

**Division of Child and Family Services
Risk Measures and Departure Conditions
2011 Aggregate Report**

INTRODUCTION

In partnership with the Provider Support Team, the Planning and Evaluation Unit (PEU) of the Division of Child and Family Services (DCFS) collects identified risk measures and departure conditions from Specialized Foster Care providers for quality improvement purposes. By collecting and analyzing all risk measure data, providers can review where the risks are occurring, determine opportunities for improvement, and implement corrective action where needed.

In September 2009, most Specialized Foster Care providers entered into contracts with DCFS and/or Clark County Department of Family Services and/or Washoe County Department of Social Services. The contracts require providers to participate in performance and quality improvement activities through DCFS's Planning and Evaluation Unit.

A few new Specialized Foster Care provider agencies opened during this 2011 reporting year and entered into contracts, while some provider agencies closed. When new agencies began to serve children, they were added to the list of participating agencies and asked to participate in this initiative. Agencies that closed but had participated up to the month they closed were kept on the list. A list of Specialized Foster Care agencies and their level of participation can be found in Attachment A.

This 2011 report is the fourth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2011 through December 2011. The overwhelming majority of Specialized Foster Care providers statewide have responded by turning in complete data sets.

During this reporting period a risk measure was added for incidents of child on child physical incidents and child on child sexual incidents. Public child welfare partners requested this data be collected and analyzed in order to further ensure child safety in out of home placement. All of the risk measure and departure conditions data is self-reported by each Specialized Foster Care provider, which presents some risk that a true count of incidences goes unreported or under-reported. Although data analysis limitations continue as a result of provider self-reporting, beginning in late 2009 and throughout 2011, 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.
- In 2011, policy implementation reviews with providers were conducted. The reviews included Structured Therapeutic Environment, Medication Management and Administration and Crisis Triage. The reviews included face-to-face meetings between PEU and providers to review 2010 risk measures and departure conditions reports in order to provide technical assistance in regard to accurate reporting of data and review recommendations for quality improvement.

The focus of the policy implementation reviews was not only to determine whether providers were implementing policies as required in the State of Nevada DCFS contract, the Washoe County Department of Social Services contract, and the Clark County Department of Family Services contract but also on improving practice standards as well as quality improvement activities such as data collection, data analysis and the further development of each provider's internal quality assurance efforts in order to better ensure complete and accurate data reporting statewide. In many instances, the PEU determined providers were tracking risk measure data accurately and they were reporting the data as required to the PEU. In those instances in which providers were not tracking and reporting data accurately, the policy implementation review further assisted the PEU and providers in addressing these issues in order to minimize data collection and analysis limitations.

Data analysis limitations do continue, however the information provided herein is useful and can be used for program improvement initiatives to better serve Nevada's children and families.

RISK MEASURES AND DEPARTURE CONDITONS

Five 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 five risk areas were:

- Suicide
- Medication errors
- AWOL (runaways)
- Restraint and Manual Guidance
- Physical and/or Sexual Incidents (child on child)

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

Collecting departure conditions data for analysis is 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 five risk areas and departure conditions based on data collected from January 2011 through December 2011.

Forty-one 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. The average monthly bed capacity and the number of youth served for the 2009, 2010, and 2011 reported 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	
2011	35.14	2011	22.82
	Range: 1 to 228		Range: 0 to 145
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 5 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:

- DCFS Family Learning Homes
- Etxea Services
- London Family and Children’s Services
- SAFY
- Trinity Youth Services

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

Table 2

SUICIDE INCIDENTS		
Reporting Period	Number of agencies reporting	Attempted Suicides
2011	5	13
2010	11	18
2009	8	16
2008	6	14

There were a total of 13 reports of suicide attempts with the following descriptive information:

- 9 (69.23%) were female and 4 (30.77%) were male
- Average age was 13.54, ranging from age 9 to 17 years
- Race
 - 10 (76.92%) were Caucasian
 - 1 (7.69%) was Asian
 - 1 (7.69%) was African-American
 - 1 (7.69%) was of mixed race
- 3 (23.08%) were of Hispanic origin
- Custody Status
 - 10 (76.92%) were in Child Welfare Custody
 - 3 (23.08%) were in Parental Custody and on Probation

Clinical and suicide attempt information:

- The 2 most frequent diagnoses were Posttraumatic Stress Disorder and Bipolar I Disorder
- Suicide means reported were 3 incidents of attempted hanging, 2 incidents of attempted stabbing, one with a knife and the other with a pen, 2 incidents where the child attempted to jump from a moving vehicle, 2 incidents where the child banged his head, 1 incident of cutting, 1 incident of overdose, and 2 incidents where there was no description or the means were unknown because it occurred at school
- 8 (61.54%) children were reported as having previous suicide attempts
- Following the suicide attempts, 6 (46.15%) were admitted to a psychiatric hospital, 1 (7.69%) resulted in emergency hospital medical procedures, and 6 (46.15%) were categorized as “other”
- In all incidents agencies implemented a suicide protocol
- In all incidents staff had received suicide awareness and prevention training
- In all incidents staff received the required annual refresher training for suicide awareness and prevention

Highlights:

- All agencies that reported a suicide attempt have a suicide protocol in place.
- All agencies that reported a suicide attempt had staff receive suicide awareness and prevention training.
- All agencies that reported a suicide attempt had staff complete an annual refresher for suicide awareness and prevention.

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. Pharmacopoeia, 1997).

