Division of Child and Family Services
2010 Aggregate Report
Risk Measures and Departure Conditions

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. A few new specialized foster care provider agencies opened during this 2010 reporting year and entered into contracts. When these new agencies began to serve children, they were added to the list of participating agencies and asked to participate in this initiative. A list of specialized foster care agencies and their level of participation can be found in Attachment A.

This 2010 report is the third year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2010 through December 2010. The overwhelming majority of specialized foster care providers statewide have responded by turning in complete data sets.

Although data analysis limitations continue as a result of provider self reporting, beginning in late 2009 and throughout 2010 the PEU, in partnership with the Provider Support Team, began to develop tools and processes to assess provider adherence to standards of practice and data reporting. These include:

- Face to face policy review meetings were conducted between PEU and contracted providers. Many of the policies reviewed in these meetings are those which address risk measures as reflected in this report (e.g., medication management, restraint, crisis triage, training curricula regarding suicide awareness, Child and Family Teams, etc.). The focus of these meetings was not only on improving practice standards but also to articulate standards regarding quality assurance activities such as data collection, data analysis and the development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide.

- The development and implementation of an internal data base for tracking data clean up issues; this endeavor has helped to minimize the limitations around missing or incomplete data which has previously impacted our interpretation and analysis of the data in past reports.

Data analysis limitations do continue as we factor in provider self reporting and our current inability to confirm the accuracy of reported incidents; 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 CONDTIONS

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
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance

Specialized Foster Care providers were also asked to track and report departure conditions for children and adolescents discharged from services during the 12-month reporting period. Collecting departure conditions data for analysis is one 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
- Child and Family Team decision making

The following is the data and analysis of the four risk areas and departure conditions based on data collected from January 2010 through December 2010.

Forty-three Specialized Foster Care providers who held contracts with DCFS and/or Clark and Washoe Counties participated in the collection of risk measures and departure conditions. They were asked to submit a bed-capacity count each month and the number of children and adolescents served per provider.

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 the 2009 and 2010 reporting periods are reflected in Table 1 along with the average monthly bed capacity for 2008.

Table 1

AVERAGE MONTHLY BED CAPACITY		**AVERAGE MONTHLY NUMBER OF YOUTH SERVED**	
Bed Capacity		**Youth Served**	
2010	40.22	2010	27.31
	Range: 0 to 228		Range: 0 to 186
2009	36.98	2009	30.37
	Range: 1 to 225		1 to 196
2008	32.45		
	Range: 0 to 225		

Suicide Incidents

Specialized Foster Care providers were asked to track and report incidents of attempted and completed suicides. A total of 11 Specialized Foster Care providers reported incidents of attempted suicide. Attempted suicide is defined as a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill him or herself but was rescued or thwarted, or changed his or her mind after taking initial action. There were no reports of completed suicides. Agencies reporting a suicide attempt were:

Agape
Apple Grove
Briarwood North
DCFS Adolescent Treatment Center
Eagle Quest
Etxea
Kids First
Koinonia
Maple Star Nevada-South
SAFY
Unity Family Services

Table 2 shows the number of agencies reporting suicide attempts and the total number of suicide attempts for each reporting period.

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Table 2

SUICIDE INCIDENTS		
Reporting Period	Number of agencies reporting	Attempted Suicides
2010	11	18
2009	8	16
2008	6	14

There were a total of 18 reports of suicide attempt with the following descriptive information:

- 10 (55.6%) were male and 8 (44.4%) were female.
- Average age was 13.83, ranging from age 8 to 17 years.
- 9 (50%) were Caucasian, 4 (22.2%) were African American, 3 (16.7%) were of mixed race, 1 (5.6%) was American Indian/Alaskan Native, and 1 (5.6%) was unknown.
- 4 (22.2%) were of Hispanic origin.

Clinical and suicide attempt information:

- The 4 most frequent diagnoses were Mood Disorder NOS, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Bipolar I Disorder.
- Suicide means reported were 3 incidents of wrist cutting, 2 incidents of using a knife to harm oneself, 2 incidents of overdose, 1 incident of attempted hanging, and 10 incidents using “other” means.
- 12 (66.7%) children and adolescents with incidents were reported as having previous suicide attempts.
- Following the suicide attempts, 9 (50%) were admitted to a psychiatric hospital, 3 (16.7%) resulted in emergency hospital medical procedures, and 6 (33.3%) were categorized as “other”.
- In all incidents, agencies implemented a suicide protocol.

- 16 (88.9%) of staff had received suicide awareness and prevention training
- 15 (83.3%) of staff received the required annual refresher training for suicide awareness and prevention

Highlight:
- All agencies that reported a suicide attempt have a suicide protocol in place.

