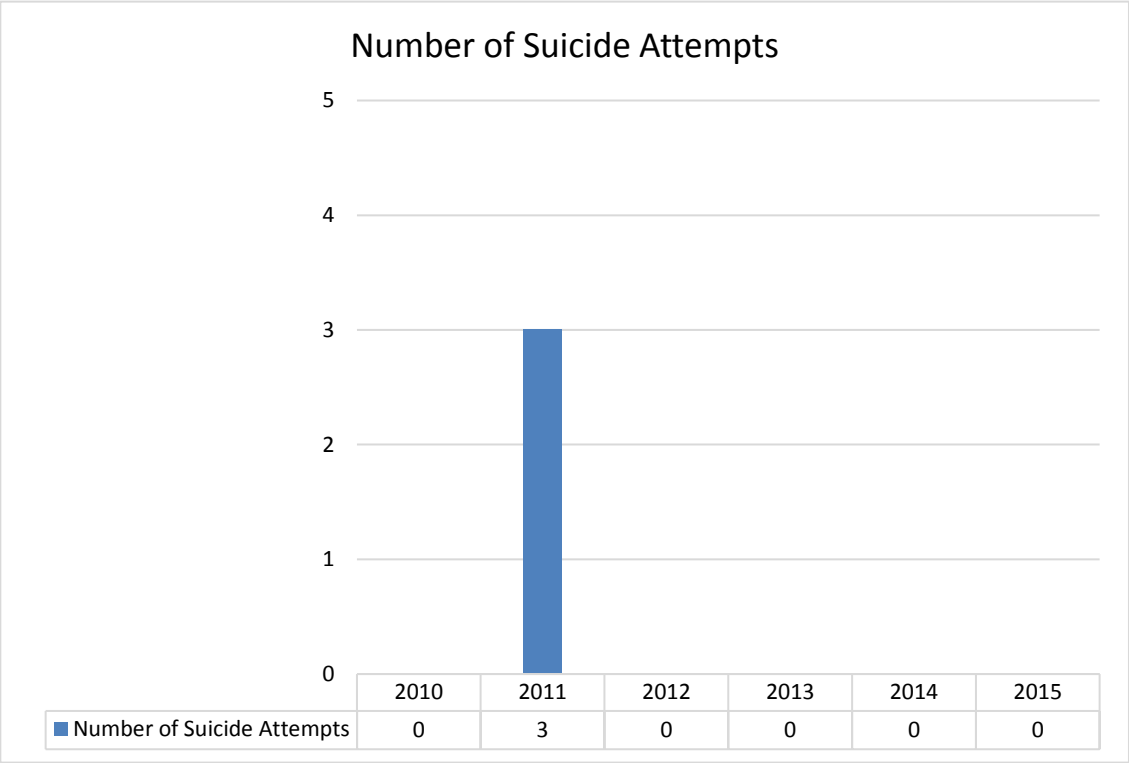
This report for Family Learning Homes is the analysis of risk measure and departure conditions data collected from January 2015 through December 2015. Providers were asked to submit a bed capacity count and the number of youth served on a monthly basis. The average monthly bed capacity and the number 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 | |
|---|---|---|---|
| 2015 | 17.33<br>Range:<br>12 to 21 | 2015 | 19.33<br>Range:<br>14 to 22 |
| 2014 | 17.25<br>Range:<br>13 to 20 | 2014 | 20.42<br>Range:<br>18 to 23 |
| 2013 | 19.08<br>Range:<br>16 to 20 | 2013 | 22.5<br>Range:<br>21 to 24 |
| 2012 | 20<br>Range:<br>20 to 20 | 2012 | 21.67<br>Range:<br>20 to 24 |
| 2011 | 18.9<br>Range:<br>16 to 20 | 2011 | 20.8<br>Range:<br>19 to 24 |

## Suicidal Behavior

There were no attempted or completed suicides during the 2015 reporting period.