Using this definition, 32 Specialized Foster Care providers reported 1,738 medication errors over the 12-month reporting cycle. Medication errors may occur at the point of prescribing, documenting, dispensing, administering, and monitoring (U.S. Pharmacopoeia, 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:

A Brighter Day	Koinonia
Apple Grove	London Family and Children’s Services
Bountiful Family Services	Majestic Community Services
Briarwood North	Maple Star-North
Briarwood South	Maple Star-Rural
Daybreak Equestrian Center	Maple Star-South
DCFS Adolescent Treatment Center	My Home
DCFS Family Learning Homes	Nova
DCFS Oasis	Olive Crest Foster Family Agency
Eagle Quest	R House Community Treatment Center
Etxea	Reagan Home
Father Flanagan’s Boys Town	Rite of Passage
Golla Homes	SAFY
Hand Up Homes	Sankofa
Hope Healthcare Services	St. Jude’s Ranch for Children
Kids First	Transformations Therapy

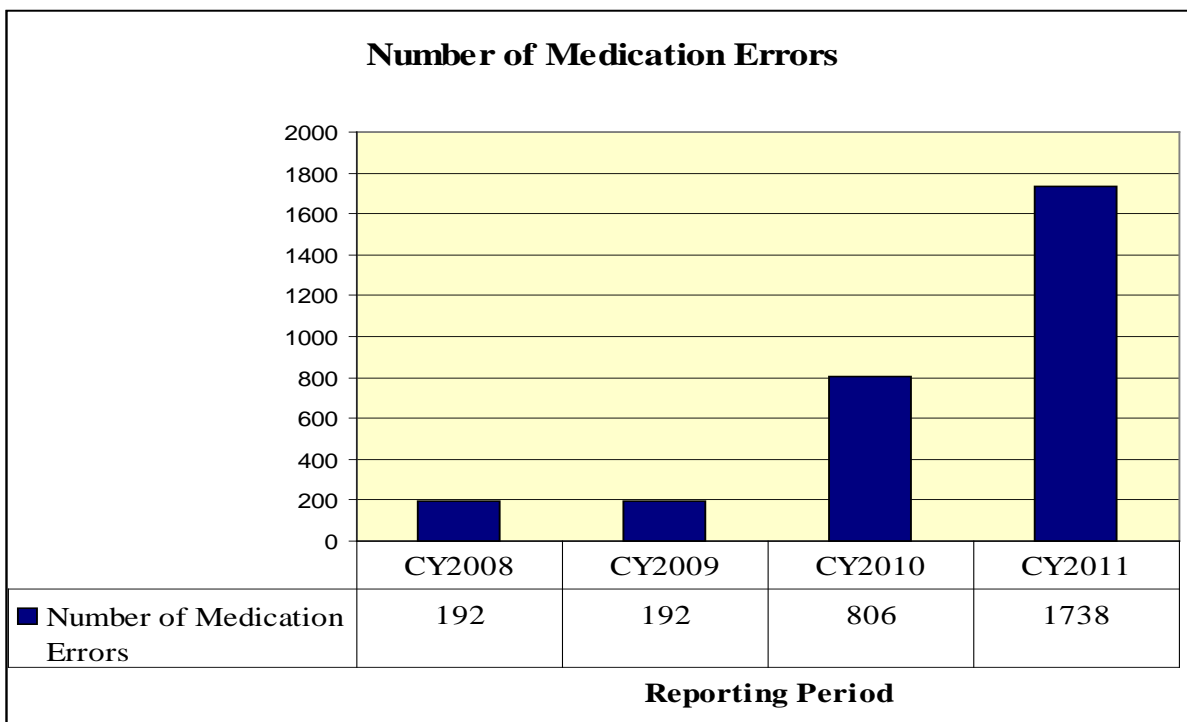
Table 3 shows the number of agencies reporting medication errors for each reporting period.

Table 3

MEDICATION ERRORS	
Reporting Period	Number of agencies reporting
2011	32
2010	29
2009	19
2008	15

Graph 1 shows the total number of errors for each reporting period.

Graph 1



There has been a sharp increase in medication error reporting starting in calendar year 2010 and again in calendar year 2011. This may indicate improvement in identifying and reporting medication errors.

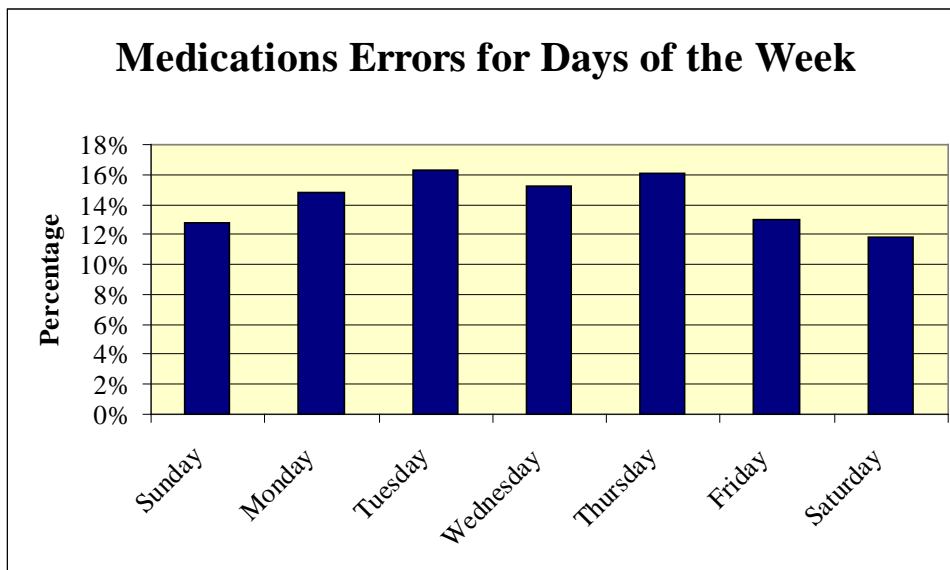
The 1738 incidents of medication errors reflect the following information.