Opportunities for improvement:
- Continue to ensure all provider agencies have a suicide protocol, and Specialized Foster Care parents and staff are trained to implement it.
- Ensure all Specialized Foster Care parents and staff are trained on suicide awareness and prevention and participate in an annual refresher course
- 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

Specialized Foster Care providers were asked to track and report medication errors. To track medication errors, a definition was needed that clearly stated what constitutes an error. The following definition was used from the U.S. Pharmacopoeia:

> 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).

Using this definition, 29 Specialized Foster Care providers reported 806 medication errors over the 12-month reporting cycle. Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopeia, 2000). Providers are encouraged to review the definitions of a medication error to ensure that if an error is made, it is being properly documented. If errors are documented, a review of errors can result in program improvements to minimize future errors.

Specialized Foster Care homes reporting medication errors were:

Agape
Briarwood North
Briarwood South
Casa De Vida
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest
Etxea
Father Flanagan's Boys Town
Hand Up Homes
Maple Star South
Mountain Circle
My Home
Olive Crest
R House Community Treatment Center
Reagan Home
Rite of Passage
SAFY
Sankofa Group
Shaw Foster Homes

Impact Community Services
Kids First
Koinonia
Lippert Home
Maple Star North
St. Jude's Ranch for Children
Transformations Therapy
Trinity Youth Services
White Pine Boys Ranch

Table 3 shows the number of agencies reporting medication errors and the total number of errors for each reporting period.

Table 3

MEDICATION ERRORS		
Reporting Period	Number of agencies reporting	Number of medication errors
2010	29	806
2009	19	192
2008	15	192

The 806 incidents of medication errors reflect the following information.

Clinical and medication error information:

- The following 5 Axis I diagnoses account for 59% of all diagnostic categories reported under medication errors.
  - 184 (22.8%) Mood Disorder NOS
  - 94 (11.7%) Attention Deficit/Hyperactivity Disorder
  - 87 (10.8%) Posttraumatic Stress Disorder
  - 55 (6.8%) Bipolar Disorder NOS
  - 55 (6.8%) Reactive Attachment Disorder of Infancy or Early Childhood
- Type of medication error
  - 4 (.5%) prescribing errors
  - 378 (46.9%) omission errors
  - 53 (6.7%) wrong time errors
  - 3 (.4%) unauthorized drug administration errors
  - 57 (7.1%) improper dose errors
  - 1 (.1%) wrong dosage – form error
  - 4 (.5%) wrong drug preparation error
  - 205 (25.4%) compliance errors
  - 64 (7.9%) other medication errors
- 491 (60.9%) of the medication errors were with psychotropic medication, 315 (39.1%) were non-psychotropic medication errors.
- The number of medication errors was spread evenly over each day of the week. The average number of medication errors per day was 115, ranging from 128 to 103.
- The most common time of day for errors was 8:00 p.m. to 8:59 p.m., with 155 of the 806 errors occurring at this time (19.2%). The morning hours of 7:00 a.m. to 7:59 a.m. and 8:00 a.m. to 8:59 a.m. had 114 (14.1%) and 102 (12.7%) medication errors respectively.
- Medication error outcome
  - 536 (66.5%) were errors that reached the client but did not cause the client harm.

- 247 (30.6%) were errors that did not reach the client
- 19 (2.4%) error reached the client and required monitoring to confirm that it resulted in no harm to the client and/or required intervention to preclude harm.
- 3 (.4%) error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
- 1 (.1%) error occurred that that may have contributed to or results in permanent patient harm

Highlights:

- Specialized Foster Care providers have increased the reporting of medication errors by more than 400%. The 806 reported medication errors are moving toward a more valid and expected amount of medication errors in treatment homes. This increase in reporting medication errors may also reflect improved tracking and documenting of medication errors by the provider community.
- The most common type of medication error reported was omission errors 378 (46.9%).
- The diagnoses of children and adolescents reflect a severity of mental health disorder that is associated with prescribed medication.
- Medication errors were evenly distributed across all the days in the week. The time of day that medication errors occurred corresponds to the most common times for administering medications.

Opportunities for improvement:

- Specialized Foster Care managers or supervisors or the agency's Quality Assurance staff should confer with the staff member involved in the error and thoroughly document how the error occurred and how its recurrence can be prevented. Medication errors are sometimes the result of system problems rather than exclusively from staff performance or environmental factors; thus error reports should be encouraged and not used for punitive purposes but to achieve correction or change. (American Society of Hospital Pharmacists, 1993
- Clients report various reasons for refusing medications. A perceived lack of benefit or experiencing side effects is a reason given for refusal. Ensure staff/treatment parents are reporting compliance errors to the agency and that the agency is making proper notifications to treating physicians and case managers per the agency's policy. Child and Family Teams should address compliance issues to include discussing the youth's reasons for refusal, providing medication education and contracting with the youth if needed to maximize adherence to the prescribed medication regimen.
- Workplace distraction is a leading factor contributing to omission medication errors. 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 (ASHP, 1993).
- Ensure medication logs are periodically reviewed for quality assurance by someone other than the person who administered the medication.
- 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.