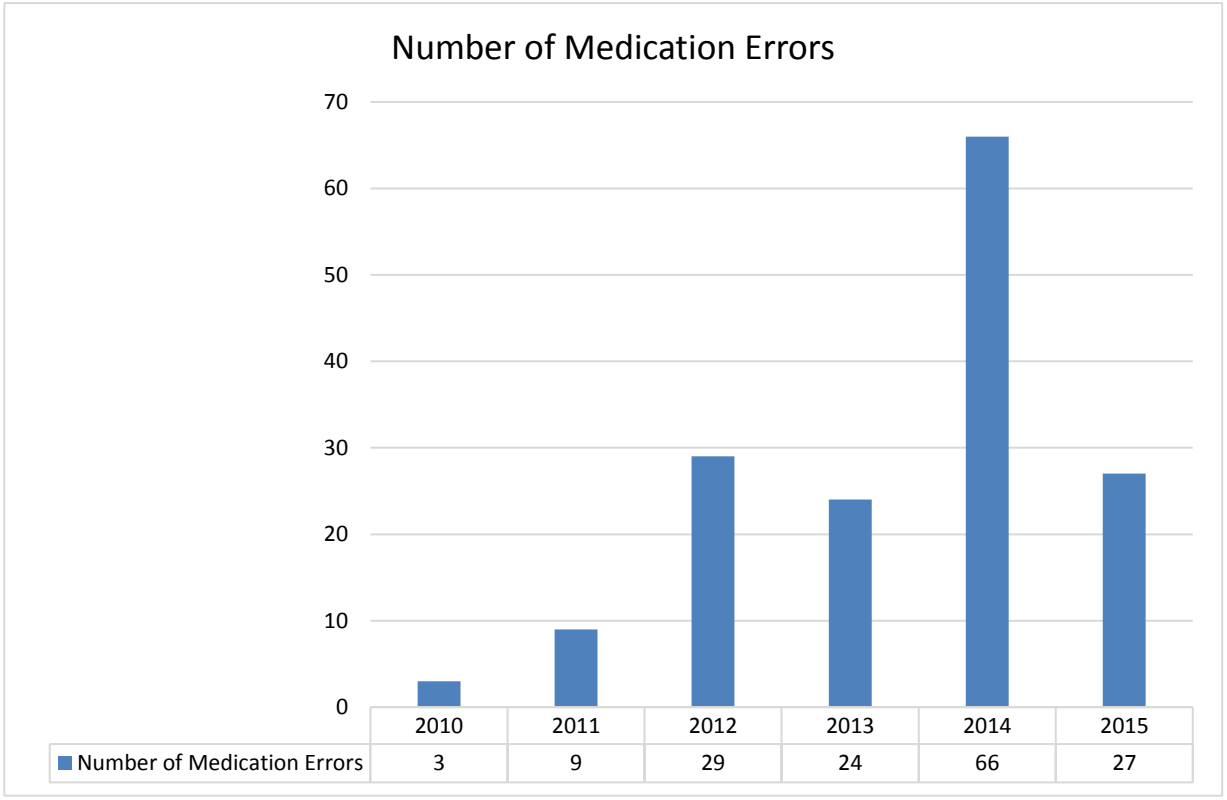
# Medication Errors

**Medication Error Location**

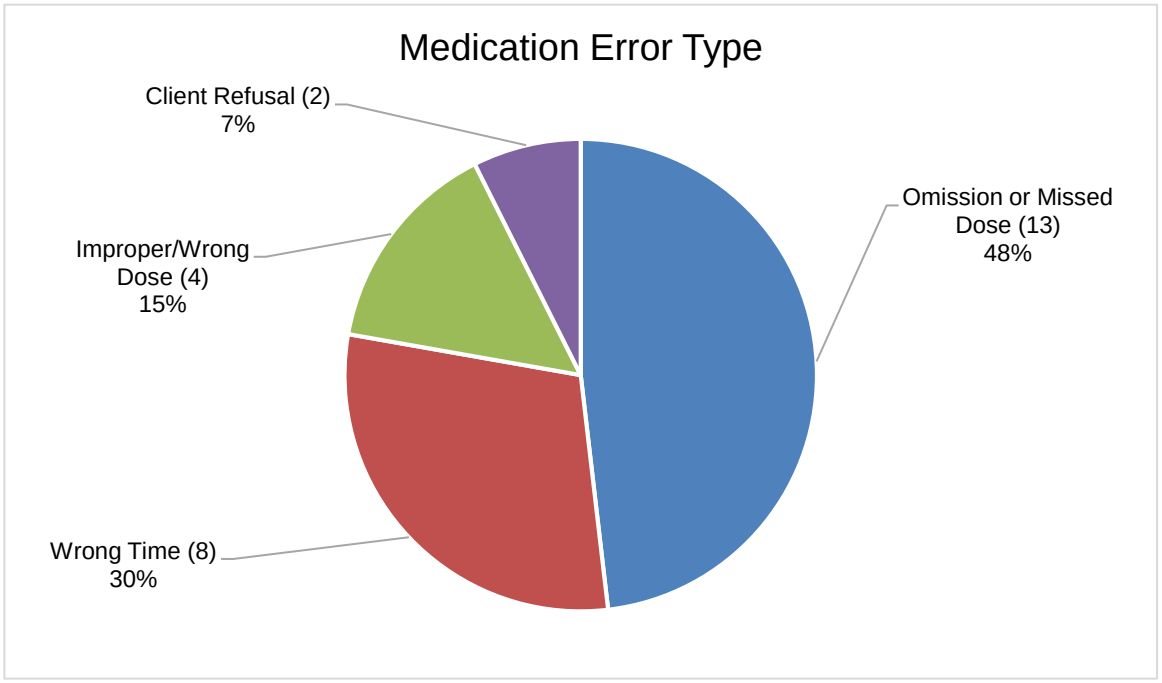
- 22 (81.48%) of the errors occurred in the home.
- 4 (14.81%) of the errors occurred on a client pass.
- 1 (3.70%) of the errors occurred on at school.

