2025

Desert Willow Treatment Center, Residential Services, Epidemiologic Profile

NEVADA DIVISION OF CHILD AND FAMILY SERVICES

PLANNING AND EVALUATION UNIT | IN COLLABORATION WITH THE DHHS OFFICE OF ANALYTICS

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Executive Summary

The Desert Willow Treatment Center (DWTC) is a 44-bed psychiatric hospital providing specialized mental health services through acute psychiatric care as well as residential treatment for Nevada youth aged 6–17. This report presents key findings and trends from calendar years 2016 through 2023, focusing on patient demographics, diagnoses, service histories, and outcomes. This patient profile is intended to identify the strengths and needs of DWTC services to better serve the youth in Nevada through this vital program.

Key Findings

Facility Volume and Patient Demographics

- DWTC served 65 youth in 2023, a 44% increase from 2022, marking the highest annual volume in eight years. (Summary of Findings)
- The median length of stay was consistent throughout the reported timeframe, at approximately four months. (Summary of Findings)
- The majority (90%) were aged 12–17; 65% were female. (Age)
- Racial diversity shifted over time, with 51% White and 38% Black/African American patients in 2023. (Race)

Diagnoses and Clinical Needs

- The most common primary diagnosis was Persistent Mood Disorders (46%). Major Depressive Disorder and Adjustment Disorders followed. (Primary Diagnosis Categories)
- There were youth identified with more than one diagnosis at admission; 38% of youth had three or more diagnoses at admission, with ADHD increasing in prevalence during treatment. (Diagnoses)
- Almost all patients (97%) had a trauma history. (Diagnoses)

Previous Children's Mental Health Services History

- Of the youth reviewed, 17% had prior placements in out-of-state residential facilities, a slight reduction from the previous year. (PRTF History)
- Over half of the youth (51%) reviewed had utilized mobile crisis services before their admission. (Community-Based Outpatient Services History)
- Twelve of the 65 youth served at DWTC in 2023 had previous admission to the facility (18%). (Previous DWTC Admissions)

Other DCFS Involvement

- Of the youth with other DCFS involvement, 86% had prior child welfare involvement, with neglect being the most common issue. (Child Welfare History)
- DWTC has had an increase in youth with prior involvement with state-level juvenile justice (JJ) programs. In 2023, all 14 children with a history of state-level JJ involvement were currently in custody when they were admitted to DWTC, and all were either furloughed or released to parole on or before the day they were admitted to DWTC. (State-Level JJ History)

Incidents and Accidents within the Facility

- DWTC's quality assurance staff track and monitor incidents and accidents that occur within the facility. These occurrences can include physical holds, chemical restraints, seclusions (Physical Holds), medication errors or variances (Medication Errors or Variances), aggression and property damage (Property Damage), allegations of abuse (Allegations of Abuse), other denial of rights, and all other incidents (All Other Incidents).
- It is important to note that trends in these different types of occurrences are highly dependent on a number of factors such as the amount of youth in the facility at any given time, influences by individual patient diagnoses, treatment plans, and staffing variables.

Youth and Family Satisfaction

- DCFS administers program satisfaction surveys with the youth and families at DWTC every fiscal year (FY) to gather valuable feedback regarding the services they receive. The feedback collected helps to identify what is going well and what may need improvement with the program's service delivery. (Youth and Family Satisfaction)
- During FY2024, the survey had a response rate of 48% of youth and 40% of parents/legally responsible individuals (LRI). (Youth and Family Satisfaction)
- Although satisfaction had shown a decline across measured domains since 2020, trends started to improve in FY2023 and continued intoFY2024. (Youth and Family Satisfaction)

Clinical Case Review Findings

- Youth with documented or suspected intellectual or developmental disabilities (ID/DD) represented 53% of the patients that received services at DWTC during calendar year 2023. (Intellectual/Developmental Disability)
- Of the youth with identifiable post DWTC records, 64% of discharged youth had no record of inpatient or emergency department (ED) visits for mental health services through the end of Q1 2024. (Post DWTC)
- Of the youth that discharged from DWTC, 30% accessed inpatient or ED services post discharge, with ID/DD youth disproportionately represented (59%). (Post DWTC)

Recommendations

- Enhance trauma-informed care and evidence-based treatments, such as Cognitive Behavioral Therapy and Dialectical Behavioral Therapy, for conditions like DMDD. (Conclusions)
- Consider creating specialized units for ID/DD youth, potentially in partnership with other regional resources. (Conclusions)
- Expand post-discharge step-down services to improve long-term outcomes and reduce readmissions. (Post DWTC)

DWTC plays an important role in addressing complex behavioral and emotional needs among Nevada's youth. However, findings show the need for targeted interventions, specialized programming, and a larger array of community resources to better serve this high-needs population and improve outcomes. Continuous data analysis and collaboration with stakeholders are essential for identifying gaps and improving care delivery.

Background and Purpose

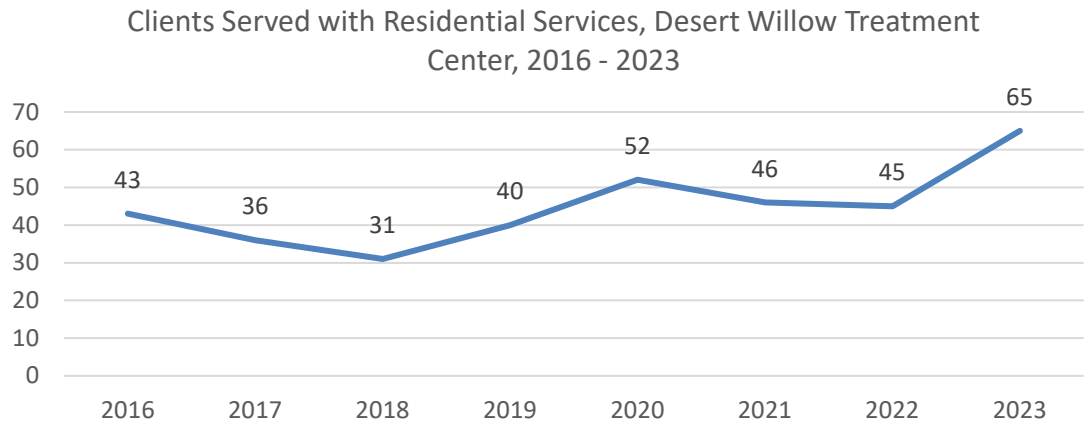
Desert Willow Treatment Center is a 44-bed psychiatric hospital accredited by the Joint Commission on Accreditation of Health Care Organizations that provides mental health treatment for children and adolescents aged 6 to 17 years old. The facility is licensed by the bureau of Health Care Quality and Compliance and is currently licensed for a 12-bed acute psychiatric care unit, an 8-bed pediatric residential treatment center (RTC) unit servicing 6 to 11-year-old patients, and two 12-bed RTC units servicing 12 to 17-year-old patients. DWTC's mission is to promote positive self-growth, create change in behavior, attitudes, values, and ways of thinking through education, therapeutic treatment, and appropriate medical and mental health services. The services include:

- Crisis intervention and stabilization
- Individual, family, and group therapies and behavior management
- Clinical case management
- Psychological evaluation and consultation
- Psychiatric evaluation and medication management
- Nursing care
- Recreational therapy
- Special education through the Clark County School District

The purpose of this patient profile is to better understand the patients served in a residential setting at DWTC, their demographic characteristics, diagnoses and clinical needs, service history with the Division, and outcomes.

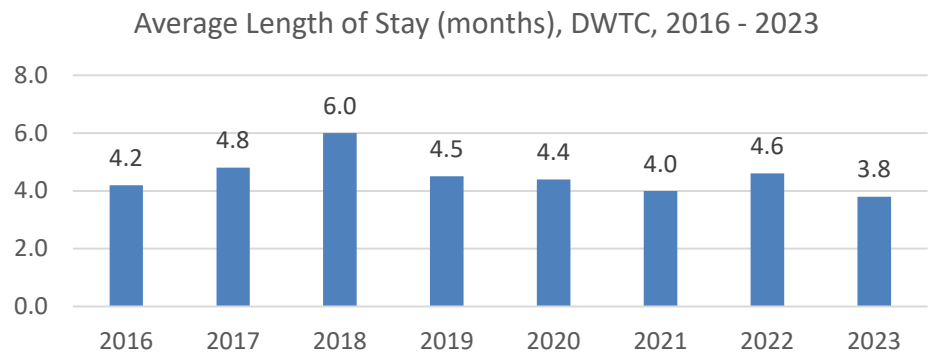
Summary of Findings

In calendar year 2023, DWTC served 65 Nevada youth in a residential setting. This is a 44% increase from 2022, and the highest volume of patients treated in the facility during the eight years considered in this analysis.

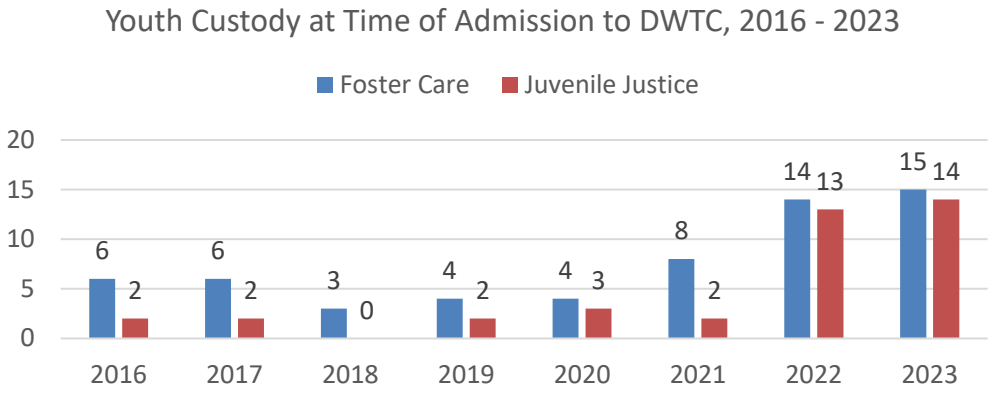


Fifty-two (80%) of youth served by DWTC in 2023 were covered by Nevada Medicaid.

The median length of stay at DWTC was consistent over the reporting timeframe, at approximately four months. Overall, length of stay for DWTC clients ranges significantly, from less than one week to almost one year.



In 2022 and 2023 it became increasingly common for youth to be in State custody at the time of admission to DWTC. In 2023, 25 youth (38%) were in State custody, either child welfare or juvenile justice, when they were admitted to DWTC. This is up from 14% in 2016.

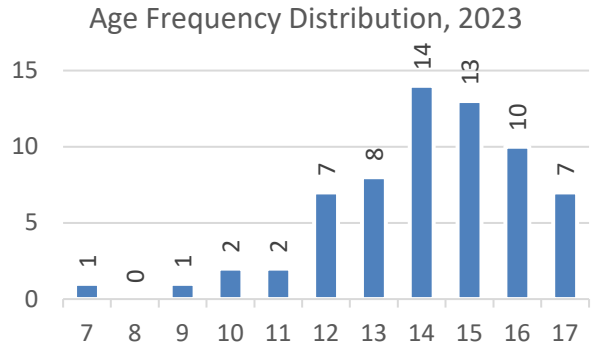


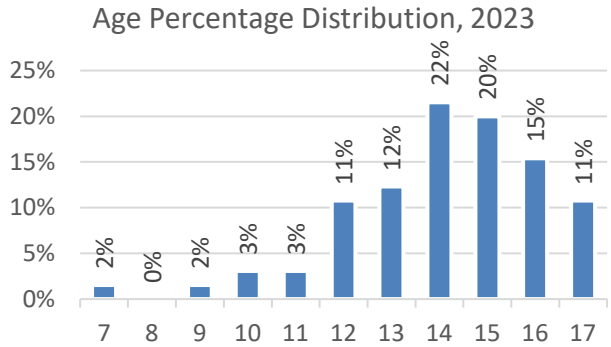
Some youth may be in both child welfare and juvenile justice custody simultaneously, so counts in the above graph are not mutually exclusive.