The PEU is available to provide technical assistance on any of these issues involving documenting, tracking and reporting medication errors, including providing clarification of medication error definitions. The PEU encourages providers to seek out technical assistance

whenever there is a need for clarity about medication administration and management and/or reporting data related to medication errors.

AWOLs – Child or adolescent absent for more than 24 hours

Specialized Foster Care providers were asked to track and report the number of children or adolescents absent for more than 24 hours (AWOLs). A total of 28 treatment home providers reported 160 incidents of child or adolescent runaway/absences of more than 24 hours. Providers reporting child or adolescent absences of more than 24 hours are listed below:

Agape
Bountiful Family Services
Briarwood North
Briarwood South
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest
Etxea Services
Father Flanagan's Boy Town
Impact Community Services
Kids First
Koinonia
London Family Services
Maple Star North
Maple Star South
Mountain Circle
My Home
Olive Crest
SAFY
Sankofa
Shaw Homes
St. Jude's Ranch for Children
Transformations Therapy
Trinity Youth Services
Unity Family Services
Unity Village
White Pine Boys Ranch

Table 4 shows the number of agencies reporting AWOLs and the total number of AWOLs for each reporting period.

Table 4

AWOL INCIDENTS		
Reporting Period	Number of agencies reporting	Number of AWOLs
2010	28	160
2009	28	166
2008	26	183

The 160 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 87 (54.4%) were male and 73 (45.6%) were female.
- Average age was 15.32, ranging from age 11 to 18 years.

- 82 (51.3%) were Caucasian, 47 (29.4%) were African-American, 6 (3.8%) were American Indian/Alaskan Native, 2 (1.3%) was Asian, 16 (10%) were of mixed race, and 7 (4.4%) were unknown.
- 29 (18.1%) were of Hispanic origin.

Clinical and AWOL information:

- The following 5 Axis I diagnoses account for 51.3% of all diagnostic categories reported under AWOLs.
  - 30 (18.8%) Posttraumatic Stress Disorder
  - 21 (13.1%) Oppositional Defiant Disorder
  - 17 (10.6%) Mood Disorder NOS
  - 14 (8.8%) Bipolar Disorder NOS
- Average length of absence was 5.13 days, with a range of 0 to 30 days.
- 135 (84.4%) of children and adolescents absent for more than 24 hours had a history of AWOL.
- Type of supervision at AWOL:
  - 55 (34.4%) left home during the day
  - 34 (21.3%) left from school or work
  - 34 (21.3%) left from treatment home at night – staff asleep
  - 25 (15.6%) left from treatment home at night – staff awake
  - 12 (7.5%) were other
- Behavior during AWOL
  - 17 (10.6%) substance abuse
  - 9 (5.6%) criminal activity
  - 9 (5.6%) assaultive to others
  - 4 (2.5%) sexual misconduct
  - 2 (1.3%) sexual activity
  - 4 (2.5%) sexual misconduct
  - 119 (74.4%) unknown
- Outcome
  - 48 (30%) returned to treatment home within 72 hours
  - 42 (26.3%) absent indefinitely – did not return to the home
  - 22 (13.8%) returned involuntarily within 72 hours
  - 16 (10%) returned through juvenile detention
  - 10 (6.3%) found with family
  - 3 (1.9%) placed in congregate care
  - 19 (11.9%) other

Highlights:

- 84.4% of the children and adolescents who ran away had a history of AWOL.
- 26.3% of children and adolescents who ran away were absent indefinitely and did not return to the Specialized Foster Care home.
- Of the 73 females that were AWOL 26 (35.6%) were African-American
- Table 5 compares the demographic information for AWOLs over the past three years. In 2010 more males were AWOL than in the previous years.

Table 5

Demographics	2010	2009	2008
Gender:			

Male	87 (54.4%)	76 (45.8%)	73 (39.9%)
Female	73 (45.6%)	90 (54.2%)	110 (60.1%)
Average Age	15.32	15.82	15.65
Race:			
Caucasian	82 (51.3%)	87 (52.4%)	94 (51.4%)
African-American	47 (29.4%)	44 (26.5%)	54 (29.5%)
American Indian/Alaskan Native	6 (3.8%)	8 (4.8%)	11 (6%)
Asian	2 (1.3%)	1 (.6%)	-
Native Hawaiian/Other Pacific Islander	-	1 (.6%)	2 (1.1%)
Mixed Race	16 (10%)	19 (11.4%)	18 (9.8%)
Unknown	7 (4.4%)	6 (3.6%)	4 (2.1%)
Hispanic	29 (18.1%)	23 (13.9%)	22 (12%)
Total	160	166	183