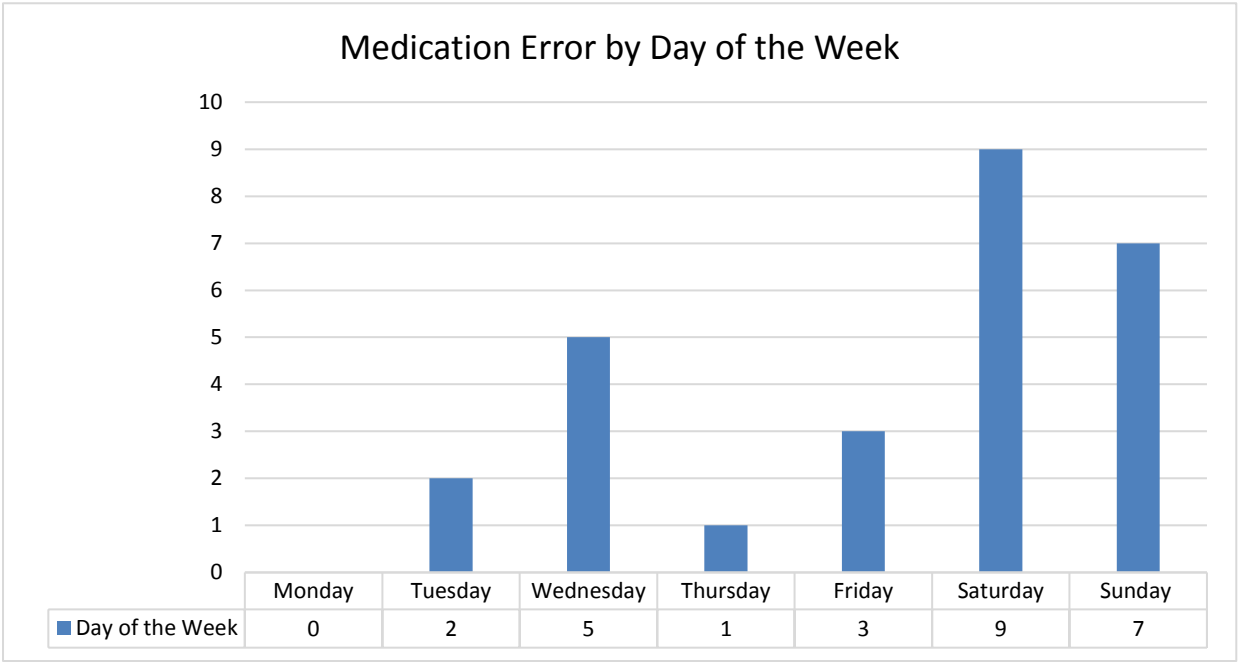
**Medication Error Type Information:**

- 23 (85.19%) of the medication errors were with non-psychotropic medication.
- 4 (14.81%) of the medication errors were with psychotropic medication.
- None of the medications errors caused the clients harm.



## Medication Errors Continued



## AWOL

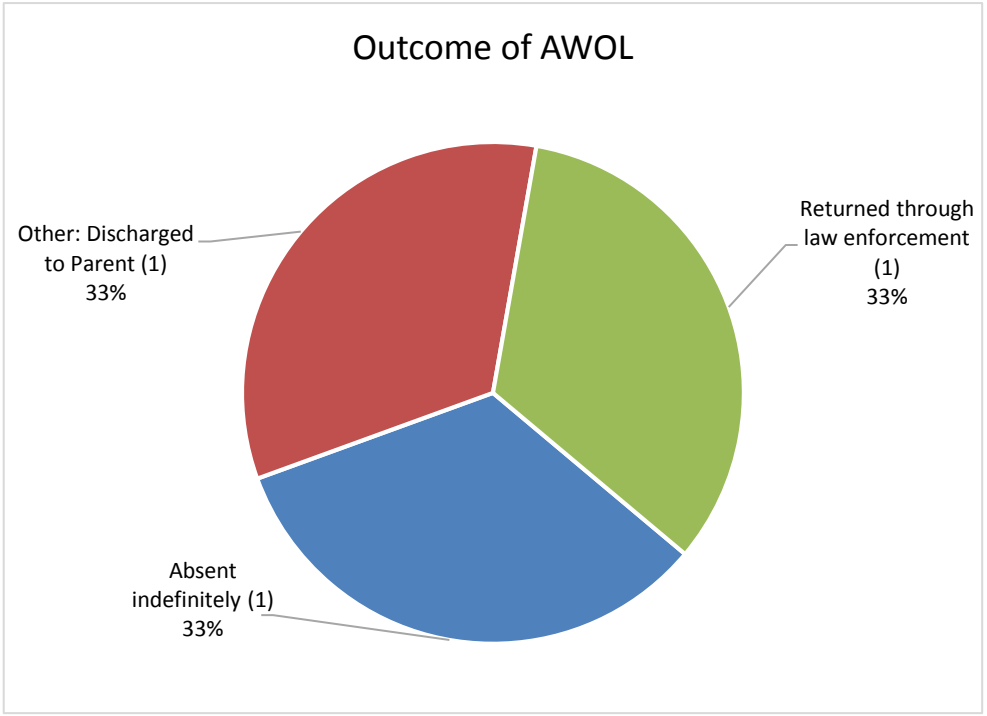
**Descriptive Information:**

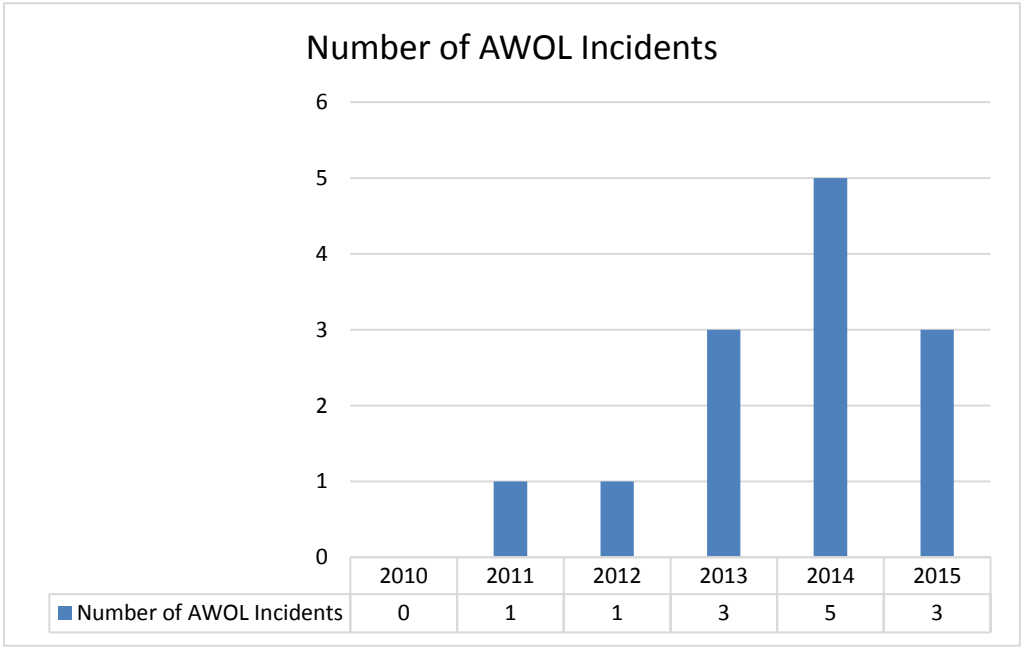
- 3 (100%) were female.
- Average age was 15.33 (range: 14 - 17 years)
- Race
  2 (66.67%) Caucasian  1 (33.33%) was Hispanic
  1 (33.33%) African American