Clinical and medication error information:

- Custody Status
 - 1001 (57.59%) Child welfare
 - 427 (24.57%) Parent and on probation
 - 186 (10.7%) DCFS youth parole
 - 105 (6.04%) Parent and not on probation
 - 19 (1.09%) Tribal

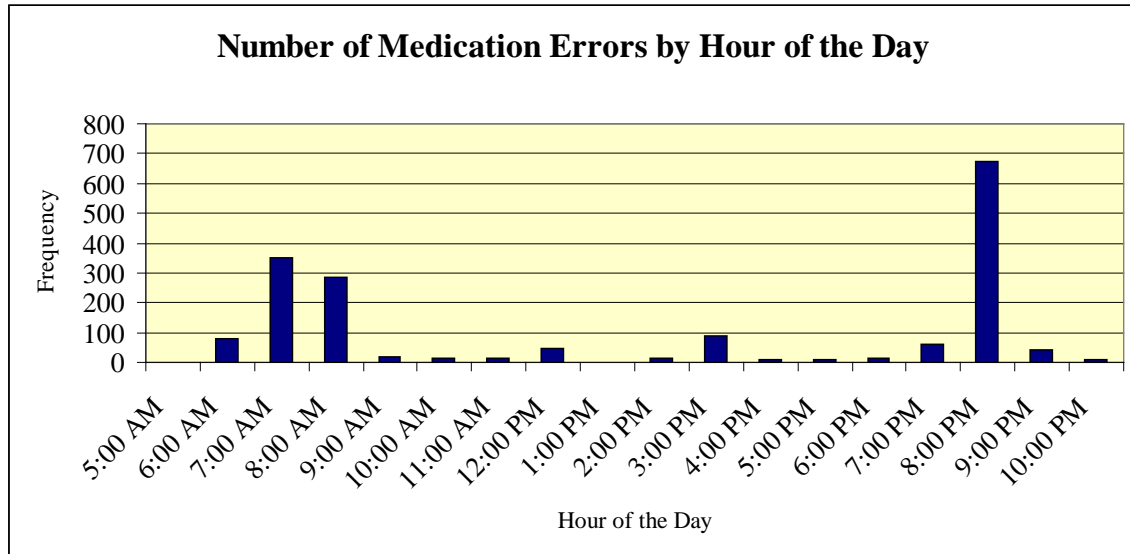
- The following 4 Axis I diagnoses account for 37.5% of all diagnostic categories reported under medication errors
 - 248 (14.27%) Bipolar Disorder NOS
 - 140 (8.06%) Posttraumatic Stress Disorder
 - 139 (8.00%) Paraphilia NOS
 - 124 (7.13%) Mood Disorder NOS
- Type of medication error
 - 38 (2.2%) prescribing errors
 - 521 (30.0%) omission errors
 - 49 (2.8%) wrong time errors
 - 2 (0.1%) unauthorized drug administration errors
 - 26 (1.5%) improper dose errors
 - 25 (1.4%) wrong drug – preparation error
 - 238 (13.7%) wrong administration technique error
 - 135 (7.8%) compliance errors
 - 704 (40.5%) other medication errors including documentation errors 271 (15.6%) and delays in prior authorization approvals 184 (10.6%)
- 1713 (98.56%) of the medication errors were with psychotropic medication, 25 (1.44%) were non-psychotropic medication errors
- The graph below shows the percentage of medications for the days of the week. The weekend days tended to have less medication errors possibly due to children being on pass

Graph 2



- The most common time of day for errors was the 8:00 p.m. hour, with 676 (38.9%) of the errors occurring at this time. The morning hours of 7:00 a.m. and 8:00 a.m. had 352 (20.3%) and 287 (16.5%) medication errors respectively. More than 75% of medication errors occurred during these three hours.

Graph 3



- Medication error outcome
 - 1370 (78.83%) were errors that reached the client but did not cause the client harm
 - 352 (20.25%) were errors that did not reach the client
 - 12 (0.69%) were errors that reached the client and required monitoring to confirm that it resulted in no harm to the client and/or required intervention to preclude harm
 - 4 (0.23%) errors occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
- 1699 (99.01%) of staff received medication administration training
- 1545 (90.03%) of staff received annual refresher training on medication management

Highlights:

- Specialized Foster Care providers have increased their reporting of medication errors. The 1738 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.
- 78% of providers are tracking, documenting, and submitting medication errors.
- The diagnoses of children reflect a severity of mental health disorder that is associated with prescribed medication.
- Nearly all staff are receiving the required training for medication administration and management.

Opportunities for improvement:

- The hour of day that most medication errors occurred corresponds to the most common times for administering medications. Specialized Foster Care parents and staff can focus their attention on these hours when there are high numbers of children receiving medications.
- 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).

- 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.