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).
- Focus on developing protocols regarding supervision in the home; over 50% of the AWOLs occurred when staff was awake and presumably available for supervision and intervention.
- Develop a protocol for children and adolescents who threaten to run away. The protocol would include the creation of a plan that provides appropriate alternatives to the runaway behavior.
- Focus on AWOL prevention at night. In the current reporting period, 50% of AWOLs occurred at night.
- Some youth runaways can be prevented through supporting family connections, normalcy, and personal safety (Courtney et al., 2005)
    - schedule regular visitation with family members
    - promote family ties such as placement with siblings
    - nurture other positive relationships in the youth's life, such as a mentor
    - offer activities and recreational opportunities that will interest youth
    - provide personal safety training
    - inform youth of risks of and alternatives to running
- 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

Specialized Foster Care providers were asked to track and report on restraint and manual guidance used on children and adolescents. A restraint is a method of restricting a child's freedom of movement for his/her safety or for the safety of others. The following 19 Specialized Foster Care providers reported a total of 351 incidents of restraints or manual guidance:

Briarwood-North
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest
Horizon Academy
Koinonia
Maple Star North
Maple Star South
Olive Crest Foster Family Agency
Reagan Home
Rite of Passage
SAFY
Sankofa
Shaw Foster Homes
St. Jude's Ranch for Children
Transformations Therapy
Unity Family Services
White Pine Boys Ranch

Table 6 shows the number of agencies reporting Restraints and Manual Guidance and the total number of Restraints and Manual Guidance for each reporting period.

Table 6

RESTRAINT AND MANUAL GUIDANCE		
Reporting Period	Number of agencies reporting	Number of Restraints
2010	19	351
2009	15	168
2008	16	154

Specialized Foster Care providers use a variety of restraint models. Below is a list of the different models that were reported.

- Aggression Replacement Training (ART)
- Conflict Prevention and Response Training (CPART or CPAR)
- Crisis Prevention Institute **(**CPI**)**
- David Mandt System
- Jireh Escort/Jireh Standing/Jireh Seated
- Therapeutic Crisis Intervention **(**TCI**)**

The 351 reports of the use of restraint and manual guidance reflect the following descriptive information:

- 257 (73.2 (%) were male and 94 (26.8%) were female.
- Average age was 10.93, ranging in age from 5 to 18 years.
- 151 (43%) were Black/African-American, 108 (30.8%) were Caucasian, 7 (2%) were American Indian/Alaskan Native, 2 (.6%) were Asian, 1 (.3%) was Native Hawaiian/Other Pacific Islander, 64 (18.2%) were of mixed race, and 18 (5.1%) were unknown.
- 69 (19.7%) were of Hispanic origin.

Clinical and restraint and manual guidance information:

- The most frequent diagnoses were
  - 116 (33.1%) Mood Disorder NOS
  - 55 (15.7%) Bipolar Disorder NOS,
  - 33 (9.4%) Posttraumatic Stress Disorder, and
  - 24 (6.9%) Reactive Attachment Disorder of Infancy or Early Childhood
  - 18 (5.1%) Depressive Disorder NOS
- 287 (81.8%) of children and adolescents had a restraint or manual used on them previously.
- Average length of restraints or manual guidance was 12.68 minutes, ranging from 1 to 75 minutes.
- Type of supervision prior to use of restraint or manual guidance
  - 144 (41%) one-on-one
  - 126 (35.9%) group of 2 or 3
  - 63 (17.9%) group – 4 or more
  - 18 (5.1%) line of sight
- Precipitating event
  - 174 (49.6%) physically assaultive toward another youth
  - 63 (17.9%) physically assaultive toward adult
  - 49 (14%) youth putting self at "risk" of harm
  - 36 (10.3%) youth running away
  - 17 (4.8%) property destruction
  - 5 (1.4%) other
- Injury report
  - 63 (17.9%) client injured
  - 12 (3.4%) staff injured
  - 3 (.9%%) peer injured
  - 273 (77.8%) no one injured
- 530 (99.7%) of staff received training on restraint and manual guidance while 346 (98.6%) received annual refresher training

Highlights:

- Almost 82% of children and adolescents placed in restraint or manual guidance had previous episodes of restraints or manual guidance.
- One-third of the children and adolescents who had restraints or manual guidance had a diagnosis of Mood Disorder NOS. The five most frequent diagnostic categories accounted for 70% of all diagnoses.
- Table 7 reflects the demographics for restraint and manual guidance over the past three years. In 2010, 43% of children and adolescents put into restraint or manual guidance were African-American. In 2009, 39.3% of children and adolescents put into restraint or manual guidance were African-American and 26% in 2008. Close attention to improvement strategies is needed to reduce restraints for African-American children and adolescents.