- Custody Status
  1 (33.33%) Child Welfare Custody
  1 (33.33%) Parental Custody/ No Probation
  1 (33.33%) DCFS Youth Parole

**Clinical and AWOL Information:**

- The diagnoses were PTSD (1 or 33%), Oppositional Defiant Disorder (1 or 33%), and Major Depressive Disorder, Recurrent, Moderate (1 or 33%).
- 4 (range: 2 - 5) of days AWOL
- 2 (66.67%) of the youth had a history of AWOL.
- All left from school or work.



# Restraint and Manual Guidance

**Descriptive Information:**

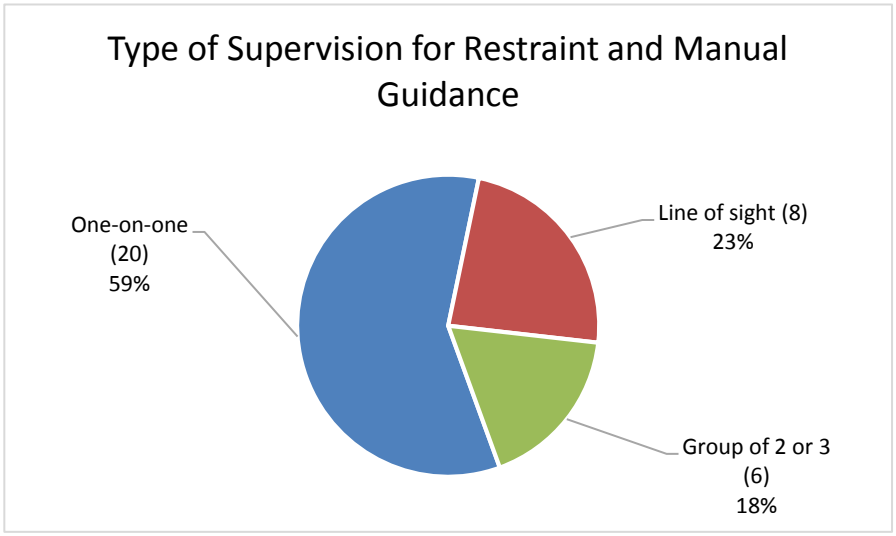
- 33 (97.06) were female and 1 (2.94%) was male.

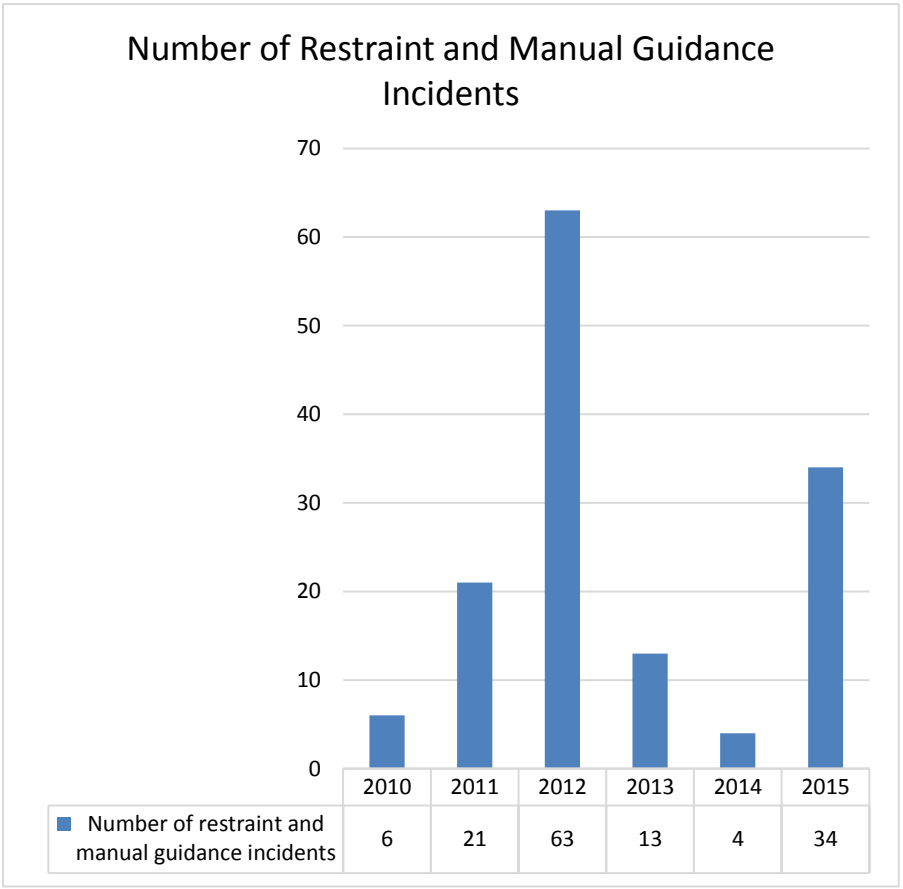
- Average age was 6.09 (range: 5- 10 years)
- Race
  27 (79.41%) Caucasian
  6 (17.65%) African American
  1 (2.94%) Native Hawaiian
- None were Hispanic.