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 27 treatment home providers reported 181 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:

- | | |
|----------------------------------|----------------------------------|
| A Brighter Day | London Family Services |
| Apple Grove | Maple Star North |
| Bountiful Family Services | Maple Star South |
| Briarwood North | Mile High Foster Family Agency |
| Briarwood South | Mountain Circle Family Services |
| DCFS Adolescent Treatment Center | My Home |
| DCFS Family Learning Homes | New Beginnings |
| DCFS Oasis | Olive Crest Foster Family Agency |
| Eagle Quest | Right of Passage |
| Etxea Services | SAFY |
| Father Flanagan’s Boy Town | Sankofa |
| JC Family Services | Transformations Therapy |
| Kids First | Unity Village |
| Koinonia | |

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
2011	27	181
2010	28	160
2009	28	166
2008	26	183

The 181 incidents of child and adolescent absence of more than 24 hours reflect the following descriptive information:

- 108 (59.67%) were male and 73 (40.33%) were female
- Average age was 15.78, ranging from age 9 to 19 years
- Race:
 - 104 (57.46%) were Caucasian
 - 52 (28.73%) were African-American
 - 12 (6.63%) were of mixed race
 - 5 (2.76%) were American Indian/Alaskan Native
 - 4 (2.21%) were unknown
 - 2 (1.1%) was Asian
 - 2 (1.1%) were Native Hawaiian
- 28 (15.47%) were of Hispanic origin
- Custody Status:
 - 106 (58.56%) child welfare
 - 39 (21.55%) DCFS youth parole
 - 23 (12.71%) parent and on probation
 - 8 (4.42%) parent and not on probation
 - 5 (2.76%) Tribal

Clinical and AWOL information:

- The following 5 Axis I diagnoses account for 45.86% of all diagnostic categories reported under AWOLs:
 - 34 (18.89%) Posttraumatic Stress Disorder
 - 17 (9.44%) Mood Disorder NOS
 - 13 (7.22%) Oppositional Defiant Disorder
 - 10 (5.56%) Attention Deficit Hyperactivity Disorder
 - 9 (5.0%) Conduct Disorder Adolescent-Onset Type
- Average length of absence was 5.26 days, with a range of 1 to 30 days
- 150 (82.87%) of children and adolescents absent for more than 24 hours had a history of AWOL
- Type of supervision at AWOL:
 - 71 (39.23%) left home during the day
 - 42 (23.20%) left from school or work
 - 39 (21.55%) left from treatment home at night – staff awake
 - 14 (7.73%) left from treatment home at night – staff asleep
 - 13 (7.18%) were other
 - 2 (1.10 %) missing data
- Behavior during AWOL
 - 142 (78.45%) unknown
 - 10 (5.52%) substance abuse
 - 8 (4.42%) assaultive to others
 - 6 (3.31%) sexual activity
 - 3 (1.66%) criminal activity
 - 3 (1.66%) sexual misconduct
 - 2 (1.10%) victim
 - 7 (3.87%) other
- Outcome
 - 67 (37.02%) absent indefinitely – did not return to the home
 - 23 (12.71%) returned voluntarily to treatment home within 72 hours

- 22 (12.15%) returned through juvenile detention or law enforcement
- 13 (7.18%) placed in congregate care
- 8 (4.42%) found with family and returned to Specialized Foster Care home
- 4 (2.21%) found with family and stayed with family
- 4 (2.21%) returned involuntarily within 72 hours
- 40 (22.10%) other
- The graph below shows the percentage of AWOLs for the days of the week

Graph 4

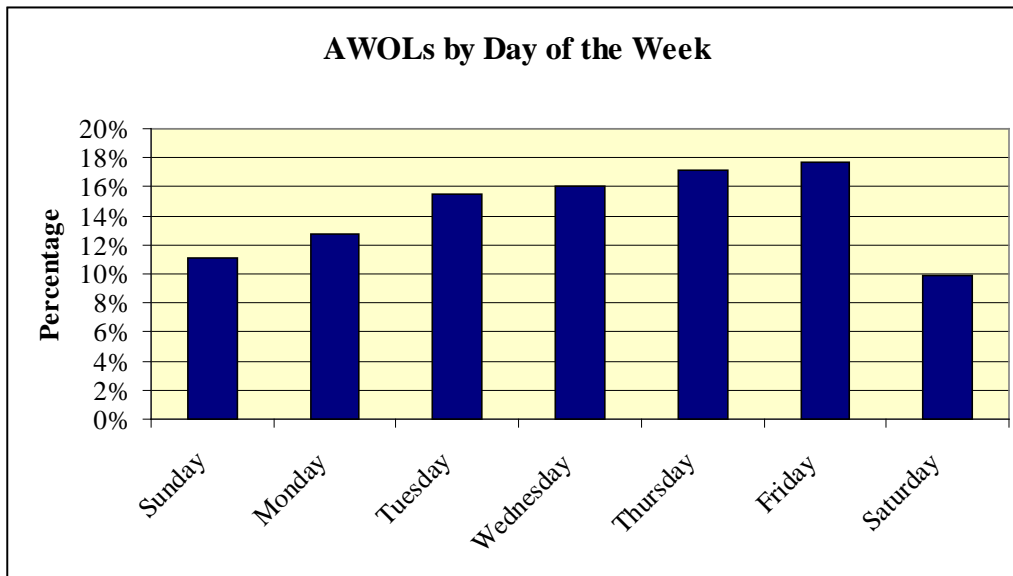


Table 5 compares the demographic information for AWOLs over the past four years.