Demographics

Age

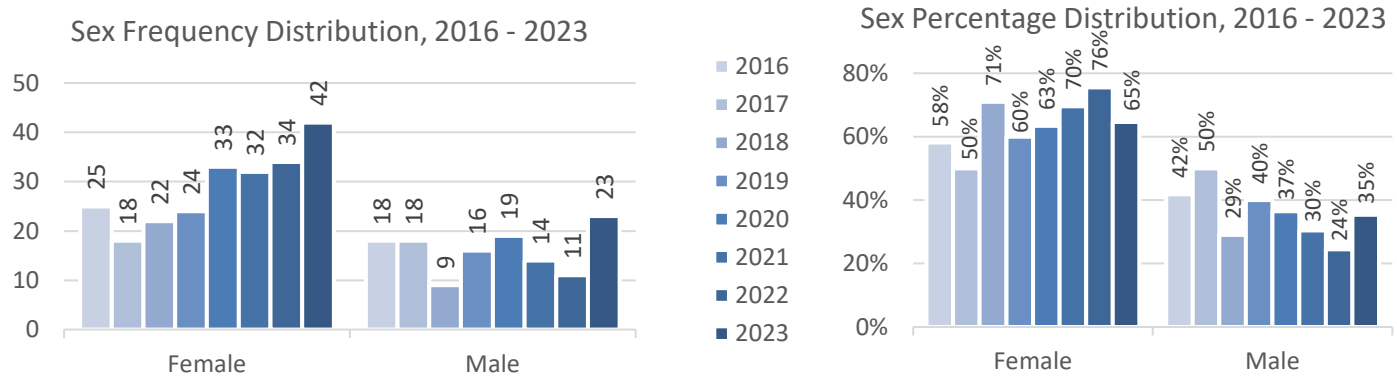
Most youth served by DWTC residential services are 12 to 17 years old (over 90% in 2023). However, youth as young as 7 were admitted for services in recent years.





Sex

Since 2016 there is an increasing trend in the number of female youth admitted for residential services at DWTC. Sixty-five percent (65%) of residential patients were female in 2023.



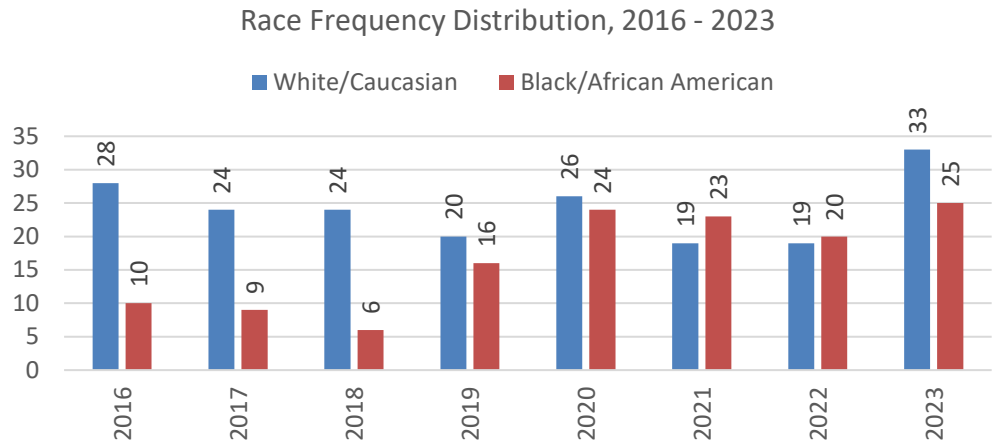
Race

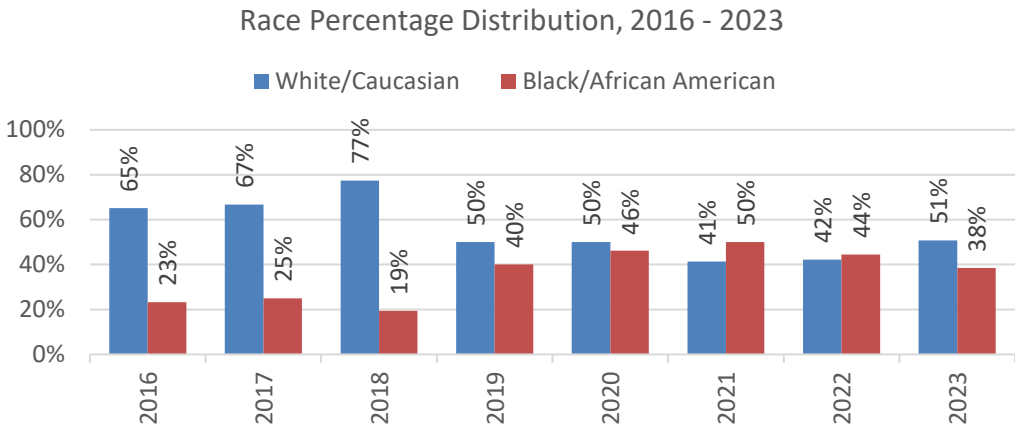
The racial composition of clients receiving residential services at DWTC has changed significantly over time. Prior to 2019, most patients were White/Caucasian, representing 70% of patients from 2016-2018. During this time approximately 23% of clients served were Black/African American and 5% were Asian. All other racial groups accounted for less than 2% of patients.

In 2019, a shift in the racial composition of patients was observed. White/Caucasian patients represented 47% of clients on average from 2019-2023, while 44% of clients served were Black/African American, and all other racial groups accounted for less than 5% of patients on average.

In 2023, 51% of DWTC residential patients were White/Caucasian and 38% were Black/African American. All other racial groups accounted for less than 5% of patients.

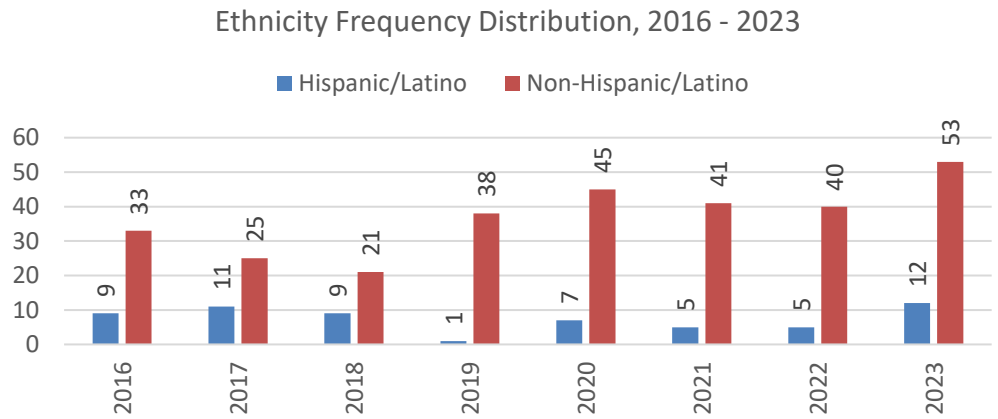
Comparatively, Nevada's general population is comprised of approximately 49% White/Caucasian, 9% Black/African American, and 10% Asian/Pacific Islander. Less than 1% of Nevada's population is American Indian/Alaska Native. Based on these data, residential clients served by DWTC are disproportionately Black/African American as compared to Nevada's population.

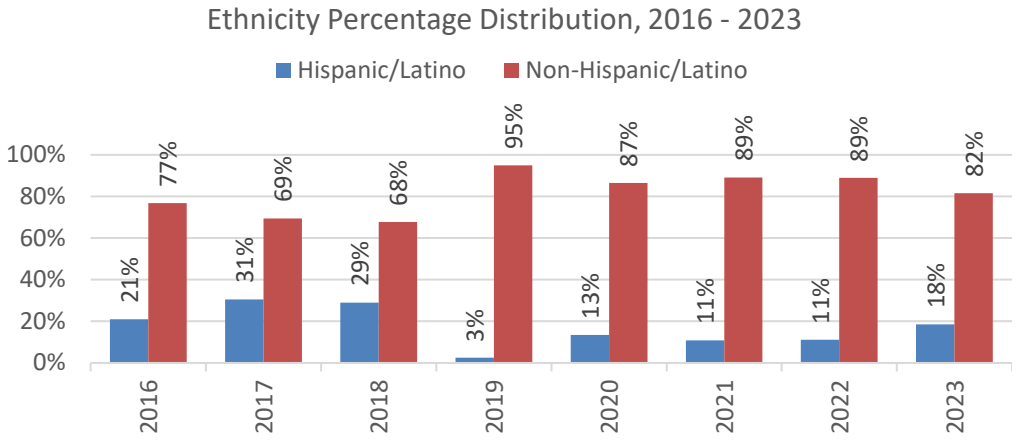




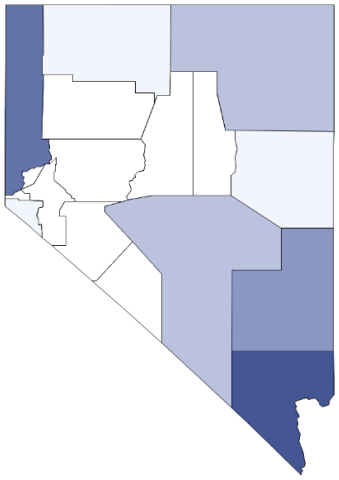
Ethnicity

Ethnic diversity of clients served at DWTC has also changed over time. Prior to 2019, about 27% of residential patients were Hispanic/Latino. In 2019 only 3% of patients were Hispanic/Latino. This percentage increased to approximately 12% in 2020-2022 and was 18% in 2023. Comparatively, Nevada's general population was estimated to be 31% Hispanic/Latino in 2023.





Resident County

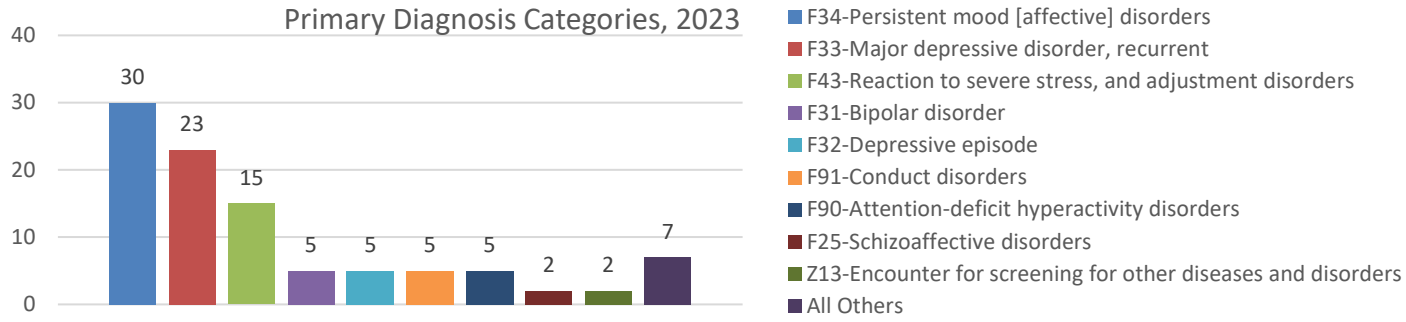


Most of the youth served at DWTC from 2016 through 2023 were residents of Clark County (77%). An additional 9% were from Washoe County; 5% from Lincoln County, 3% from Elko County, 3% from Nye County, and 2% had an unknown county of residence. Other regions combined, including out of state, made up approximately 2% of clients.

Diagnoses and Clinical Needs

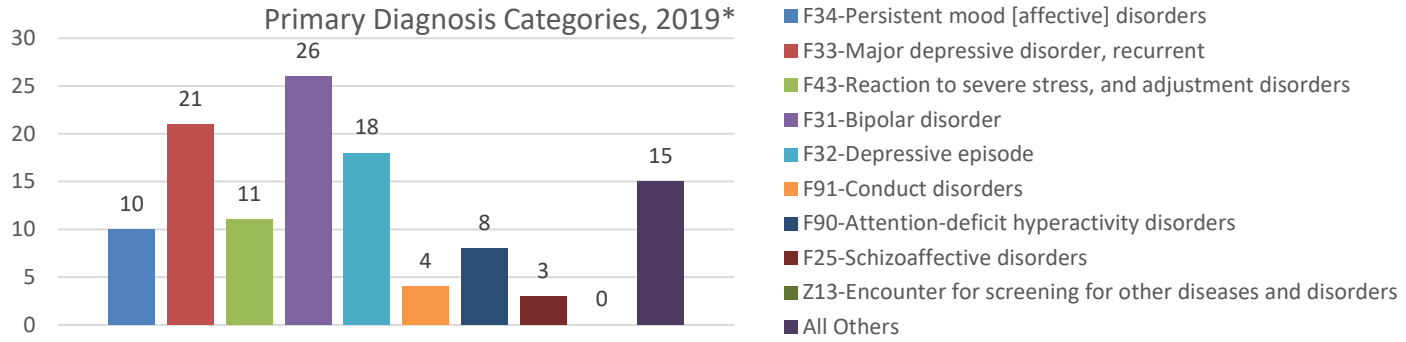
Primary Diagnosis Categories

The most common primary diagnosis category among youth who received residential treatment at DWTC in 2023 was *Persistent Mood [Affective] Disorders*, with 46% (n=30) youth receiving this primary diagnosis. The second and third most common primary diagnosis categories were *Major Depressive Disorders, Recurrent* (35.4%; n=23) and *Reaction to Severe Stress and Adjustment Disorders* (23.1%; n=15) respectively.