- Custody Status
  33 (97.06%) Child Welfare Custody
  1 (2.94%) Parental Custody no Probation

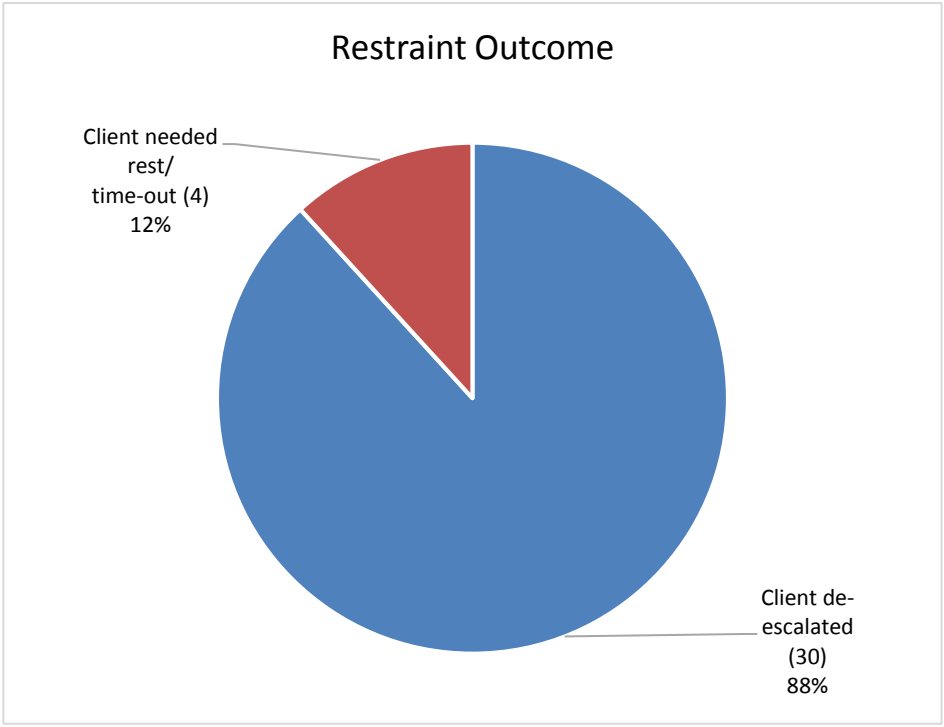
**Clinical and Restraint and Manual Guidance Information:**

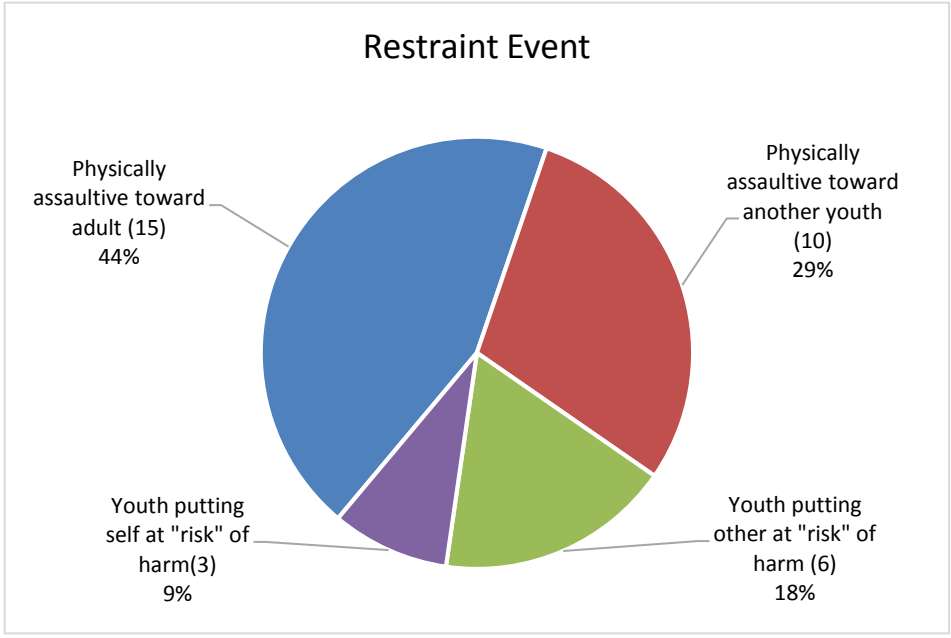
- Post-Traumatic Stress Disorder (24 or 70.59% of youth) was the most frequent diagnosis.
- 32 (94.12%) of the youth had a history of restraint and manual guidance.
- A manual guidance was not used during any restraint.
- 7.91 (range: 1-32) average length of restraint in minutes.
- Afternoon (14 or 41.18%) was the most common time for a restraint.
- All of the restraints included a debriefing.
- Each restraint averaged a total of four interventions.
- 25 (96.15%) had no injury and 1 (33.85) client was injured (bumped head, and ice pack and children's ibuprofen was given).



## Restraint and Manual Guidance Continued



## Departure Conditions

Family Learning Homes reported 29 discharges in the 2015 reporting period.

**Descriptive Information:**

- 15 (37.50%) were female and 25 (62.50%) were male.
- Average age was 11.66 (range: 5 - 18 years)
- Race
  20 (68.97%) Caucasian
  8 (27.59%) African American
  1 (3.45%) Native Hawaiian

- 3 (10.34%) were Hispanic.