Table 5

Demographics	2011	2010	2009	2008
<u>Gender:</u>				
Male	108 (59.7%)	87 (54.4%)	76 (45.8%)	73 (39.9%)
Female	73 (40.3%)	73 (45.6%)	90 (54.2%)	110 (60.1%)
<u>Average Age</u>	15.78	15.32	15.82	15.65
<u>Race:</u>				
Caucasian	104 (57.5%)	82 (51.3%)	87 (52.4%)	94 (51.4%)
African-American	52 (28.7%)	47 (29.4%)	44 (26.5%)	54 (29.5%)
American Indian/Alaskan Native	5 (2.8%)	6 (3.8%)	8 (4.8%)	11 (6%)
Asian	2 (1.1%)	2 (1.3%)	1 (.6%)	-
Native Hawaiian/Other Pacific Islander	2 (1.1%)	-	1 (.6%)	2 (1.1%)
Mixed Race	12 (6.6%)	16 (10%)	19 (11.4%)	18 (9.8%)
Unknown	4 (2.2%)	7 (4.4%)	6 (3.6%)	4 (2.1%)
<u>Hispanic</u>	28 (15.5%)	29 (18.1%)	23 (13.9%)	22 (12.0%)
<u>Total</u>	181	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).
- Nearly 83% of children and adolescents absent for more than 24 hours had a history of AWOL. 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.
- 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 20 Specialized Foster Care providers reported a total of 232 incidents of restraints or manual guidance:

Briarwood-North	Maple Star North
Daybreak Equestrian Center	Maple Star South
DCFS Adolescent Treatment Center	My Home
DCFS Family Learning Homes	R House Community Treatment Center
DCFS Oasis	Rite of Passage
Eagle Quest	SAFY
Etxea Services	Sankofa
Hand Up Homes	St. Jude's Ranch for Children
Koinonia	Transformations Therapy
London Family and Children's Services	Unity Family Services

Table 6 shows the number of agencies reporting restraints and manual guidance and the total number of reported restraints and manual guidance incidents for each reporting period.

Table 6

RESTRAINT AND MANUAL GUIDANCE		
Reporting Period	Number of agencies reporting	Number of Restraints
2011	20	232
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.

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

The 232 reports of the use of restraint and manual guidance reflect the following descriptive information:

- 178 (76.72%) were male and 54 (23.28%) were female
- Average age was 10.67, ranging in age from 4 to 18 years
- Race
 - 127 (54.74%) were Caucasian
 - 78 (33.62%) were Black/African American
 - 13 (5.60%) were of mixed race
 - 9 (3.88%) were unknown
 - 3 (1.29%) were American Indian/Alaskan Native
 - 2 (0.86%) were Native Hawaiian/Other Pacific Islander
- 33 (14.86%) were of Hispanic origin
- Custody Status:
 - 177 (76.29%) child welfare
 - 29 (12.50%) parent and not on probation
 - 20 (8.62%) parent and on probation
 - 6 (2.59%) DCFS youth parole

Clinical and restraint and manual guidance information:

- The most frequent diagnoses were
 - 52 (22.41%) Mood Disorder NOS
 - 36 (15.52%) Posttraumatic Stress Disorder
 - 23 (9.91%) Bipolar Disorder NOS
 - 19 (8.19%) Reactive Attachment Disorder of Infancy or Early Childhood
 - 18 (7.76%) Oppositional Defiant Disorder
 - 14 (6.03%) Attention Deficit/Hyperactivity Disorder
- 172 (74.14%) of children and adolescents had a restraint or manual guidance used on them previously
- Average length of restraints or manual guidance was 10.04 minutes, ranging from 1 to 60 minutes

- Type of supervision prior to use of restraint or manual guidance
 - 113 (48.71%) group of 2 or 3
 - 62 (26.72%) one-on-one
 - 49 (21.12%) group – 4 or more
 - 6 (2.59%) line of sight
 - 4 (1.72%) other
- Precipitating event
 - 102 (43.97%) physically assaultive toward adult
 - 47 (20.26%) youth putting self at “risk” of harm
 - 38 (16.38%) physically assaultive toward another youth
 - 21 (9.05%) youth putting others at “risk” of harm
 - 15 (6.47%) youth running away
 - 6 (2.59%) property destruction
 - 3 (1.29%) other
- Injury report
 - 175 (75.43%) no one injured
 - 40 (17.24%) client injured
 - 14 (6.03%) staff injured
 - 3 (1.29%) peer injured
- 232 (100%) of staff received training on restraint and manual guidance while 193 (92.34%) received annual refresher training

Graph 5 below shows the frequency of restraints by the hour of the day; 30.43% of restraints occur from 5:00 p.m. to 8:00 p.m.