Primary diagnosis categories are somewhat consistent since 2016, with a few noteworthy changes over time:

- Prior to 2022, *Bipolar disorder* was the second most common primary diagnosis category in most years since 2016.
- *Depressive Episodes* and *Conduct Disorders* were other primary diagnosis categories more common prior to 2020.



**The year 2019 was chosen for comparison purposes because it was the last year included in this review (2016-2023) that demonstrated a different distribution of primary diagnosis categories as compared to the years since 2019.*

Distribution of Primary Diagnosis Categories by Calendar Year*

Nevada, 2016 - 2023

Note: red cells indicate diagnoses groups that are in the top 10%.

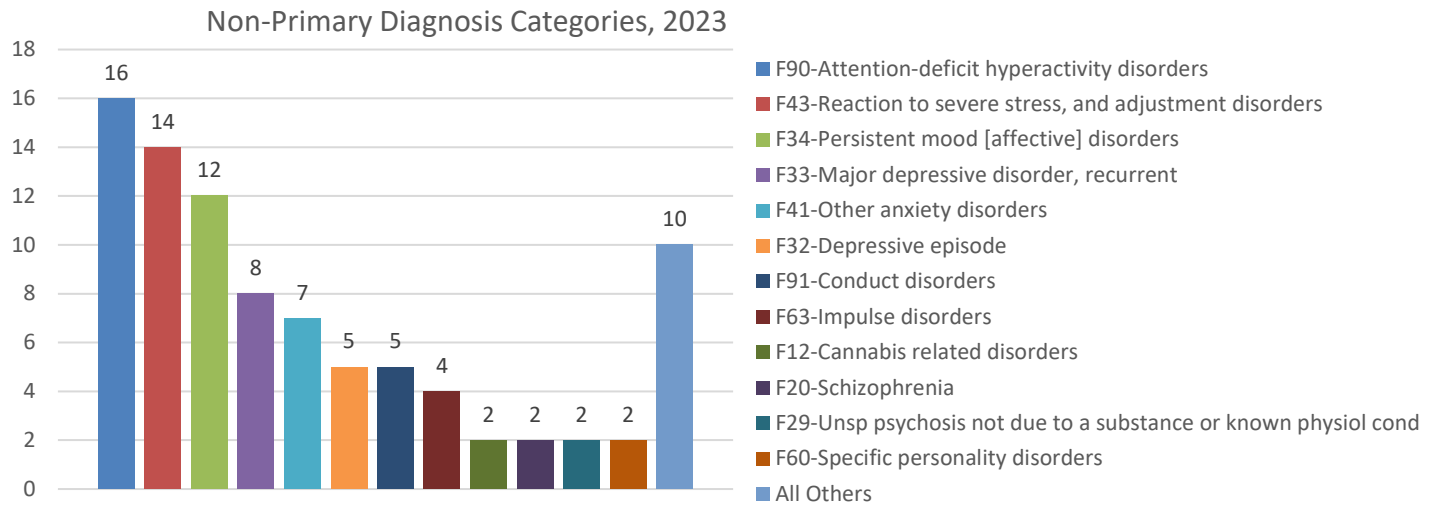
	2016	2017	2018	2019	2020	2021	2022	2023
F34-Persistent mood [affective] disorders	18.6%	27.8%	25.8%	25.0%	53.8%	63.0%	48.9%	46.2%
F33-Major depressive disorder, recurrent	67.4%	41.7%	48.4%	52.5%	48.1%	37.0%	33.3%	35.4%
F43-Reaction to severe stress, and adjustment disorders	9.3%	25.0%	25.8%	27.5%	5.8%	8.7%	22.2%	23.1%
F31-Bipolar disorder	37.2%	47.2%	45.2%	65.0%	30.8%	30.4%	17.8%	7.7%
F32-Depressive episode	30.2%	30.6%	35.5%	45.0%	11.5%	6.5%	11.1%	7.7%
F91-Conduct disorders	20.9%	33.3%	29.0%	10.0%	0.0%	2.2%	11.1%	7.7%
F90-Attention-deficit hyperactivity disorders	9.3%	13.9%	16.1%	20.0%	3.8%	4.3%	6.7%	7.7%
F25-Schizoaffective disorders	2.3%	2.8%	3.2%	7.5%	0.0%	0.0%	2.2%	3.1%
Z13-Encounter for screening for other diseases and	0.0%	0.0%	0.0%	0.0%	1.9%	0.0%	8.9%	3.1%
F29-Unsp psychosis not due to a substance or known	7.0%	8.3%	6.5%	2.5%	1.9%	2.2%	2.2%	1.5%
F20-Schizophrenia	0.0%	0.0%	0.0%	7.5%	1.9%	0.0%	4.4%	1.5%
F39-Unspecified mood [affective] disorder	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	2.2%	1.5%
F41-Other anxiety disorders	0.0%	2.8%	3.2%	2.5%	0.0%	0.0%	0.0%	1.5%
F50-Eating disorders	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
F60-Specific personality disorders	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
F63-Impulse disorders	0.0%	0.0%	0.0%	2.5%	1.9%	4.3%	0.0%	1.5%
F10-Alcohol related disorders	2.3%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.0%
F84-Pervasive developmental disorders	2.3%	2.8%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
Z86-Personal history of certain other diseases	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
F19-Other psychoactive substance related disorders	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.0%
F22-Delusional disorders	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
F28-Oth psych disorder not due to a sub or known physiol	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
F42-Obsessive-compulsive disorder	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
F71-Moderate intellectual disabilities	0.0%	2.8%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
F94-Disord social w onset specific to childhood and	0.0%	2.8%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
F99-Mental disorder, not otherwise specified	0.0%	2.8%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Q86-Congen malform syndromes due to known exogenous	0.0%	0.0%	0.0%	0.0%	0.0%	2.2%	0.0%	0.0%
R41-Oth symptoms and signs w cognitive functions and	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
R46-Symptoms and signs involving appearance and	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
R69-Illness, unspecified	0.0%	0.0%	0.0%	2.5%	1.9%	0.0%	2.2%	0.0%
Z60-Problems related to social environment	0.0%	0.0%	3.2%	5.0%	0.0%	0.0%	0.0%	0.0%
Z65-Problems related to other psychosocial circumstances	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

**Children may have multiple primary diagnosis categories, and therefore these diagnoses groups are not mutually exclusive.*

Non-Primary Diagnosis Categories

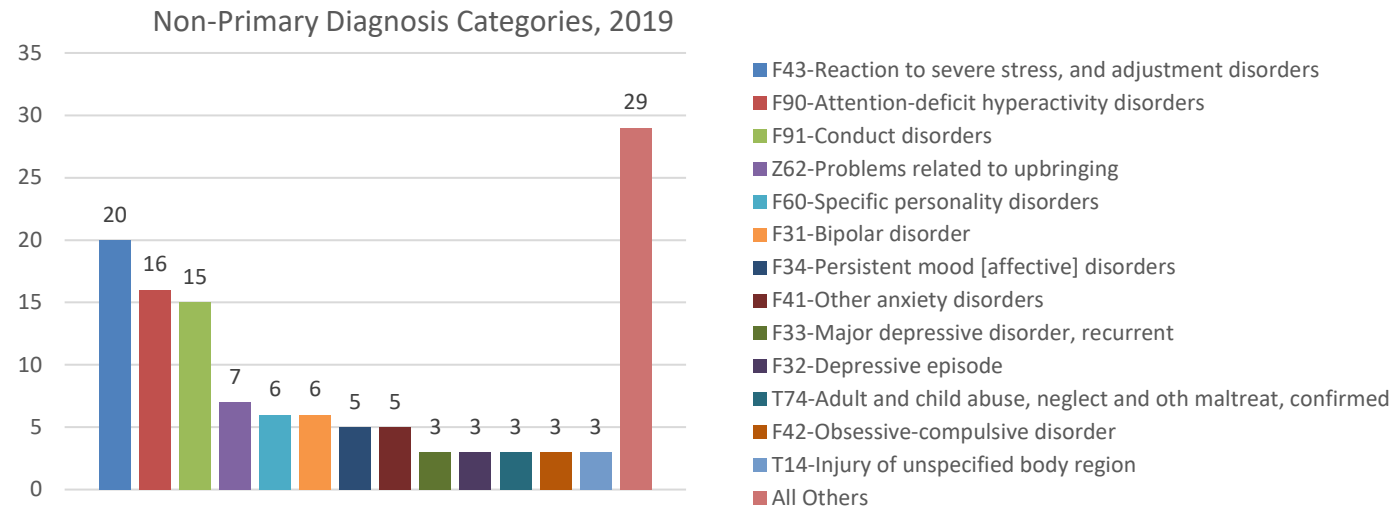
The most common non-primary diagnosis category among youth who received residential treatment at DWTC in 2023 was *Attention-deficit hyperactivity disorders*, accounting for 18% (n=16) of youth. The second and third most common non-primary diagnosis categories were *Reaction to severe stress, and adjustment disorders* (15.7%; n=14) and *Persistent mood [affective] disorders* (13.5%; n=12), respectively. Other non-primary diagnosis categories that accounted for at least 5% of total non-primary diagnoses include:

- F33-Major depressive disorder, recurrent (9.0%; n=8)
- F41-Other anxiety disorders (7.9%; n=7)
- F32-Depressive episode (5.6%; n=5)
- F91-Conduct disorders (5.6%; n=5)



Non-primary diagnosis categories have varied significantly since 2016, with the following noteworthy changes over time:

- In 2021, *Vitamin D deficiency* stood out as an outlier, as the third most common non-primary diagnosis category (18.5%, n=15). This category was not documented for any youth in 2023.
- In 2019, *Problems related to upbringing* was the fourth most common non-primary diagnosis category (5.6%, n=7). This was not an uncommon diagnosis from 2016 – 2019 but has not been documented since 2019. *Bipolar disorder* was the fifth most common non-primary diagnosis category (4.8%, n=6).
- In 2016, *Adult and child abuse, neglect and other maltreatment* and *Eating disorders* both accounted for 5.7% of non-primary diagnoses (n=4).



Distribution of Non-Primary Diagnosis Categories by Calendar Year*

Nevada, 2016 - 2023

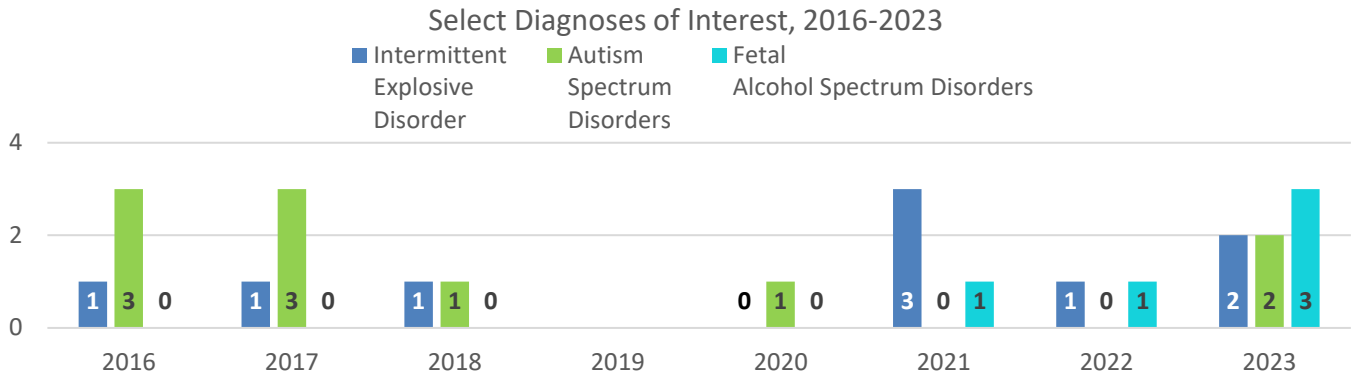
Note: red cells indicate diagnoses groups that are in the top 10%.