- Custody Status
  18 (62.07%) Child Welfare Custody
  9 (31.03%) Parental Custody no Probation
  2 (6.90%) DCFS Youth Parole

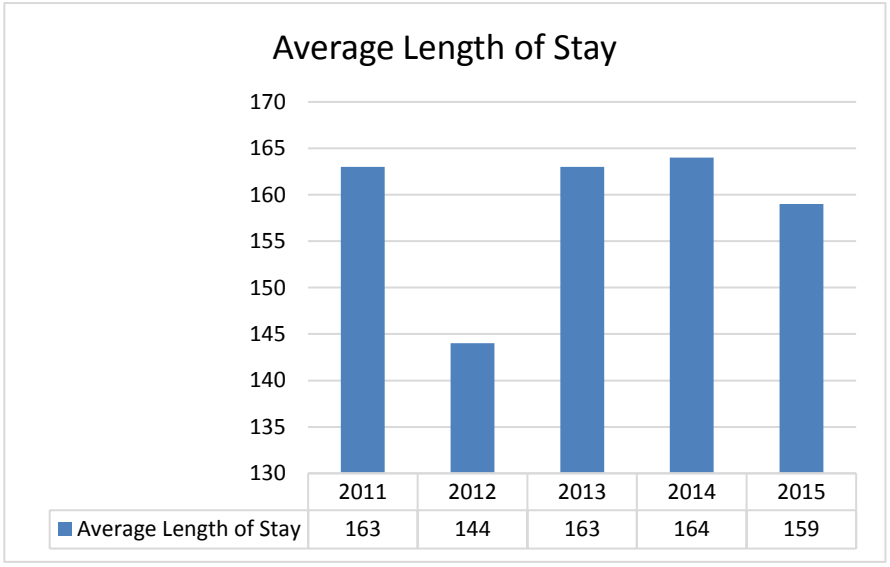
- 28 (96.55%) were Medicaid recipients.
- The average length of stay at Family Learning Homes was 159.62 days, ranging from 1 days to 278 days (0.76 years).

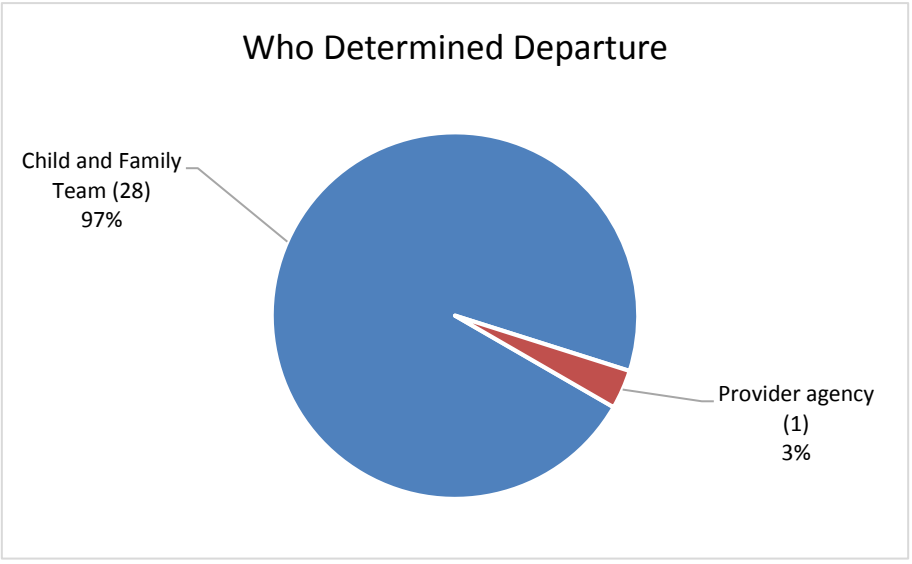
**Clinical and Departure Information:**

- PTSD (8 or 27.59% of youth) was the most frequent diagnosis at admission.
- Most frequent diagnosis at discharge was Major Depressive Disorder, Recurrent, Moderate (4 or 13.79%) and Attention Deficit Hyperactivity Disorder (4 or 13.79%).
  Unspecified (1 or 11.11%).
- The average CASII composite score at admission was 23.59.
- The average CASII composite score at discharge was 22.24
- 26 (89.66%) stayed more than 90 days.
- 9 (31.03%) 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.