Table 7

Demographics	2010	2009	2008
Gender:			
Male	257 (73.2%)	94 (56%)	102 (66.2%)
Female	94 (26.8%)	74 (44%)	52 (33.8%)
Average Age	10.93	10.88	12.59

Race:			
Caucasian	108 (30.8%)	84 (50%)	103 (66.9%)
African-American	151 (43%)	66 (39.3%)	40 (26%)
American Indian/Alaskan Native	7 (2%)	6 (3.6%)	1 (.6%)
Asian	2 (.6%)	-	-
Native Hawaiian/Other Pacific Islander	1 (.3%)	1 (.6%)	-
Mixed Race	64 (18.2%)	11 (6.5%)	10 (6.5%)
Unknown	18 (5.1%)	-	-
Hispanic	69 (19.7%)	16 (9.5%)	6 (3.9%)
Total	351	168	154

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 safety hold history of each child and adolescent as early in the pre-placement process as possible. (GAO, September 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)
- 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)
- Information or data obtained during the post analysis event and debriefing processes should be used as part of the provider's and/or facility's quality assurance and performance improvement activities and should assist the program in establishing performance measurements. The purpose is:
    1. To learn whether restraint and seclusion are being used as emergency interventions;
    2. To identify rates of restraints broken down by unit and youth characteristics;
    3. To review trends in restraint use – are your program's rates increasing or decreasing?
    4. To compare rates and trends between your program and similar "benchmark" programs.
    5. To identify opportunities for improving the rate and safety of use; and,
    6. To identify staff training needs. (Iowa Department of HHS, 2006)
- Focus on collecting and aggregating these specific data on each restraint and seclusion episode on a regularly scheduled basis in order to identify frequencies, trends, and the like data analysis for continuous quality and program improvement initiatives. (Haimowitz, Urff, and Huckshorn, 2006)
- 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 treatment home parents and staff receives ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Departure Conditions

Specialized Foster Care providers were asked to track and report departure conditions on children and adolescents discharged from services for calendar year 2010. 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 Specialized Foster Care home within the same agency. Therefore, providers may have reported more than one admission and departure for the same child throughout the reporting period. The following list of 42 Specialized Foster Care providers reported a total of 940 departures.

Agape
Apple Grove
Bountiful Family Services
Briarwood North
Briarwood South
Casa De Vida
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest
Etxea Services
Father Flanagan's Boys Town
Golla Home
Hand Up Homes
Hope Healthcare Services
Horizon Academy
Impact Community Services
Kathy House
Kids First
Koinonia
Lippert Home
London Family Services
Maple Star North
Maple Star Rural
Maple Star South
Mile High Foster Family Agency
Mountain Circle Family Services
My Home
New Beginnings
Olive Crest Foster Family Agency
Reagan Home
Rite of Passage
SAFY
Sankofa
Shaw Foster Homes
St. Jude's Ranch for Children
Transformations Therapy
Trinity Youth Services
Unity Family Services
Unity Village
Visions Treatment Home
White Pine Boys Ranch

Table 8 shows the number of agencies reporting Departures and the total number of Departures for each reporting period.

Table 8

DEPARTURES		
Reporting Period	Number of agencies reporting	Number of Departures
2010	42	940
2009	39	907
Sept – Dec 2008	30	351

The 940 departures reflect the following descriptive information.

- 580 (61.7%) were male and 360 (38.3%) were female.
- Average age at departure was 13.84, ranging from less than 1 year of age to 21 years.
- 533 (56.7%) were Caucasian, 260 (27.7%) were Black/African-American, 35 (3.7%) were American Indian/Alaskan Native, 2 (.2%) were Asian, 6 (.6%) were Native Hawaiian/Other Pacific Islander, 74 (7.9%) were of mixed race, and 30 (3.2%) were unknown.
- 166 (17.7%) were of Hispanic origin.
- Custody Status
  - 491 (52.2%) were in child welfare custody
  - 226 (24%) were in parental custody and on probation
  - 120 (12.8%) were in custody of youth parole
  - 92 (9.8%) were in parental custody
  - 11 (1.2%) were in Tribal custody
- 908 (96.6%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 292.74 days with a range of 1 to 4402 days (or 12.06 years); the median length of stay is 185.50 days.