Non-primary diagnoses that were not present on at least 3% of clients in any given year are not shown.

	2016	2017	2018	2019	2020	2021	2022	2023
F90-Attention-deficit hyperactivity disorders	14.0%	22.2%	29.0%	40.0%	42.3%	45.7%	28.9%	24.6%
F43-Reaction to severe stress, and adjustment disorders	18.6%	25.0%	25.8%	50.0%	23.1%	39.1%	26.7%	21.5%
F34-Persistent mood [affective] disorders	9.3%	11.1%	9.7%	12.5%	0.0%	8.7%	13.3%	18.5%
F33-Major depressive disorder, recurrent	4.7%	8.3%	3.2%	7.5%	3.8%	6.5%	8.9%	12.3%
F41-Other anxiety disorders	16.3%	11.1%	9.7%	12.5%	9.6%	13.0%	8.9%	10.8%
F32-Depressive episode	14.0%	13.9%	12.9%	7.5%	0.0%	2.2%	11.1%	7.7%
F91-Conduct disorders	20.9%	41.7%	38.7%	37.5%	15.4%	26.1%	17.8%	7.7%
F63-Impulse disorders	2.3%	2.8%	3.2%	2.5%	0.0%	0.0%	4.4%	6.2%
F12-Cannabis related disorders	2.3%	5.6%	3.2%	5.0%	7.7%	6.5%	6.7%	3.1%
F20-Schizophrenia	0.0%	0.0%	0.0%	0.0%	0.0%	2.2%	4.4%	3.1%
F29-Unsp psychosis not due to a substance or known physiol	0.0%	2.8%	6.5%	0.0%	1.9%	0.0%	0.0%	3.1%
F60-Specific personality disorders	2.3%	2.8%	3.2%	15.0%	0.0%	0.0%	6.7%	3.1%
F15-Other stimulant related disorders	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
F31-Bipolar disorder	2.3%	8.3%	6.5%	15.0%	3.8%	6.5%	2.2%	1.5%
F84-Pervasive developmental disorders	4.7%	8.3%	3.2%	0.0%	0.0%	0.0%	0.0%	1.5%
R41-Oth symptoms and signs w cognitive functions and awar	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	1.5%
T74-Adult and child abuse, neglect and oth maltreat, confirm	9.3%	8.3%	3.2%	7.5%	0.0%	0.0%	0.0%	1.5%
D50-Iron deficiency anemia	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%
E03-Other hypothyroidism	0.0%	0.0%	3.2%	2.5%	3.8%	2.2%	0.0%	0.0%
E55-Vitamin D deficiency	0.0%	0.0%	3.2%	5.0%	3.8%	32.6%	2.2%	0.0%
E66-Overweight and obesity	0.0%	0.0%	0.0%	0.0%	0.0%	6.5%	0.0%	0.0%
F10-Alcohol related disorders	0.0%	0.0%	3.2%	2.5%	3.8%	2.2%	2.2%	0.0%
F13-Sedative, hypnotic, or anxiolytic related disorders	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
F16-Hallucinogen related disorders	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
F40-Phobic anxiety disorders	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	0.0%
F42-Obsessive-compulsive disorder	0.0%	0.0%	6.5%	7.5%	1.9%	0.0%	0.0%	0.0%
F50-Eating disorders	9.3%	2.8%	0.0%	0.0%	5.8%	2.2%	0.0%	0.0%
F51-Sleep disorders not due to a substance or known physio	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
F64-Gender identity disorders	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
F70-Mild intellectual disabilities	0.0%	0.0%	3.2%	2.5%	1.9%	2.2%	0.0%	0.0%
F71-Moderate intellectual disabilities	0.0%	2.8%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
F79-Unspecified intellectual disabilities	2.3%	0.0%	6.5%	5.0%	0.0%	0.0%	0.0%	0.0%
F88-Other disorders of psychological development	0.0%	0.0%	3.2%	2.5%	3.8%	4.3%	0.0%	0.0%
F94-Disord social w onset specific to childhood and adolesce	2.3%	5.6%	9.7%	2.5%	0.0%	0.0%	0.0%	0.0%
F95-Tic disorder	0.0%	0.0%	3.2%	0.0%	0.0%	2.2%	0.0%	0.0%
F98-Oth behav/emotn disord w onset usly occur in chldhd an	0.0%	2.8%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
F99-Mental disorder, not otherwise specified	0.0%	2.8%	6.5%	2.5%	0.0%	0.0%	0.0%	0.0%
G31-Oth degenerative diseases of nervous system, NEC	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
H54-Blindness and low vision	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%
J45-Asthma	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%
K62-Other diseases of anus and rectum	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
L70-Acne	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Q99-Other chromosome abnormalities, not elsewhere classif	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
R07-Pain in throat and chest	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
R09-Oth symptoms and signs involving the circ and resp sys	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
R45-Symptoms and signs involving emotional state	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
R69-Illness, unspecified	7.0%	8.3%	3.2%	2.5%	1.9%	0.0%	0.0%	0.0%
R73-Elevated blood glucose level	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	2.2%	0.0%
R79-Other abnormal findings of blood chemistry	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	0.0%
S09-Other and unspecified injuries of head	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
S59-Other and unspecified injuries of elbow and forearm	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
S62-Fracture at wrist and hand level	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
S69-Other and unspecified injuries of wrist, hand and finger(	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
S89-Other and unspecified injuries of lower leg	0.0%	0.0%	6.5%	0.0%	0.0%	0.0%	0.0%	0.0%
S91-Open wound of ankle, foot and toes	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
T14-Injury of unspecified body region	0.0%	0.0%	3.2%	7.5%	0.0%	0.0%	0.0%	0.0%
Z62-Problems related to upbringing	7.0%	11.1%	19.4%	17.5%	0.0%	0.0%	0.0%	0.0%
Z65-Problems related to other psychosocial circumstances	0.0%	0.0%	3.2%	2.5%	0.0%	0.0%	0.0%	0.0%
Z69-Encntr for mental health serv for victim and perp of abus	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Z86-Personal history of certain other diseases	4.7%	2.8%	3.2%	0.0%	0.0%	0.0%	2.2%	0.0%

Specific Non-Primary Diagnoses of Interest

The specific diagnoses of *intermittent explosive disorder, autism, and fetal alcohol syndrome* were also considered based on particular interest of clinical staff at DWTC. From 2016 to 2023, there were a few of these diagnoses, but they appear to be most common in 2023, with two youth being diagnosed with *intermittent explosive disorder,* and one youth being diagnosed with both *autism* and *fetal alcohol syndrome* (not necessarily the same youth). These diagnoses were not documented on DWTC youth in 2019 or 2020. To determine if an increasing trend is present, monitoring will remain ongoing.



Previous Children's Mental Health Services History

DCFS' mental health services include Community-Based Outpatient Services and Residential Services. Community-Based Outpatient Services include early childhood mental health services, children's clinical services, mobile crisis response and stabilization, and Wrap-Around in Nevada. More detailed information on these programs can be found online. Residential services include Psychiatric Residential Treatment Facilities (PRTFs) and Desert Willow Treatment Center.

Community-Based Outpatient Services History

Fifty-one percent (51%) of residential DWTC clients served in 2023 had previously placed a call for mobile crisis response and stabilization (MCRT) services (n=33), with an average of two calls prior to their DWTC admission date. Note that MCRT does not always collect client information when they do not provide services, so these may be underestimates. Twenty-nine (29; 45%) of those clients received a face-to-face MCRT response, with an average of two occurrences of face-to-face stabilization services per youth.

Additionally, among residential DWTC clients served in 2023, 11% (n=7) previously received Children's Clinical Services, 6% (n=4) previously received Early Intervention Services, and 9% (n=6) previously received Wrap-Around in Nevada Services.

Psychiatric Residential Treatment Facility History

As an integral component to Nevada's System of Care continuum, Psychiatric Residential Treatment Facilities (PRTFs) are committed to delivering evidence-informed services to Nevada youth aged 6-18 with severe emotional disturbance (SED). DWTC provides similar services to other PRTFs, as they also provide 24-hour, highly structured services for children and youth ages 6-17 who are severely emotionally disturbed. However, unlike DWTC, other PRTFs are not locked facilities, and rather staff-secured. Licensed by HCQC and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), services are provided by Medicaid-credentialed staff and include:

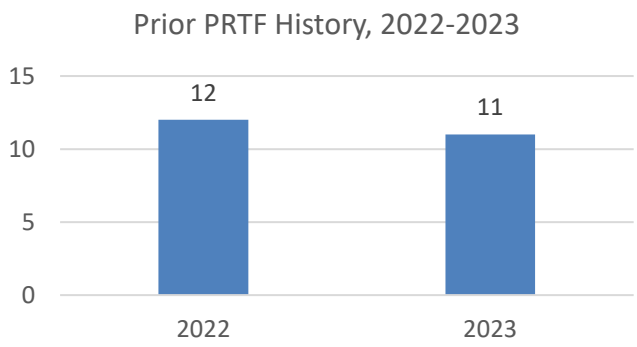
- Psychiatric oversight
- Comprehensive psychological assessment, psychiatric evaluation, and medication management

- Individual, family, and group psychoeducation and therapy, interactive parent training, guided family visits, recreation therapy, milieu therapy, and crisis intervention
- Child and Family Team Meetings (CFTs) that include the Primary Behavioral Health Provider and essential members of each youth's support network
- Coordination of care, and warm handoffs with community-based services
- Behavior therapy services
- Nursing services

The objective is to help youth with behavioral, emotional, psychiatric and/or psychological disorders or conditions, who are no longer appropriate for an acute level of care, or who cannot effectively respond to services from a less restrictive setting. Average length of stay in a PRTF is about 90 days.

Out of the youth served by DWTC residential in 2023, 11 (17%) had previous history in an in-state PRTF. On average, these youth were discharged from a PRTF about 16 months before entering DWTC.

PRTF services were identified through DCFS records and Medicaid claims using the list of currently licensed PRTFs in 2024. Services from residential treatment facilities licensed in earlier years but no longer licensed at the time of this report may have been missed, resulting in data suppression for years prior to 2022.

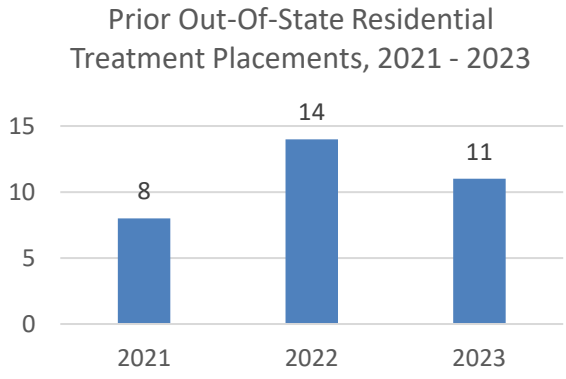


Previous DWTC Admissions

Twelve of the 65 youth served at DWTC in 2023 had previous admission to the facility (18%), with at least one youth having as many as six admissions over their lifetime. For youth with multiple admissions, the median time between admissions was 70 days, with a range of 24 days to one year.

Previous Out of State Residential Treatment

Seventeen percent (17%; n=11) of the patients at DWTC in 2023 had prior placements to out of state residential treatment facilities. This is down from 31% in 2022 (n=14). The median time from their most recent out of state residential treatment facility discharge to admission at DWTC was 206 days, or just under seven months.



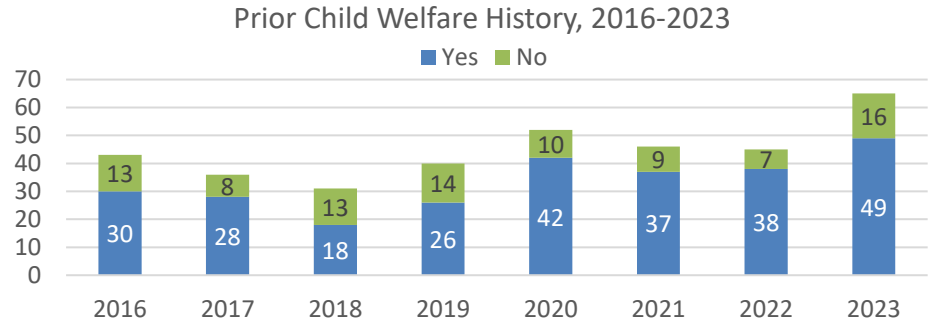
Other DCFS Involvement

Youth admitted for residential psychiatric treatment at DWTC often have prior involvement with other DCFS programs outside of children's mental health, like child welfare and/or juvenile justice, even when they were not referred directly from these programs. Understanding the overlap in youth served across these systems can help inform programming to ensure DWTC provides the services necessary in the lowest level of care, and as early as possible.