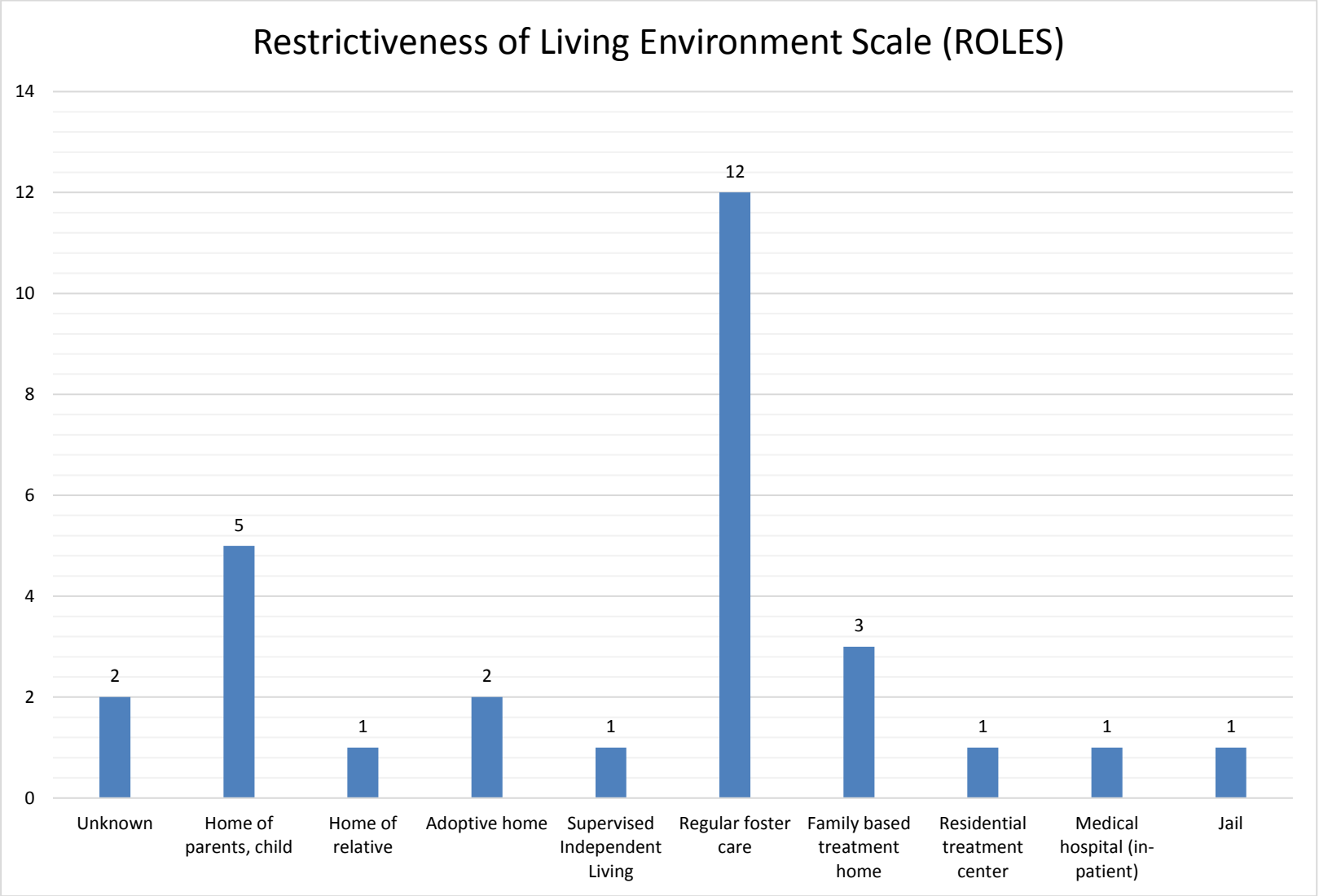
| RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES) | | |
|---|---|---|
| Reporting Period | Restrictiveness Score | Setting |
| 2015 | 9.96 | Regular foster care |
| 2014 | 8.16 | Home of a family friend |
| 2013 | 8.6 | Supervised independent living |
| 2012 | 9.74 | Regular foster care |
| 2011 | 6.6 | Adoptive Home |

- In 2015, the ROLES score resulted in an average of 9.96, which equals the restrictiveness score of regular foster care.



## Departure Conditions (Continued)



## Departure Conditions - Youth in Child Welfare Custody

Of the 29 discharges reported by Family Learning Homes in the 2015 reporting period, 18 (62%) were in the custody of a public child welfare agency.

**Descriptive Information:**

- 10 (55.56%) were female and 8 (44.44%) were male.
- Average age was 11.11 (range: 5 - 18 years)
- Race
  13 (72.22%) Caucasian  5 (27.78%) African American
- 2 (11.11%) were Hispanic.
- The average length of stay at Family Learning Homes was 166.17 days, ranging from 81 days to 267 days (0.73 years).

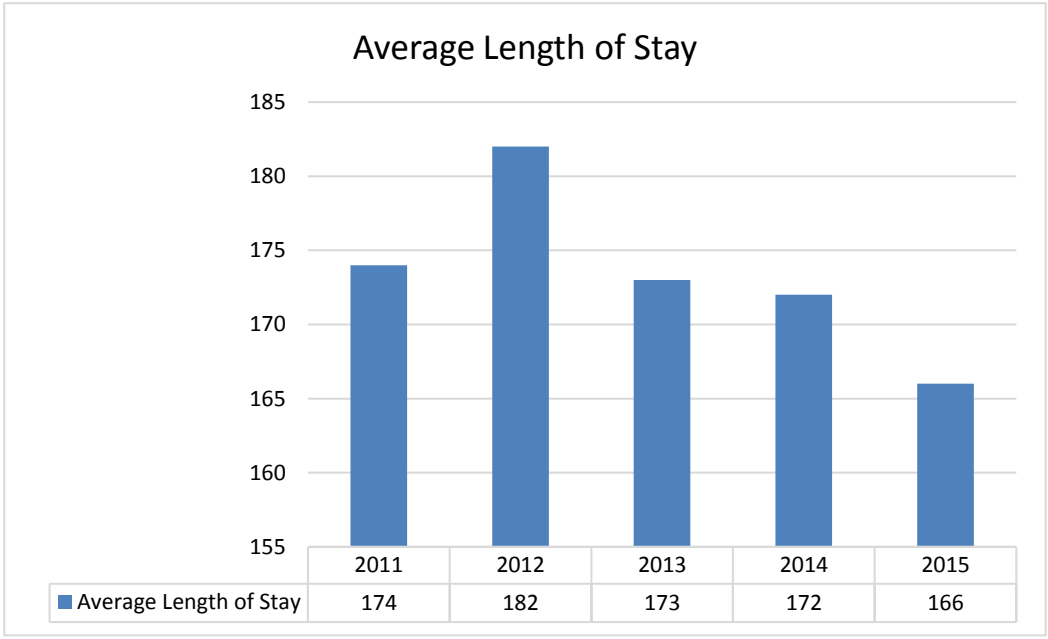
**Clinical and Departure Information:**

- PTSD (5 or 27.78% of youth) was the most frequent diagnosis at admission.
- Most frequent diagnosis at discharge was PTSD (2 or 11.11%), Mood Disorder NOS (2 or 11.11%), Major Depressive Disorder, Recurrent, Moderate (2 or 11.11%), and Major Depressive Disorder, Recurrent, Unspecified (2 or 11.11%).
- The average CASII composite score at admission was 23.59.
- The average CASII composite score at discharge was 22.24
- 17 (94.44%) stayed more than 90 days.
- 3 (16.67%) continued services after discharge.
- All were in child welfare custody and had Medicaid.
- All departures were recommended by a Child and Family Team.