Clinical and departure information:

- The most frequent diagnoses at admission were:
  - 171 (18.3%) Posttraumatic Stress Disorder
  - 57 (6.1%) Mood Disorder NOS
  - 54 (5.8%) Depressive Disorder NOS
  - 54 (5.8%) Bipolar Disorder NOS
  - 48 (5.1%) Conduct Disorder
  - 46 (4.9%) Attention Deficit/Hyperactivity Disorder
- The most frequent diagnoses at discharge were:
  - 173 (18.5%) Posttraumatic Stress Disorder
  - 64 (6.9%) Mood Disorder NOS
  - 55 (5.9%) Attention Deficit/Hyperactivity Disorder
  - 53 (5.7%) Bipolar Disorder NOS
  - 49 (5.2%) Conduct Disorder
  - 47 (5%) Depressive Disorder NOS
- The average CASII composite score at admission was 22.79.
- The average CASII composite score at departure was 21.90.
- Reason for departure
  - 287 (30.5%) were reunified with biological family
  - 58 (6.2%) were adopted
  - 29 (3.1%) were placed with a relative
  - 22 (2.3%) were placed in independent living
  - 30 (3.2%) were emancipated or reached age 18 (aged out)
  - 82 (8.7%) were placed in a less restrictive setting (e.g. family foster care)
  - 175 (18.6%) were placed in a more restrictive environment (e.g. RTC, acute psychiatric hospital, juvenile detention, etc.)
  - 87 (9.3%) were AWOL (runaway) from placement
  - 75 (8%) were admitted to a new specialized foster care home, different agency
  - 31 (3.3%) were removed by placing agency
  - 26 (2.8%) were admitted to another home within the same agency
  - 38 (4%) were other responses

- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.6, which equals the restrictiveness score of a regular foster home.
  - 20 (2.1%) independent living by self
  - 11 (1.2%) independent living with friend
  - 54 (5.7%) home of parents for an 18-year-old
  - 284 (30.2%) home of parents for a child
  - 3 (.3%) school dormitory
  - 64 (6.8%) home of relative
  - 22 (2.3%) adoptive home
  - 6 (.6%) home of a family friend
  - 21 (2.2%) supervised independent living
  - 38 (4%) regular foster care
  - 2 (.2%) individual home emergency shelter
  - 120 (12.8%) family-based treatment home
  - 61 (6.5%) group treatment home
  - 1 (.1%) residential job corps center
  - 21 (2.2%) group emergency shelter
  - 61 (6.5%) residential treatment center
  - 5 (.5%) wilderness camp (24-hour, year round)
  - 11 (1.2%) medical hospital
  - 5 (.5%) drug-alcohol rehabilitation center
  - 10 (1.1%) intensive treatment center
  - 46 (4.9%) youth correction center
  - 19 (2%) county detention center
  - 15 (1.6%) state and private mental hospital
  - 20 (2.1%) jail
  - 20 (2.1%) missing information
- 379 (40.3%) completed treatment.
- In the provider's opinion was the transition plan appropriate?
  - 806 (85.7%) yes
- Did the provider agree that the discharge was appropriate?
  - 804 (85.5%) yes
- Who recommended departure
  - 85 (9%) provider agency
  - 88 (9.4%) child welfare case manager
  - 43 (4.6%) parole/probation officer
  - 29 (3.1%) parent
  - 2 (.2%) relative guardian
  - 1 (.1%) CASA
  - 46 (4.9%) judge or hearing master
  - 11 (1.2%) child's mental health practitioner
  - 525 (55.9%) child and family team
  - 85 (9%) child went AWOL
  - 20 (2.1%) other
  - 5 (.5%) missing information

Highlights:

- Using the ROLES, 45.1% of children and adolescents achieved or returned to a permanent placement upon discharge (i.e. reunified with family, adopted, or relative placement).

- The ROLES score of 10.6 for all discharged children and adolescents is equal to the restrictiveness of a regular foster home. The ROLES score for family-based treatment homes is 13 and for group homes is 14. This may indicate that, upon discharge from a family-based or group treatment home, children tend to be placed in a less restrictive environment.
- Upon departure, 50.9 % of children and adolescents were going to a less restrictive setting to live (e.g.reunified with family, adopted, relative placement, independent living or less restrictive setting such as family foster care).
- 55.9% of discharges from treatment homes were recommended by Child and Family Teams. In 2009, 48.4% of the discharges were recommended by the Child and Family Team and in 2008, 39.3% of the discharges were recommended by the Child and Family Team.
- Of the 379 children and adolescents who completed treatment, 308 (81.3%) of the discharges were recommended by the Child and Family Team. In 2009, 290 (77.3%) of the discharges were recommended by the CFT and in 2008, only 138 (39.3%) of the discharges were recommended by the CFT.
- There is a high degree of agreement by the providers that the transition plan was appropriate (85.7%) and that the discharge was appropriate (85.5%).

Opportunities for improvement:

- Table 9 below shows treatment completion status by custody type.