Child Welfare History

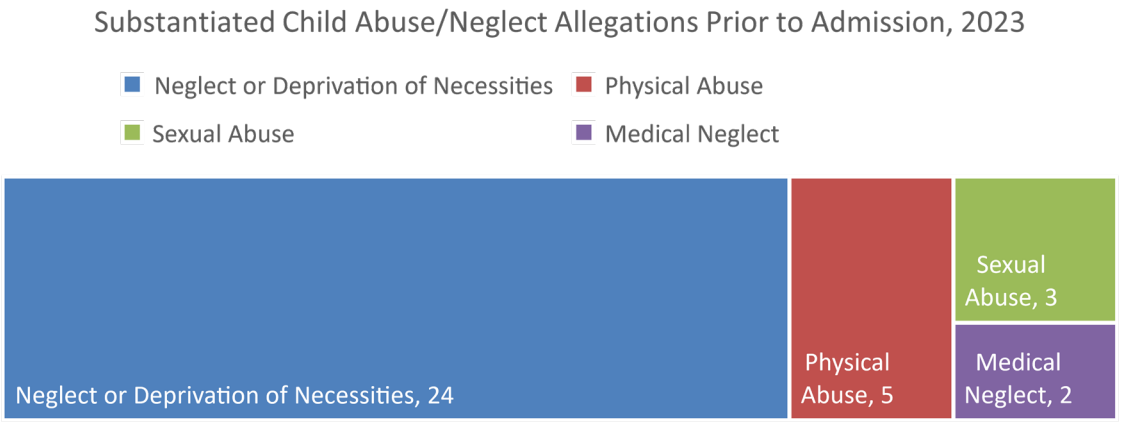
In 2023, 56 out of the 65 youth (86%) admitted to DWTC residential were referred to a Nevada child welfare agency for concerns of child abuse or neglect. The median age at first referral was eight years old. For those youth who had any screened-out referrals before their first referral screened in for investigation, an average of two referrals were screened-out prior to the referral that was ultimately investigated for child abuse and neglect.

In any given year from 2016 to 2023, over half of the youth admitted to DWTC for residential services had a previous report screened in for investigation. For this report, this is considered as having a prior child welfare history, regardless of the findings from the investigation. In the last four years, from 2020 through 2023, this proportion was consistently higher than 75% of DWTC youth.



Of the 49 youth at DWTC in 2023 with previous child welfare involvement, the average youth had three prior investigations. The average time between the last screened-in child welfare report and the admission to DWTC was 1-2 years, with outliers ranging from 9 days to nearly 14 years.

Further, abuse and/or neglect was substantiated on 29 youth (45%) served by DWTC residential in 2023. Twenty-four youth (37%) were substantiated for neglect or deprivation of necessities, five youth (8%) were substantiated as being victims of physical abuse, three youth (5%) were substantiated as being victims of sexual abuse, and two (3%) were substantiated as being victims of medical neglect. Youths may have a history of more than one type of substantiated abuse; these categories are not mutually exclusive.

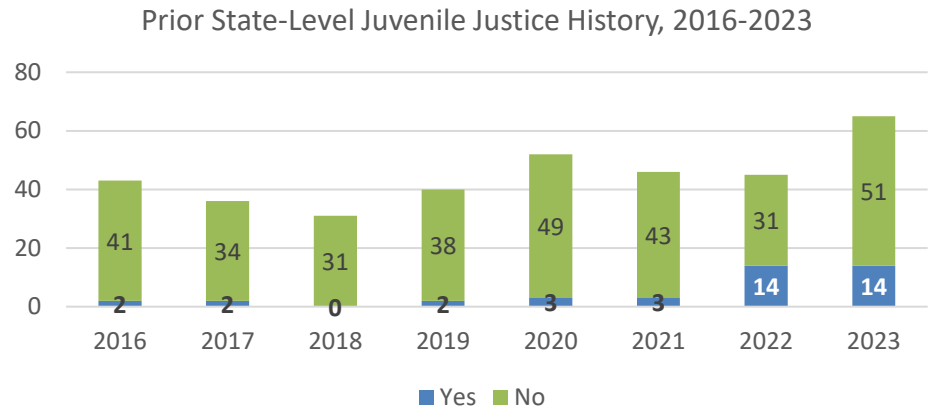


For 27 of these youth, the perpetrator substantiated for child abuse or neglect was a parent. Twenty-four of these youth had previously been removed to foster care. Out of those who had previously been removed to foster care, five youth had two previous removals, one youth had three removals, and one youth had as many as four removal episodes prior to their 2023 admission to DWTC.

Fifteen of the youth who had ever been removed to foster care were in custody at the time they were admitted to DWTC. Nine were not in custody when admitted but had previously been in foster care: three adopted, one placed in a non-relative guardianship, and five re-unified with their non-custodial parent prior to entering DWTC.

State-Level Juvenile Justice History

DWTC has observed a notable increase in youth with prior involvement in state-level juvenile justice (JJ) programs. Prior to 2022, DWTC observed a few youth each year with prior state-level JJ involvement (<4 annually). However, as of 2022, over 20% of DWTC residential youth had prior encounters with the state-level JJ system. Note that children referred to the state JJ system are first committed to a juvenile detention facility, so all children with past JJ involvement spent some amount of time in a detention facility prior to their admittance to DWTC.



In 2023, all 14 children with a history of state-level JJ involvement were currently in custody when they were admitted to DWTC, and all were either furloughed or released to parole on or before the day they were admitted to DWTC. Among those on parole before entering DWTC (n=6), the median time on parole was about 153 days, or five months, when they entered DWTC.

It is important to note that this report does not include JJ involvement at the county level. In addition to the 14 youth with state-level juvenile justice involvement admitted to DWTC in 2023, six youth had prior involvement with juvenile justice in Clark County and four youth had prior involvement with juvenile justice in Washoe County.

Additionally, please note that the state JJ system transitioned from tracking data in UNITY to Enterprise Supervision in 2018, resulting in data entry disruption; this chart may reflect an underestimate of children with a history of JJ involvement that occurred in 2018.

Incidents and Accidents within the Facility

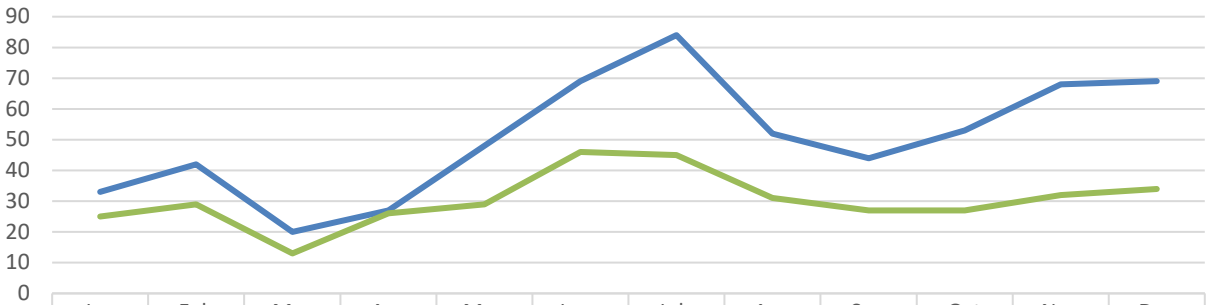
DWTC's quality assurance staff track incidents and accidents that occur within the facility. These incidents can be categorized into the following groups: physical holds, chemical restraints, seclusions, medication errors or variances, property damage, aggression, denial of rights (other than seclusions and restraints), allegations of abuse, and other (to include visitor-related incidents, contraband, and medical emergencies, among others). The trend graphs on the following pages quantify the frequencies of occurrence for these incidents and accidents in the residential units of DWTC.

It is important to note that trends in these occurrences are highly dependent on the mix of patients in the facility at any given time and are influenced by individual patient diagnoses as well as treatment plans. On some days there may be multiple incidents of restraint on the same patient. For example, in one residential unit, one outlier patient accounted for 35% of all seclusions and restraints for that unit. In another unit, there were two outlier patients that accounted for 17% and 14% of all seclusions and restraints respectively. In some cases, patients have prior history with each other from previous placements in detention facilities, complicating interpersonal dynamics among patients. The frequency of incidents also varies based on the number of beds occupied in any given month. These factors add complexity when attempting to interpret seasonal trends.

It is the policy of DWTC that all patients be treated and managed in the least restrictive manner consistent with their clinical status and needs and that restraint/seclusion will only be used as an emergency safety measure in situations of imminent danger to patients, staff, or others and when less restrictive interventions were determined to be ineffective to protect the patient or others from harm. The decision to use restraint/seclusion is driven not by diagnosis, but by comprehensive individual assessment that concludes for this patient, at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion. An emergency need is identified as high risk of self-injury, high risk of injury to others, physically harming others, self-injurious behavior, and property destruction that could lead to harm to self or others.

Physical Holds, 2023 by Month

Physical holding of patients is limited to scenarios where patients are an imminent danger to self or others. A physical hold is a restraint and requires a doctor's order.

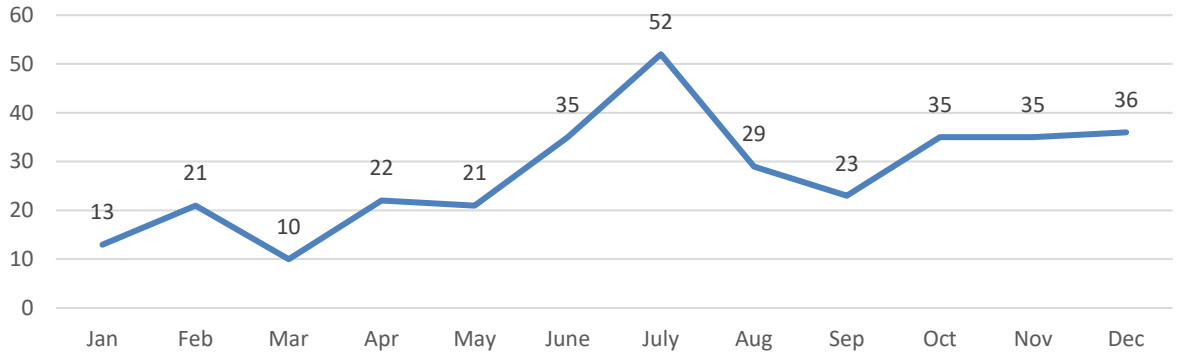


	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Physical Restraints	33	42	20	27	48	69	84	52	44	53	68	69
Escort	25	29	13	26	29	46	45	31	27	27	32	34

Chemical Restraints, 2023 by Month

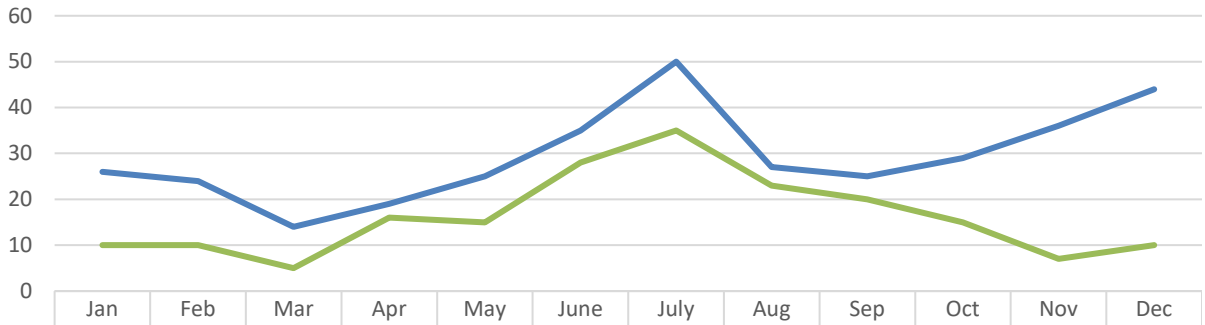
The administration of medication for the specific and exclusive purpose of controlling an acute or episodic aggressive behavior when alternative intervention techniques failed to limit or control the behavior. This term does not include the

administration of medication on a regular basis, as prescribed by a physician, to treat the symptoms of mental, physical, emotional, or behavioral disorders and for assisting a person in gaining self-control over his or her impulses.