Graph 5

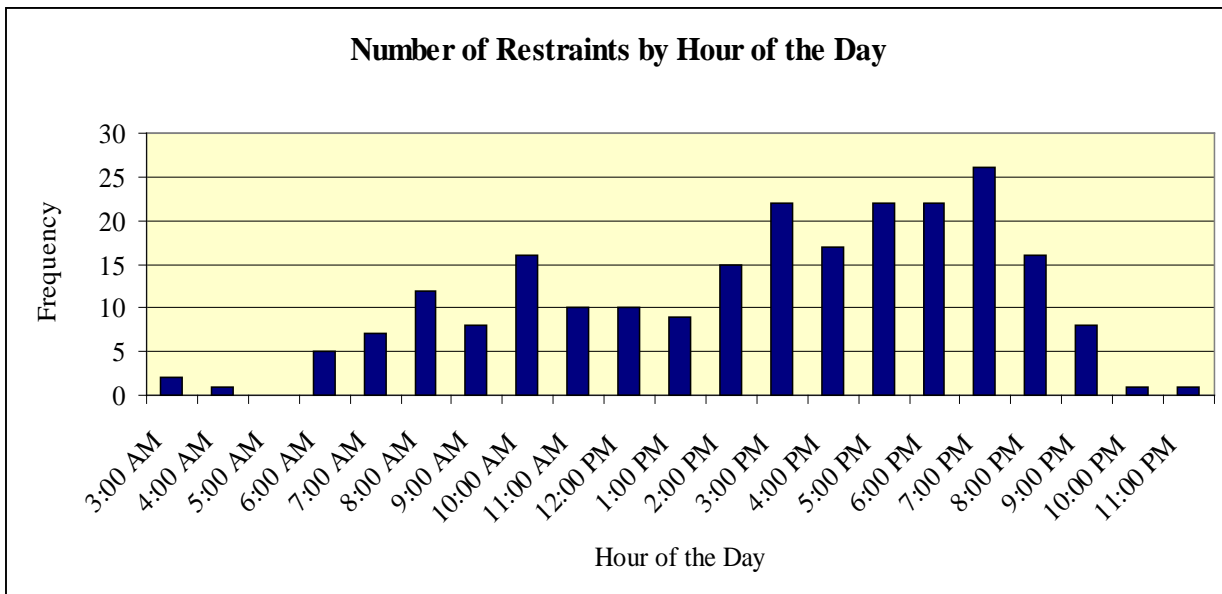


Table 7 reflects the demographics for restraint and manual guidance over the past four years. In 2011, one-third of the children and adolescents who were restrained were African-American. In 2010, 43% of children and adolescents put into restraint or manual guidance were African-American and over 39% in 2009. Close attention to improvement strategies is needed to reduce restraints for African-American children and adolescents.

Table 7

Demographics	2011	2010	2009	2008
<u>Gender:</u>				
Male	178 (76.7%)	257 (73.2%)	94 (56%)	102 (66.2%)
Female	54 (23.3%)	94 (26.8%)	74 (44%)	52 (33.8%)
<u>Average Age</u>	10.67	10.93	10.88	12.59
<u>Race:</u>				
Caucasian	127 (54.7%)	108 (30.8%)	84 (50%)	103 (66.9%)
African-American	78 (33.6%)	151 (43%)	66 (39.3%)	40 (26%)
American Indian/Alaskan Native	3 (1.29%)	7 (2%)	6 (3.6%)	1 (.6%)
Asian	-	2 (.6%)	-	-
Native Hawaiian/Other Pacific Islander	2 (.9%)	1 (.3%)	1 (.6%)	-
Mixed Race	13 (5.6%)	64 (18.2%)	11 (6.5%)	10 (6.5%)
Unknown	9 (3.9%)	18 (5.1%)	-	-
<u>Hispanic</u>	33 (14.9%)	69 (19.7%)	16 (9.5%)	6 (3.9%)
<u>Total</u>	232	351	168	154

The 232 reports of the use of restraint and manual guidance included 56 reports in the northern region, 156 in the southern region and 20 in the rural region. Table shows the providers who reported restraints and manual guidance in each region.

Table 8

Providers		
North	South	Rural
Briarwood-North	DCFS Oasis	Daybreak Equestrian Center
DCFS ATC	Eagle Quest	Rite of Passage
DCFS FLH	London Family & Children's Services	
Etxea Services	Maple Star Nevada-South	
Hand Up Homes	SAFY	
Koinonia	Sankofa	
Maple Star Nevada-North	St. Jude's Ranch for Children	
My Home	Unity Family Services	
R House Community Treatment Center		
Transformations Therapy		

Table 9 shows demographic and descriptive information by region.