Table 9

TREATMENT COMPLETION STATUS

Custody Type	Yes	No	Missing
Child Welfare	149 (30.3%)	342 (69.7%)	-
Parental on probation	142 (62.8%)	83 (36.7%)	1 (.4%)
Youth Parole	33 (27.5%)	87 (72.5%)	-
Tribal	5 (45.5%)	6 (54.5%)	-
Parental	50 (54.3%)	40 (43.5%)	2 (2.2%)
Total	379 (40.3%)	558 (59.4%)	3 (.3%)

- Upon departure, 40.3% of children and adolescents had completed services in the treatment home. In 2009, 42% of children and adolescents completed treatment. In 2008, 39.3% of children and adolescents had completed treatment. Children and adolescents are in Specialized Foster Care to receive treatment for their mental health needs. When treatment is not completed, one would assume that the client has not achieved the goals and objectives that would allow him/her to successfully function in a less structured, more normal environment. Although many premature departures may be due to escalation of the child or adolescents' mental health or behavioral issues, public and provider agencies will want to examine any internal program and/or systemic reasons for the lack of treatment completion.

Children and Adolescents in Child Welfare Custody

Of the 940 departures reported in 2010, 491 or 52.2% of the children and adolescents were in the custody of a child welfare agency. Thirty-seven provider agencies reported departure conditions for child welfare custody children. The 491 child welfare custody departures reflect the following descriptive information.

- 253 (51.5%) were male and 238 (48.5%) were female.

- Average age at departure was 12.67, ranging from less than 1 year of age to 21 years.
- 257 (52.3%) were Caucasian, 170 (34.6%) were Black/African-American, 10 (2%) were American Indian/Alaskan Native, 1 (.2%) were Asian, 3 (.6%) were Native Hawaiian/Other Pacific Islander, 36 (7.3%) were of mixed race, and 14 (2.9%) were unknown.
- 78 (15.9%) were of Hispanic origin.
- 489 (99.6%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 333.34 days with a range of 1 to 4402 days (or 12.06 years); the median length of stay is 188 days.

Clinical and departure information:

- The most frequent diagnoses at admission were:
  - 118 (24.3%) Posttraumatic Stress Disorder
  - 30 (6.2%) Bipolar Disorder NOS
  - 27 (5.6%) Attention Deficit/Hyperactivity Disorder
  - 24 (4.9%) Mood Disorder NOS
  - 24 (4.9%) Depressive Disorder NOS
  - 24 (4.9%) Oppositional Defiant Disorder
- The most frequent diagnoses at discharge were:
  - 119 (24.5%) Posttraumatic Stress Disorder
  - 34 (7%) Attention Deficit/Hyperactivity Disorder
  - 29 (6%) Mood Disorder NOS
  - 28 (5.8%) Bipolar Disorder NOS
  - 26 (5.3%) Oppositional Defiant Disorder
- The average CASII composite score at admission was 22.32.
- The average CASII composite score at departure was 21.82.
- Reason for departure
  - 109 (22.2%) were reunified with biological family
  - 54 (11%) were adopted
  - 18 (3.7%) were placed with a relative
  - 12 (2.4%) were placed in independent living
  - 16 (3.3%) were emancipated or reached age 18 (aged out)
  - 42 (8.6%) were placed in a less restrictive setting (e.g. family foster care)
  - 67 (13.6%) were placed in a more restrictive environment (e.g. RTC, acute psychiatric hospital, juvenile detention, etc.)
  - 54 (11%) were AWOL (runaway) from placement
  - 60 (12.2%) were admitted to a new specialized foster care home, different agency
  - 15 (3.1%) were removed by placing agency
  - 19 (3.9%) were admitted to another home within the same agency
  - 25 (5.1%) were other responses
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.10, which equals the restrictiveness score of a regular foster home.
  - 14 (2.9%) independent living by self
  - 4 (.8%) independent living with friend
  - 13 (2.6%) home of natural parents for an 18-year-old
  - 124 (25.3%) home of natural parents for a child
  - 2 (.4%) school dormitory
  - 34 (6.9%) home of relative
  - 21 (4.3%) adoptive home
  - 3 (.6%) home of a family friend

    - 11 (2.2%) supervised independent living
    - 31 (6.3%) regular foster care
    - 2 (.4%) individual home emergency shelter
    - 97 (19.8%) family-based treatment home
    - 37 (7.5%) group treatment home
    - 18 (3.7%) group emergency shelter
    - 29 (5.9%) residential treatment center
    - 8 (1.6%) medical hospital
    - 2 (.4%) drug-alcohol rehabilitation center
    - 4 (.8%) intensive treatment center
    - 5 (1%) youth correction center
    - 7 (1.4%) county detention center
    - 13 (2.6%) state and private mental hospital
    - 3 (.6%) jail
    - 9 (1.8%) missing information
- 149 (30.3%) completed treatment.
- In the provider's opinion was the transition plan appropriate?
    - 413 (84.1%) yes
- Did the provider agree that the discharge was appropriate?
    - 408 (83.1%) yes
- Who recommended departure
    - 35 (7.1%) provider agency
    - 81 (16.5%) child welfare case manager
    - 3 (.6%) parole/probation officer
    - 5 (1%) parent
    - 2 (.4%) relative guardian
    - 1 (.2%) CASA
    - 28 (5.7%) judge or hearing master
    - 7 (1.4%) child's mental health practitioner
    - 260 (53%) child and family team
    - 51 (10.4%) child went AWOL
    - 15 (3.1%) other
    - 3 (.6%) missing information