Seclusions, 2023 by Month

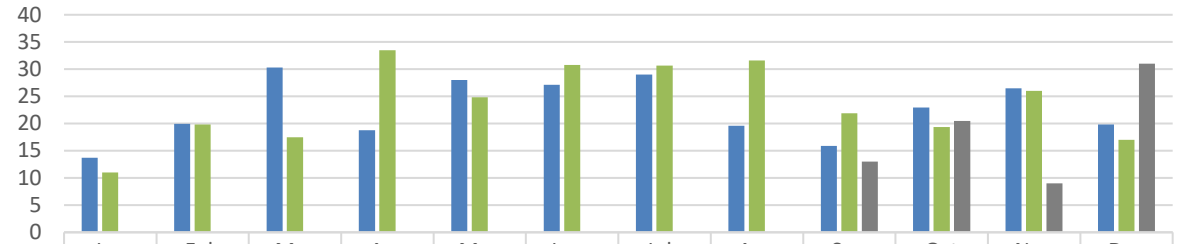
Seclusion of patients is limited to scenarios where patients are an imminent danger to self or others. Seclusion requires a doctor's order.



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Unlocked Seclusion	26	24	14	19	25	35	50	27	25	29	36	44
Locked Seclusion	10	10	5	16	15	28	35	23	20	15	7	10

Average Length of Seclusions in Minutes, 2023 by Month and Unit

Seclusion may not exceed 2 hours for youth ages 9-17 or 1 hour for youth ages 8 and below. The average length of seclusion in minutes for patients in 2023 was 23 minutes.



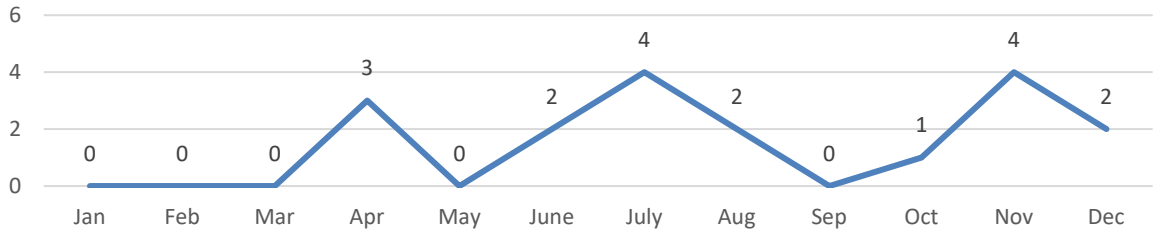
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
RTC-I	14	20	30	19	28	27	29	20	16	23	26	20
RTC-II	11	20	18	33	25	31	31	32	22	19	26	17
RTC-III									13	21	9	31

Medication Errors or Variances, 2023 by Month

Medication errors are typically identified by staff or the pharmacy when a nurse or physician either enters information incorrectly or fails to enter it at all. Many orders are communicated verbally to nurses, or the physician enters them directly into the system. The most common error occurs when a medication override is used for emergency administration, but the medication was not entered into the system before the pharmacy generated a report.

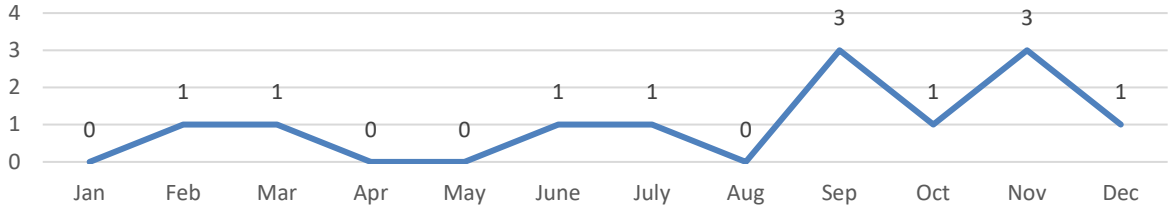
When medication errors are discovered, the nurse is responsible for completing an incident report to document the occurrence, which is then reviewed by a supervisor and sent to the pharmacy for review and sign off.

DWTC observed a decrease in medication errors recently, as the facility now requires a double sign off in the medication dispensing device before a medication is removed without an order.

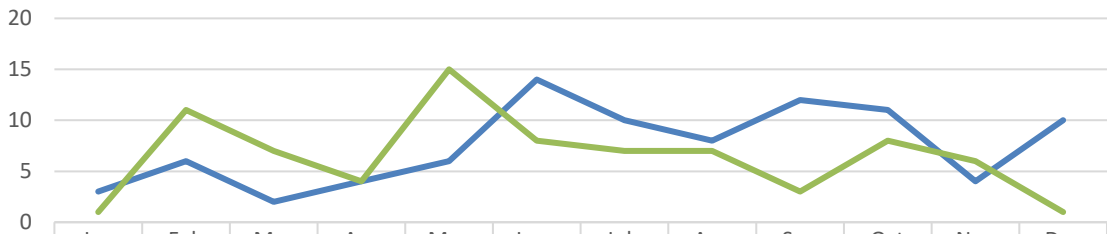


Property Damage, 2023 by Month

Property damage decreased from previous years as unit nurses' stations were remodeled to be enclosed per State Public Works Division Project 21-M02(16). For example, there were 14 instances of property damage in April 2021. The project began July 2022 and competed in April 2023; the overall decrease in property destruction incidence in 2023 demonstrates the legislative funds issued for this improvement project improved outcomes by ensuring a safer physical environment.



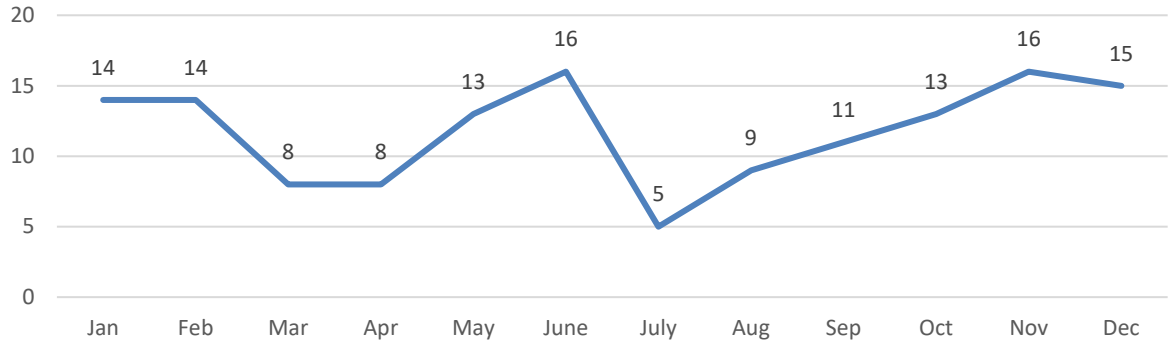
Aggression, 2023 by Month



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Patient to Staff Aggression	3	6	2	4	6	14	10	8	12	11	4	10
Patient to Patient Aggression	1	11	7	4	15	8	7	7	3	8	6	1

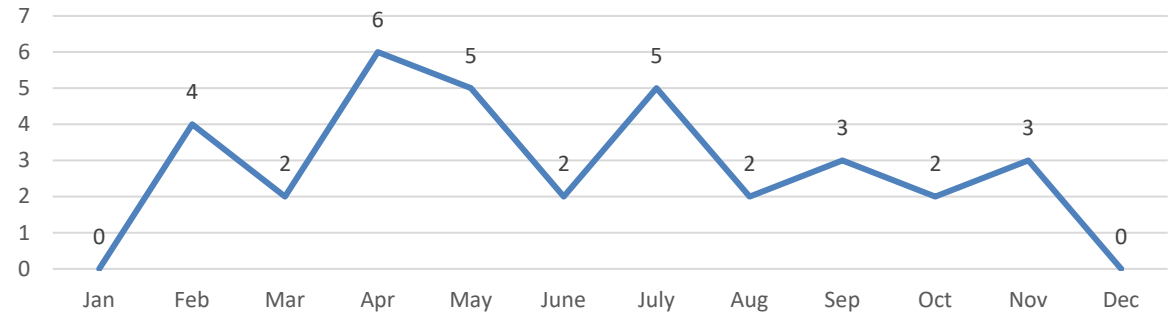
Denial of Rights (other than Restraints/Seclusions), 2023 by Month

Denial of Rights include all doctor's orders that restrict the rights of a patient for their safety. These may include special precautions for increased patient monitoring for patients at risk of self-harming or assaultive behavior, 10-foot restrictions preventing patients at risk of endangering others from interacting with specific patients, any clothing or item restriction, or monitoring or restricting physical/telephonic contact with persons based on documented safety concerns. All denial of rights are time-limited and discontinued when the restriction or precaution is no longer necessary for safety.

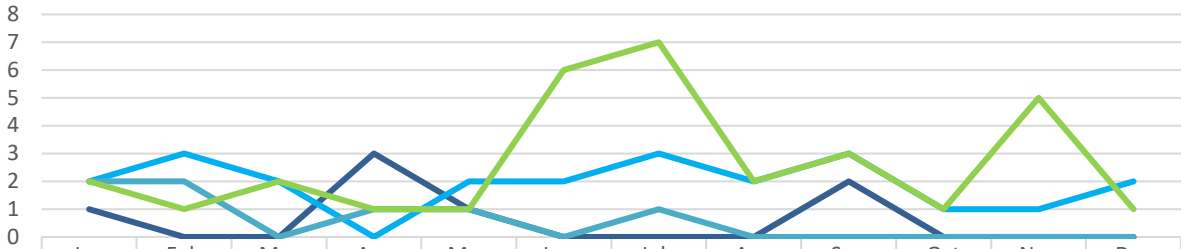


Allegations of Abuse, 2023 by Month

The allegations of abuse represented in the following chart include all calls to Child Protective Services (CPS), including both calls to report historical abuse in the home or community, and suspected abuse by DWTC staff, and should not be misconstrued as representing only allegations of abuse within the facility.



All Other Incidents, 2023 by Month



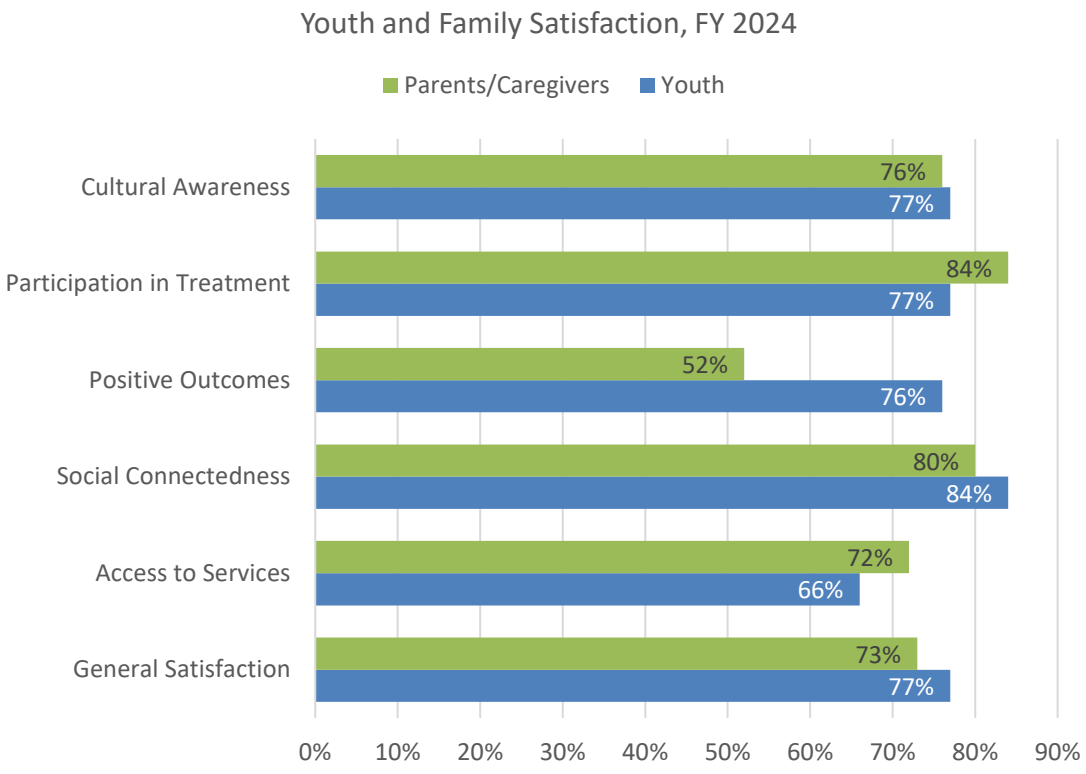
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Visitor	1	0	0	3	1	0	0	0	2	0	0	0
Contraband	2	3	2	0	2	2	3	2	3	1	1	2
Medical Emergency	2	2	0	1	1	0	1	0	0	0	0	0
Other	2	1	2	1	1	6	7	2	3	1	5	1

Youth and Family Satisfaction

DCFS conducts a family satisfaction survey every fiscal year (FY) to obtain valuable feedback from youth and families regarding the services they receive. The information collected helps inform service delivery, engage programs in the Continuous Quality Improvement (CQI) cycle, as well as inform decisions regarding policies and procedures for residential programs. All participants are given the opportunity to provide feedback at the time of discharge.