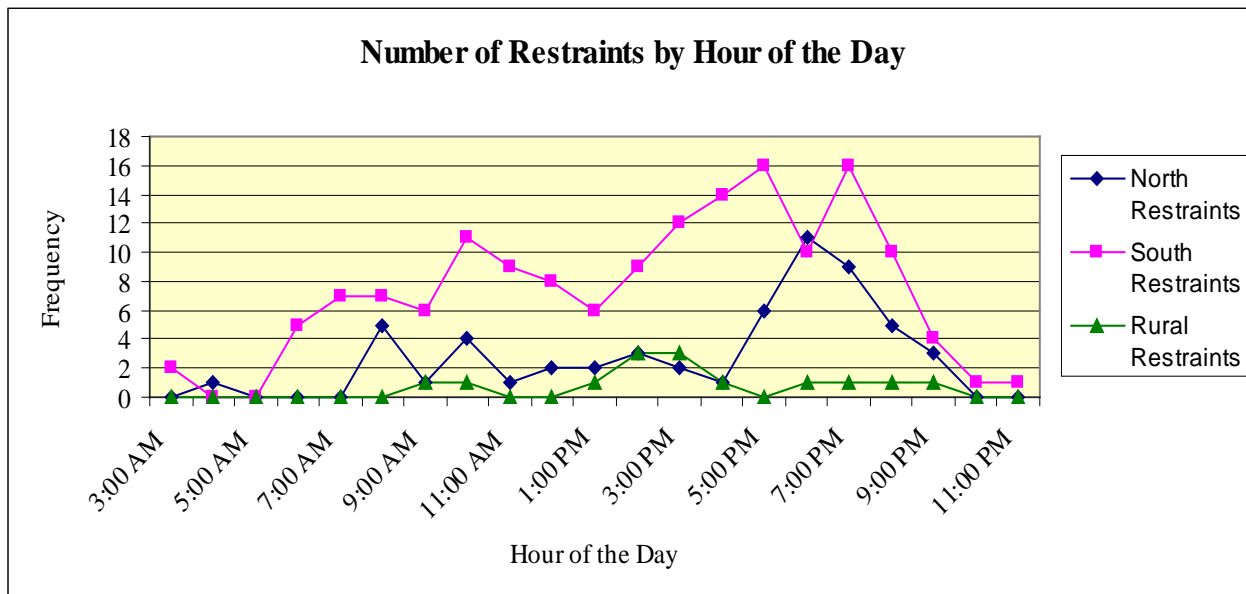
Table 9

	North	South	Rural
<u>Gender:</u>			
Male	49 (87.5%)	118 (75.6%)	11 (55.0%)
Female	7 (12.5%)	38 (24.4%)	9 (45.0%)
<u>Average Age</u>	10.52	10.12	15.35
<u>Race:</u>			
Caucasian	45 (80.4%)	81 (51.9%)	1 (5.0%)
African-American	6 (10.7%)	57 (36.5%)	15 (75.0%)
American Indian/Alaskan Native	3 (5.4%)	-	-
Asian	-	-	-
Native Hawaiian/Other Pacific Islander	-	-	2 (10.0%)
Mixed Race	2 (3.6%)	9 (5.8%)	2 (10.0%)
Unknown	-	9 (5.8%)	-
<u>Hispanic</u>	12 (21.4%)	19 (13.0%)	2 (10.0%)
<u>Custody</u>			
Child welfare	45 (80.4%)	123 (78.9%)	9 (45.0%)
DCFS youth parole	5 (8.9%)	-	1 (5.0%)
Parental/no probation	4 (7.1%)	25 (16.0%)	-
Parental/on probation	2 (3.6%)	8 (5.1%)	10 (50.0%)
<u>Most frequent diagnosis</u>	Posttraumatic Stress Disorder (44.6%) Bipolar Disorder NOS (12.5%) Attention Deficit/Hyperactivity Disorder (7.1%) Bipolar I Disorder (5.4%)	Mood Disorder NOS (32.7%) Reactive Attachment Disorder (10.9%) Oppositional Defiant Disorder (10.9%) Bipolar Disorder NOS (10.3%)	Depressive Disorder NOS (30.0%) Conduct Disorder (20.0%) Bipolar I Disorder (20.0%) Major Depressive Disorder (15.0%)
<u>Restraint Method</u>			
CPAR	25 (44.6%)	113 (72.4%)	-
CPI	28 (50.0%)	34 (21.8%)	9 (45.0%)
Jireh	-	-	11 (55.0%)
TCI	1 (1.8%)	5 (3.2%)	-
Mandt	-	4 (2.6%)	-
Other	2 (3.6%)	-	-
<u>Restraint or manual guidance used previously</u>	34 (60.7%)	131 (84.0%)	7 (35.0%)
<u>Average length of restraint or manual guidance in minutes</u>	9.39	10.99	4.45
<u>Type of supervision</u>			
Group of 4 or more	19 (33.9%)	19 (12.2%)	11 (55.0%)
Group of 2 or 3	18 (32.1%)	92 (59.0%)	3 (15.0%)
One-on-one	14 (25.0%)	42 (26.9%)	6 (30.0%)

Line of sight	5 (8.9%)	1 (0.6%)	-
Other		2 (1.3%)	-
<u>Precipitating event</u>			
Physically assaultive toward adult	14 (25.0%)	80 (51.3%)	8 (40.0%)
Physically assaultive toward another youth	17 (30.4%)	15 (9.6%)	6 (30.0%)
Youth putting self at “risk” of harm	15 (27.0%)	27 (17.3%)	5 (25.0%)
Youth putting others at “risk” of harm	6 (10.7%)	14 (9.0%)	1 (5.0%)
Property destruction	2 (3.6%)	4 (2.6%)	-
Youth running away	2 (3.6%)	-	-
Other	-	3 (1.9%)	-
<u>Injury report</u>			
No one injured	51 (91.1%)	107 (68.6%)	17 (85.0%)
Client injured	1 (1.8%)	39 (25.0%)	-
Staff injured	4 (7.2%)	7 (4.5%)	3 (15.0%)
Peer injured	-	3 (2.0%)	-
<u>Staff received training</u>	56 (100%)	156 (100%)	20 (100%)
<u>Staff received annual refresher training</u>	43 (76.8%)	131 (84.0%)	19 (95.0%)

Graph 6 shows the frequency of restraints by hour of the day for each region.

Graph 6



Opportunities for improvement in all regions:

- 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 episode on a regularly scheduled basis in order to identify frequencies and trends 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 receive ongoing and regular training in best practices in restraint, crisis intervention, and de-escalation techniques.

Physical and/or Sexual Incidents (Child on Child)

Commencing in January 2011, Specialized Foster Care providers were asked to track and report the number of child on child physical and/or sexual incidents.

A physical incident is defined as any intentional aggressive physical contact occurring between 2 youth (e.g., biting, choking, jumping on, kicking, punching, scratching, pushing, spitting, etc.) regardless of injury. Such an incident would have resulted in an incident report or other required documentation to licensing entities, legal guardian, etc.

A sexual incident is defined as a program participant (i.e., child or youth in placement with the provider) sexually touching or assaulting another individual without consent. Some type of physical touching behavior characterizes this behavior.