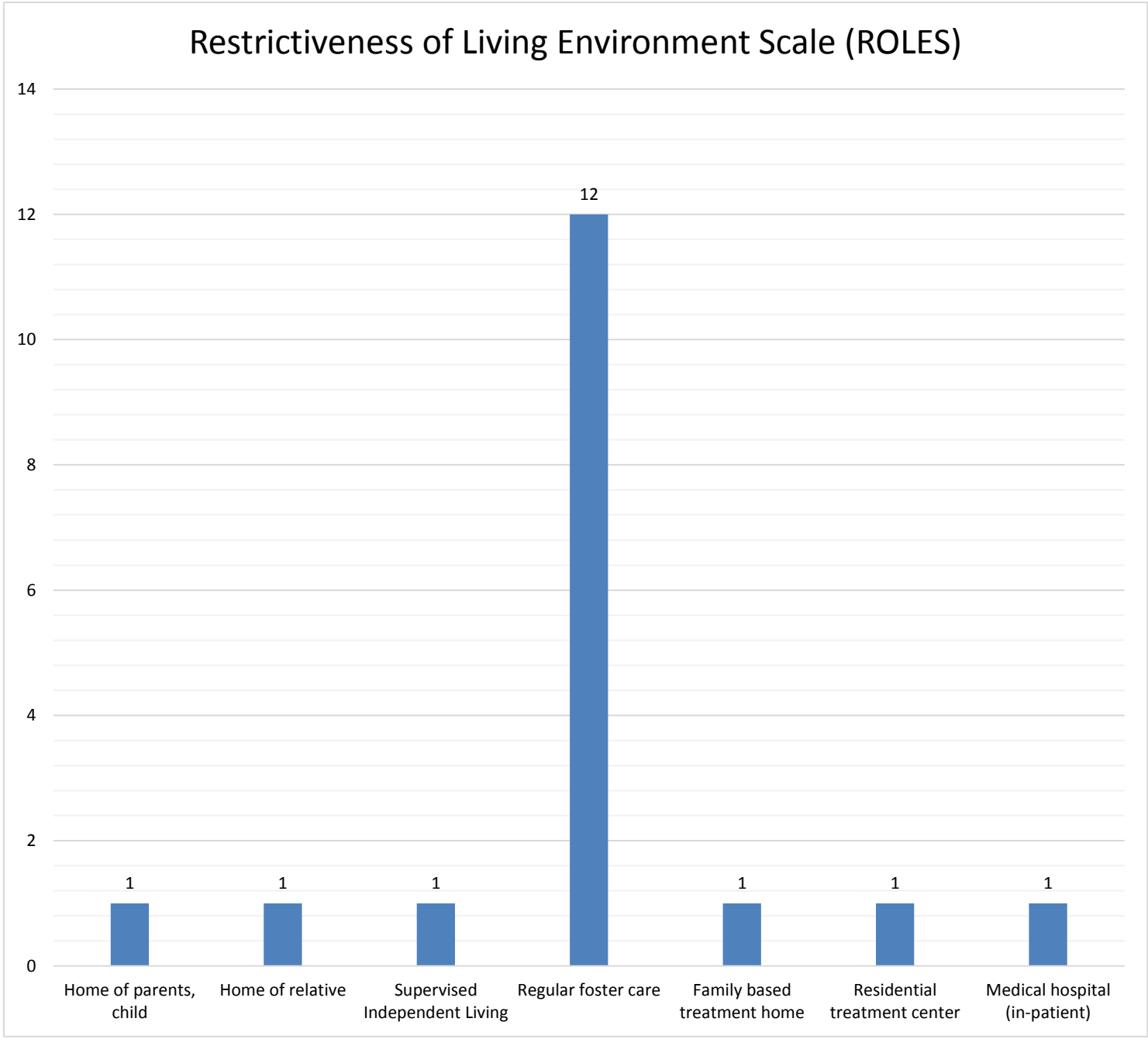
| RESTRICTIVENESS OF LIVING ENVIRONMENT SCALE (ROLES) | | |
|---|---|---|
| Reporting Period | Restrictiveness Score | Setting |
| 2015 | 10.44 | Regular foster care |
| 2014 | 10.94 | Specialized foster care |
| 2013 | 9.56 | Regular foster care |
| 2012 | 11.5 | Specialized foster care |
| 2011 | 11.3 | Specialized foster care |

- In 2015, the ROLES score resulted in an average of 10.44, which equals the restrictiveness score of regular 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.



## Departure Conditions - Youth in Child Welfare Custody (Continued)



## 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 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:**

- There was a 59% decrease in medication errors compared to last year and none of the errors caused the clients harm. In addition, 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.

**Highlights:**

- There was a decrease in AWOLs compared to last year.

**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
- When a youth returns from a runaway episode a quality risk assessment can be conducted to help prevent future runaway behavior.  Discuss his/her
- 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).

**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-
- 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, 21 or 72.41% of the youth were placed in less restrictive settings.
- 97% of the discharges were determined by a Child and Family Team.

**Children in Child Welfare Custody Highlights:**

- Upon discharge, 15 or 83% of 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).
- All departures were recommended by a CFT. In 2014, 15 or 79% of departures for children in the custody of a child welfare agency were recommended by a CFT.

**Practice Guidelines and Opportunities for Improvement:**

- 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 2015, Family Learning Homes did not complete any Trauma Informed Care training.

## Summary

Family Learning homes submitted all of its 2015 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 2015 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 2015 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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