The most recent satisfaction survey was offered to youth, parent/caregivers, and legally responsible individuals (LRI) at discharge from July 1, 2023, through June 30, 2024, and incudes results from 49 youth, 31 parent/caregiver, and 10 LRI surveys. The survey had a response rate of 48% of youth and 40% of parents/LRI.

Participants responded to a series of statements relating to the six domains identified in the following graph. Percentages reflect the percent of respondents who positively agreed to domain statements ('Strongly Agree' and 'Agree' on a five-point Likert scale). Satisfaction rates are presented for youth and parents/caregivers.



Satisfaction across all domains has declined since 2020. The lowest level of satisfaction was observed in 2022, and trends started to improve in 2023 and 2024. For more detail, please reference the full Family Satisfaction Survey Report.

Clinical Case Review Findings and Recommendations: 2023

The DCFS Planning and Evaluation Unit (PEU) conducted clinical case reviews on all 65 youth admitted to DWTC RTC units in 2023. Over time, these reviews are intended to evaluate appropriateness of the placements, understand factors that lead up to residential treatment and prior services utilized at a lower level in the community, and better understand outcomes related to youth who received residential treatment at DWTC.

Data Sources

The PEU gathered data from Avatar, primarily within a few key documents in youth records – Mental Health Admission, Children's Uniform Mental Health Assessment, Psychiatric Evaluation, Aftercare Plan, Discharge Summary, and Progress Notes. This data was combined with information provided by the Office of Analytics and data collected internally by the program to highlight key findings from metrics surrounding youth characteristics, experiences, and outcomes.

Diagnoses

In addition to the diagnostic information included earlier in this report, pulled from the State's electronic health record (Avatar), diagnosis results were also obtained by reviewing the Psychiatric Evaluation that occurs upon admission and discharge from DWTC RTC. Changes in diagnosis can be indicative of the treatment process, as more clarity is gained due to symptom stabilization, increased observation, and participation in therapy and skills training. These evaluations are completed by the youth's attending psychiatrist and do not specify primary versus secondary, or tertiary diagnoses. These data provide insight into the following:

- 38% of youth had three or more diagnoses at admission to the facility (excluding medical diagnoses).
- At admission, the most frequent diagnosis assigned was Disruptive Mood Dysregulated Disorder (DMDD) at 48% and increased to 55% at discharge.
- At admission, 40% of youth also had a diagnosis of ADHD, and this increased to 74%, making it the most frequent diagnosis at discharge.

DMDD diagnosis is characterized by severe temper outbursts, angry and/or irritable mood and issues with daily functioning due to irritability. One of the lifestyle factors that increase the risk of DMDD is early childhood trauma. This is consistent with findings that 97% of the 65 youth reviewed had a trauma history. The two major evidenced based treatments for DMDD are Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT).

Based on the review findings, it is recommended that clinical staff be trained and certified in one of the two evidence-based models (CBT, DBT) to treat DMDD. The almost universal finding of a trauma history for all youth reviewed lends itself to the recommendation that a trauma-informed lens needs to be applied when working with these youth. Also, for future data collecting and reporting, ACE (Adverse Childhood Experiences) scores should be collected upon admission.

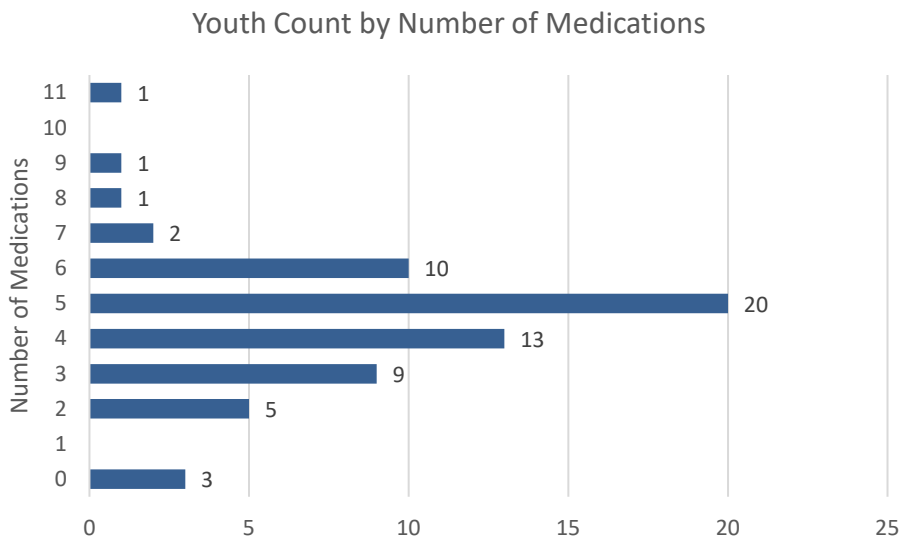
Medications

A review of youths' psychiatric follow-up notes indicated that 54% of youth received at least five unique psychiatric medications during their stay. Length of duration for each medication was not analyzed during this review. Throughout the youths' stay, changes in medication occurred for a variety of reasons, such as adverse side effects, ineffective symptom reduction, and parent/caregiver refusal. The number of medications used to treat youth during their stay at DWTC speak to the complexity and severity of the youth symptoms and behavior.

The use of antipsychotics is consistent with treatment for DMDD especially for youth in which other treatment approaches have been unsuccessful. Also, research has shown that youth in foster care are prescribed antipsychotic medication at twice the rate of other Medicaid-insured youth [1]. Twenty-three percent (23%) of the youth admitted to DWTC during this review period were in foster care.

It is important to note if medication management is provided, it is used in a coordinated treatment approach that utilizes other direct services such as crisis intervention and stabilization, individual, family, and group therapies, behavior management, etc.

1. Vanderwerker LC, Laff RE, Kadan-Lottick NS, McColl S, Prigerson HG. Psychiatric disorders and mental health service use among caregivers of advanced cancer patients. Journal of Clinical Oncology: Official journal of the American Society of Clinical Oncology. 2005;23(28):6899-6907.



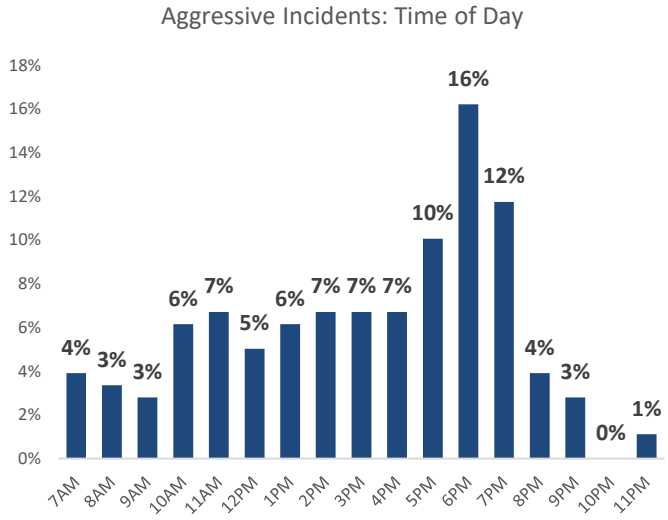
Aggressive Incidents and Law Enforcement Involvement

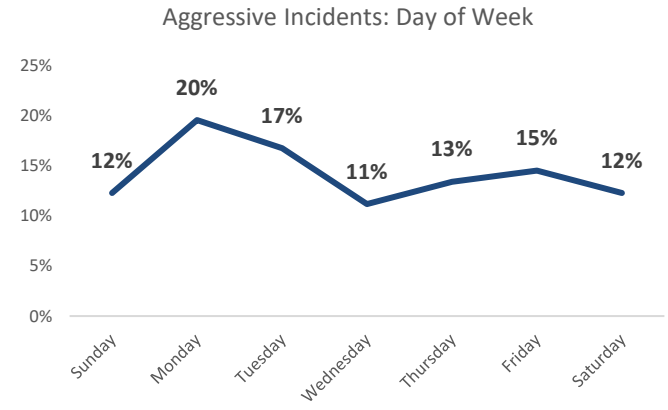
Aggressive incidents are defined as any aggressive behavior that involves either the youth and staff or the youth and another youth. Only youth determined as the primary instigator are included in the analysis. For the 65 youth that received services from DWTC during 2023:

- 37 youth (57%) had an aggressive incident on the unit during their stay. Of the 37 youth that had at least one aggressive incident, 9 youth (24%) were responsible for 63% of all the aggressive incidents.

Included here is a breakdown of youth that had aggressive incidents by time of day, day of week, and location of the incident. The results suggest that a handful of youth are responsible for the majority of aggressive incidents that occurred during this review period. It is yet to be determined if this is a stable pattern, which could indicate that adjustments to staffing, training, supervision, and location of these youth can be discussed to decrease the number of incidents and reduce any other collateral/downstream impacts.

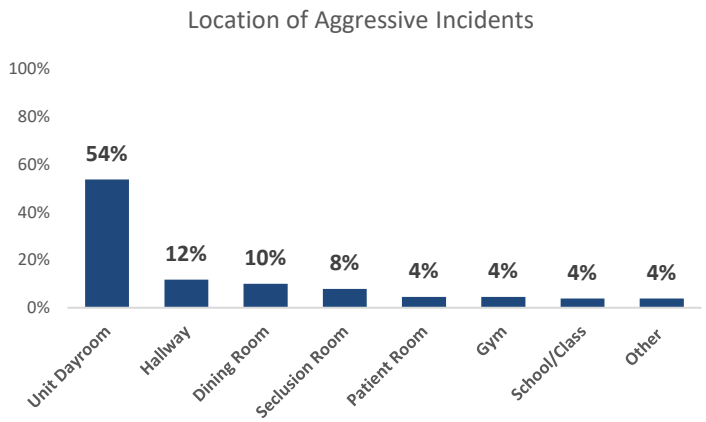
Another finding that can potentially inform procedures and staffing is the location and timing of the aggressive incidents. Fifty-four percent (54%) of the aggressive incidents occurred in the day room suggesting that increased staff presence and supervision might be needed when youth are in this location. Also, 38% of the aggressive





incidents took place between 5pm and 7pm; and 20% of incidents occurred on Mondays. Again, these results suggest that staffing and supervision levels during this time frame should be examined further to determine gaps.

- There were 11 situations that led to law enforcement involvement; 8 youth were responsible for all 11 situations.
- Of the 11 situations that led to law enforcement involvement, 1 youth was responsible for 36% of the law enforcement encounters.



While law enforcement involvement due to aggression is a relatively rare event at DWTC, it nonetheless causes significant disruption in programming on many levels. DCFS will continue to work to understand contributing factors and potential solutions to reduce these incidents.

Intellectual/Developmental Disability

The Intellectual/Developmental Disability (ID/DD) designation spans a broad spectrum of disorders and conditions. Some of these include fetal alcohol syndrome disorder, autism spectrum disorder, genetic and chromosomal conditions such as Down syndrome and Fragile X, and certain infections that can impact development during pregnancy. Youth with both an ID/DD designation and mental health diagnosis pose unique challenges for treatment providers as programming is not typically designed to address both these needs.