Highlights:

- Using the ROLES, 39.1% of children and adolescents achieved or returned to a permanent placement upon discharge (i.e. reunified with family, adopted, or relative placement).
- The ROLES score of 10.10 for all discharged children and adolescents in child welfare custody is equal to the restrictiveness of a regular foster home.
- 53% of discharges from treatment homes were recommended by Child and Family Teams.
- Of the 149 children and adolescents in child welfare custody that completed treatment 115 (77.2%) were discharged as recommended by their Child and Family Team.
- Upon departure, 47.9% of children and adolescents were going to a less restrictive setting to live (i.e. reunified with family, adopted, relative placement, independent living or less restrictive setting such as family foster care).

SUMMARY

This report outlines opportunities for improvement for provider agencies to address. One of the primary opportunities for improvement will be to continue to report risk measures and departure conditions in an accurate and timely manner.

Based on aggregate data collected, areas of improvement can be addressed. Some of those recommended areas are:

- Provider agencies will have medication error policies that target positive actions steps when an error occurs and implement these policies.
- Provider agencies will maintain medication logs in children's Specialized Foster Care home agency records and implement medication log reviews by someone who does not administer the medication.
- Provider agencies will implement policies or protocols that address AWOL behaviors, including a section on the prevention of AWOLs when children and adolescents threaten to runaway and a section on crisis planning.
- Provider agencies will be trained in a nationally recognized model of restraint and manual guidance that emphasizes de-escalation techniques. Providers must be prepared in the event that an intervention becomes necessary.
- Provider agencies and referring agencies will want to address the reason(s) for the low percentage rate of successful treatment completion. Areas for improvement may include:
    - The need for Child and Family Team decision-making around client discharge and other treatment issues
    - Comprehensive, individualized treatment plans that are reviewed and revised, as needed, every 90 days
    - Clarity with regard to the agency's discharge criteria and how the provider measures whether a child or adolescent's progress has met the criteria for discharge to a less restrictive environment
    - Appropriate initial placement and admission assessments and the criteria by which a provider agency accepts a child or adolescent into its program

In partnership with the Provider Support Team, the PEU will prioritize areas for program improvement and develop an action plan for implementation.

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PARTICIPATING PROVIDER LIST

	PROVIDER NAME	# of Provider Reporting Periods	# of Provider Reports Submitted	% of Reports Completed
1.	Agape	12	12	100%
2.	Apple Grove	12	12	100%
3.	Bountiful Family Services - NEW	2	2	100%
4.	Briarwood - North	12	12	100%
5.	Briarwood - South	12	12	100%
6.	Casa De Vida	12	12	100%
7.	DCFS Adolescent Treatment Center	12	12	100%
8.	DCFS Family Learning Homes	12	12	100%
9.	DCFS Oasis	12	12	100%
10.	Eagle Quest of Nevada	12	12	100%
11.	Etxea Services	12	12	100%
12.	Father Flanagan's Boys Town	12	12	100%
13.	Golla Home	12	12	100%
14.	Hand Up Homes	12	12	100%
15.	Hope Healthcare Services, Inc.	12	12	100%
16.	Horizon Academy	12	12	100%
17.	Impact Community Services	12	12	100%
18.	Kathy's House–TEMPORARILY CLOSED	12	9	75%
19.	Kids First	12	12	100%
20.	Koinonia	12	12	100%
21.	Lippert Home - CLOSED	12	9	NA
22.	London Family & Children's Services	12	12	100%
23.	Maple Star Nevada - North	12	12	100%
24.	Maple Star Nevada – Rural	12	12	100%
25.	Maple Star Nevada – South	12	12	100%
26.	Mile High Foster Family Agency	12	12	100%
27.	Mountain Circle Family Services	12	12	100%
28.	My Home	12	12	100%
29.	New Beginnings	12	12	100%
30.	Olive Crest Foster Family Agency	12	12	100%
31.	R House Community Treatment Center	12	12	100%
32.	Reagan Home	12	12	100%
33.	Rite of Passage	12	12	100%
34.	SAFY	12	12	100%
35.	Sankofa Group	12	12	100%
36.	Shaw Foster Homes, Inc. - CLOSED	12	3	NA
37.	St. Jude's Ranch for Children	12	12	100%
38.	Transformations Therapy - NEW	7	7	100%
39.	Trinity Youth Services	12	12	100%
40.	Unity Family Services	12	12	100%
41.	Unity Village	12	12	100%
42.	Visions Treatment Home - CLOSED	12	1	NA
43.	Impact Community Services	12	12	100%