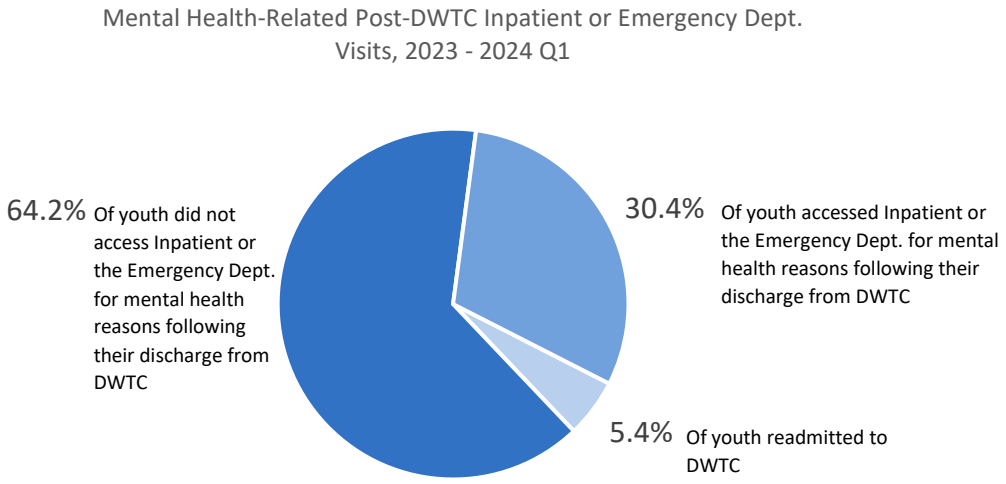
- 53% (n = 34) of the youth that received services at DWTC during 2023 either had a documented ID/DD diagnosis or were suspected to have one. This designation is given at admission on the mental health admission form and was not found elsewhere in the records reviewed. This finding supports the conclusion that these youth with either suspected or documented ID/DD require specialized programming and youth with a suspected designation should receive diagnostic clarity upon discharge thus allowing them to access needed resources for ongoing care in the community.
- Of the 37 youth that had an aggressive incident during their stay, 20 (54%) had a documented or suspected ID/DD designation and were responsible for 50% of all the aggressive incidents at DWTC RTC in 2023.
- 1 youth with a documented ID/DD diagnosis was responsible for 15% (n = 28) of all aggressive incidents.

These preliminary results speak to the challenges that the dual diagnosis population present to care providers. It also suggests that these youth require and divert a lot of the available resources as they have significant needs. While further staff time and resource utilization should be analyzed to provide more specific recommendations, it is worth considering the creation a specific RTC unit designed to meet the needs of this population. Partnering with Desert Regional Center (DRC) for purposes of cross training, treating, and identifying available resources once discharged might also benefit these youth.

Post DWTC

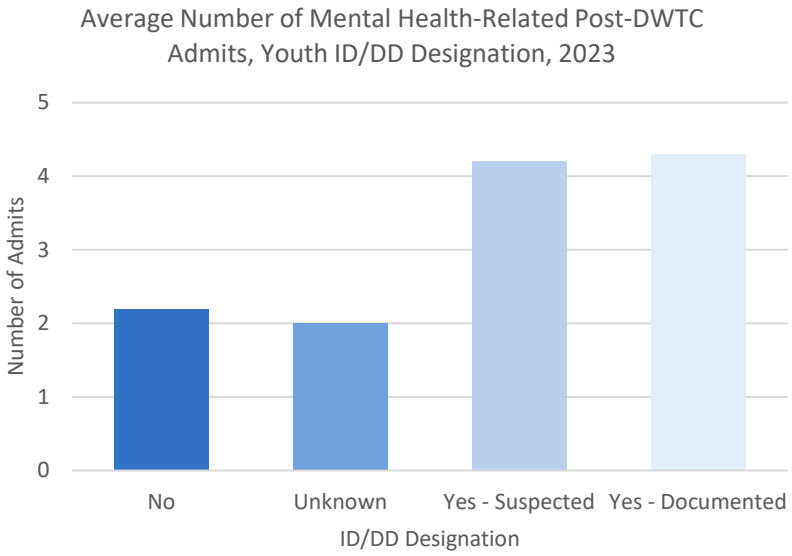
Records for inpatient/emergency department visits that occurred during 2023 or through quarter one of 2024 were examined to identify how many of the 65 youth were admitted for mental health reasons following discharge from DWTC. Nine youth were still admitted to DWTC during the first quarter of 2024 and were excluded from this part of the analysis.

- A majority of youth (n = 36, or 64%) were observed to have no record of inpatient/emergency department visits for mental health reasons following discharge from DWTC.
- 3 youth (5%) were readmitted to DWTC.



These findings suggest that the majority of youth when discharged from DWTC RTC successfully transitioned back to the community without needing to access inpatient/emergency departments for mental health reasons for at least one month and up to 14 months (average of 7 months). Further longitudinal research needs to be completed to better track these youth once discharged to get a better understanding of long-term outcomes.

- Over a quarter of youth discharged from DWTC RTC (n = 17, or 30%) accessed inpatient services or an emergency department for a mental health reason.
- Ten of the 17, or 59% of youth, that accessed an inpatient hospital or emergency department post-discharge from DWTC for mental health reasons had a suspected or documented ID/DD. These youth also accessed inpatient services or an emergency department for a mental health reason more frequently than youth with no or unknown intellectual or developmental disability designation.



This points to a documented and consistent finding that Nevada does not possess an adequate and easily accessible mental/behavioral health service array for youth with significant mental health needs.

If future and more expansive research reinforce the above findings for the ID/DD population, DWTC should consider step-down programming for these youth before they transition back to the community. The PRTFs or a comprehensive

long-term, in-home, team-based program could be used for this purpose and aid these youth in successfully transitioning back into their homes.

The data collected during this case review should be considered preliminary and is intended to provide a snapshot of the program and the youth served at DWTC RTC units. It is recommended that data collection efforts be expanded and reviewed periodically to identify trends and needs related to staffing, training, treatment modalities, and other program improvement needs. It is essential to involve program staff and leadership to ensure specific program needs and the needs of the youth being served are addressed.

Recent Enhancements

During 2023, DWTC worked to increase its capacity and ability to provide additional services by reopening the pediatric RTC unit, which provides services to youth aged 6-11, and increasing admission capacity on its acute unit. To support these efforts, DWTC increased its staffing through use of contracted resources. This allowed DWTC to increase its registered and licensed nurse count from 10 nurses to 28. This includes nursing supervisory staff. As of October 2023, DWTC added 11 contracted registered nurses (RNs). DWTC further augmented its nursing staff by recruiting 7 licensed practical nurses (LPNs). LPNs provide most services that an RN can provide, however, they must work under the supervision of a fully licensed RN. The addition of the LPN role allowed DWTC to increase its nursing staff in a manner which provided for an increase in acute admissions and the ability to provide in-state services to the State's 6-11-year-old youths requiring a residential level of care. This addition reduced the likelihood of out-of-state treatment placement for some of Nevada's most vulnerable youth.

Additional Pyxis medication dispensing machines were acquired and brought online to support the new units. With this increase in both patients and staff, additional Automated External Defibrillator (AED) machines were acquired to support any emergency medical needs throughout the hospital. Also, to further support patient needs, DWTC added a portable oxygenator and esophageal suctioning machine to the facility to assist in the provision of emergency care and stabilization of youth experiencing tonic-clonic seizures.

In a continued commitment to strengthening the workforce, DWTC introduced clinical rotations for nursing students from Chamberlain University. This initiative aims to provide students with valuable hands-on experience while encouraging them to pursue long-term employment with the State upon graduation. To date, three cohorts of students successfully completed these rotations, providing them with an opportunity to gain practical exposure while fostering a strong pipeline of qualified nursing professionals for future employment. DWTC also partnered with the Nevada Rural Hospital Partners Foundation (NHRPF) to support participants of the Nursing Apprenticeship Program (NAP). Nursing students have the opportunity to learn and earn within the DWTC facility while completing their studies.

DWTC also proudly began participation in the SkillBridge program, offering transitioning military veterans the opportunity to gain valuable training and experience in children's mental health before their military service concludes. By welcoming two veterans into this initiative, DWTC not only supports their career transition but also contributes to building a skilled workforce in an area of critical need.

Additionally, DWTC also worked to contract with an in-house Board-Certified Behavior Analyst (BCBA) to further support the individual needs of youth requiring Applied Behavioral Analysis (ABA) services as part of their prescriptive treatment. Work is in progress to reclassify some unfilled positions within the hospital to further support the onboarding of developmental specialists to the DWTC staff as Registered Behavioral Technicians (RBTs), and a speech pathologist. This will further allow DWTC to provide an increased level of care to youths presenting with intellectual and developmental delays, and some pervasive developmental disorders.

To further enhance DWTC's infrastructure to provide continued support to its youth and community, DWTC installed an upgraded camera surveillance system within the hospital, including upgraded servers and server capacity. This upgrade allows for increased ability to monitor activities within and outside of the facility with more stability and a decreased likelihood of downtime interruptions. DWTC also installed protective barriers at the nursing stations to reduce staff assaults by patients, the ease of access to contraband by patients, and property destruction by patients.

DWTC also worked with the Southern Nevada Child and Adolescent Services (SNCAS) Maintenance team to facilitate the installation of two new high-capacity water heaters. This replacement of water heaters will provide two-fold results with regard to increased hot water capacity to support the reopening of units and increase in patients as well as reducing any likelihood of Legionella contamination.

To enhance operational efficiency and streamline the feedback process, Wi-Fi was installed at the facility, enabling the electronic administration of parent/guardian satisfaction surveys. This upgrade allows for real-time data collection and immediate access to survey results, significantly reducing the administrative burden on staff by eliminating the need for manual data entry. As a result, staff can focus more on direct engagement with families, while ensuring timely and accurate feedback that drives continuous improvement.

Lastly, the facility has taken proactive steps to enhance its internal training capabilities by implementing in-house CPR training and N95 Fit Testing. This initiative not only supports the hospital's ongoing training needs but also reduces external training costs and increases scheduling flexibility for staff. By bringing these critical trainings and assessments in-house, the facility ensures more efficient use of resources while maintaining a high standard of preparedness and safety for employees.

Conclusion

The community need for youth residential psychiatric services has increased over the last decade, as demonstrated by the increasing number of children served in DWTC year-over-year. The complexity of treating youth in this setting requires highly specialized staff, including child and adolescent psychiatrists, therapists, nurses, and other mental health professionals trained in adolescent development and crisis management. These professionals must not only have expertise in diagnosing and treating mental health conditions but also possess the skills to work with the emotional, cognitive, and social complexities of youth. Given that each young person's needs are often highly individualized, treatment plans must be personalized, requiring additional time and resources. Providing comprehensive care for this population requires a multifaceted approach that balances clinical expertise, emotional support, environmental stability, and financial sustainability.

A small group of high-needs youth account for a disproportionately large share of time and resources at DWTC. In addition to their mental health diagnoses, these youth tend to have a history of trauma and either a documented or suspected intellectual or developmental delay, along with a significant record of involvement in various systems such as mental health, juvenile justice, and child welfare. Developing a comprehensive system capable of identifying these youth early on and directing them toward appropriate programs would not only enhance their treatment and rehabilitation outcomes but also help DWTC optimize its resource management, including staffing and training efforts.

In 2023, DWTC made significant strides in expanding its capacity and improving services for vulnerable youth. Efforts included reopening the pediatric RTC unit, increasing staffing levels, and enhancing medical infrastructure, such as additional medication dispensing machines and emergency care equipment. To address staffing needs, DWTC recruited nurses, including 11 contracted RNs and 7 LPNs, and launched clinical rotations for nursing students, supporting workforce development. The facility also introduced programs for transitioning military veterans and partnered with

organizations like the Nevada Rural Hospital Partners Foundation to strengthen its workforce. Other improvements included upgraded surveillance systems, enhanced water heater capacity, and the installation of Wi-Fi for real-time parent/guardian feedback. DWTC also focused on internal training, implementing in-house CPR training and N95 Fit Testing, ensuring increased efficiency and preparedness. These efforts reflect DWTC's commitment to providing higher-quality care and strengthening its workforce and infrastructure.

Despite significant challenges, the Division of Child and Family Services is committed to utilizing a continuous quality assurance process and will continue to assess youth who required out-of-state Residential Treatment Center placements, as well as those receiving services from Desert Willow Treatment Center. This ongoing evaluation will focus on identifying the specific interventions and treatment approaches offered by these facilities not currently available at DWTC. This approach will allow DWTC to focus efforts on the development and implementation of more robust, evidence-based, treatment approaches.