The following 18 Specialized Foster Care providers reported a total of 84 child on child physical and/or sexual incidents:

A Brighter Day	Koinonia
Bountiful Family Services	London Family and Children's Services
Briarwood - North	Maple Star Nevada - South
DCFS ATC	R House Community Treatment Center
DCFS FLH	SAFY
DCFS Oasis	Sankofa
Eagle Quest of Nevada	St. Jude's Ranch for Children
Etxea Services	Transformations Therapy
Father Flanagan's Boys Town	Trinity Youth Services

Physical and/or sexual incidents (child on child) reflect the following descriptive information:

- Victim
 - 59 (70.34%) were male, 24 (28.57%) were female, and 1 (1.19%) was missing data
 - Average age was 11.24 with an age range of 3 to 17 years
 - 56 (66.67%) were child welfare custody, 13 (15.48%) were parental custody not on probation, 11 (13.10%) were parental custody on probation, 1 (1.19%) was DCFS youth parole, 1 (1.19%) was Tribal custody, and 2 (2.38%) were missing data
- Initiator
 - 69 (82.14%) were male and 15 (17.86%) were female
 - Average age was 11.81 with an age range of 4 to 19 years
 - 65 (77.38%) were child welfare custody, 10 (11.90%) were parental custody on probation, 5 (5.95%) were DCFS youth parole, 2 (2.38%) were Tribal custody, and 2 (2.38%) were parental custody not on probation

Clinical and Physical and/or Sexual Incident (child on child) Information:

- The most frequent diagnosis were
 - Posttraumatic Stress Disorder (16 or 19.51% of youth) and Attention Deficit/Hyperactivity Disorder (14 or 17.07%) for the victim
 - Posttraumatic Stress Disorder (15 or 17.86% of youth) for the initiator
- Physical and/or sexual incident
 - 50 (59.52%) were physical incidents
 - 32 (38.10%) were sexual incidents
 - 2 (2.38%) were both physical and sexual incidents
- History of physical or sexual incidents
 - 45 (53.57%) of the victims
 - 65 (77.38%) of the initiators
- 70 (83.33%) of the initiator youth had a history of initiating against other children
- Type of supervision for the incident
 - 47 (55.95%) occurred in the home during the day, staff awake
 - 22 (26.19%) occurred in the home at night, staff awake
 - 8 (9.52%) occurred in the community during a supervised outing
 - 4 (4.76%) occurred in the home at night, staff asleep
 - 1 (1.19%) at school

- 1 (1.19%) during supervised family visit
- 1 (1.19%) other
- 81 (96.43%) of the incidents were reported to the legal guardian
- 31 (36.90%) of the incidents were reported to child protective services

Opportunities for Improvement:

- At the time of pre-placement planning and admission, an assessment of relevant risk factors and the youth’s history of being the victim or being the initiator of physical or sexual incidents should be explored as this will inform the treatment planning and services provided in order to better ensure child safety and placement stability.
- Focus on developing protocols regarding supervision in the home; 69 (82.14%) of the incidents reported occurred when staff was awake and presumably available for supervision.
- Teach staff and supervisors how to identify behavioral symptoms of possible physical and sexual incident including but not limited to:
 - Nightmares, sleep problems, and/or extreme fears without explanation
 - An older child regressing to a younger child’s typical behavior (finger- sucking, bedwetting, etc.)
 - Using different or adult words for body parts
 - Begins to show fear of going to certain places and/or spending time with another youth
 - Resists routine bathing
 - Observation of unexplained marks or injuries
 - Changes in interactions with another youth (Stop It Now, 2010; World Health Organization, 2006)
- Teach staff and supervisors how to provide support to youth concerning the disclosure of the physical and/or sexual incident (World Health Organization, 2006).

Departure Conditions

Specialized Foster Care providers were asked to track and report departure conditions on children and adolescents discharged from services for calendar year 2011. 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 41 Specialized Foster Care providers reported a total of 937 departures.

- | | |
|----------------------------------|----------------------------------|
| A Brighter Day | Majestic Community Services |
| Apple Grove | Maple Star North |
| Bountiful Family Services | Maple Star Rural |
| Briarwood North | Maple Star South |
| Briarwood South | Mile High Foster Family Agency |
| Daybreak Equestrian Center | Mountain Circle Family Services |
| DCFS Adolescent Treatment Center | My Home |
| DCFS Family Learning Homes | New Beginnings |
| DCFS Oasis | Nova |
| Eagle Quest | Olive Crest Foster Family Agency |

Etxea Services
 Father Flanagan's Boys Town
 Golla Home
 Hand Up Homes
 Hope Healthcare Services
 Horizon Academy
 JC Family Services
 Kids First
 KidsPeace
 Koinonia
 London Family and Children's Services

R House Community Treatment Center
 Reagan Home
 Rite of Passage
 SAFY
 Sankofa
 St. Jude's Ranch for Children
 Transformations Therapy
 Trinity Youth Services
 Unity Family Services
 Unity Village

Table 10 shows the number of agencies reporting departures and the total number of departures for each reporting period.

Table 10

DEPARTURES		
Reporting Period	Number of agencies reporting	Number of Departures
2011	41	937
2010	42	940
2009	39	907
Sept – Dec 2008	30	351

The 937 departures reflect the following descriptive information:

- 577 (61.58%) were male and 360 (38.42%) were female
- Average age at departure was 13.79, ranging from less than 1 year of age to 19 years
- Race:
 - 511 (54.54%) were Caucasian
 - 277 (29.56%) were Black/African-American
 - 82 (8.75%) were of mixed race
 - 18 (1.92%) were American Indian/Alaskan Native
 - 11 (1.17%) were Native Hawaiian/Other Pacific Islander
 - 9 (0.96%) were Asian
 - 29 (3.09%) were unknown
- 158 (16.86%) were of Hispanic origin
- Custody Status
 - 557 (59.45%) were in child welfare custody
 - 184 (19.64%) were in parental custody and on probation
 - 94 (10.03%) were in custody of youth parole
 - 92 (9.82%) were in parental custody no probation
 - 10 (1.07%) were in Tribal custody
- 920 (98.29%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 299.36 days with a range of 1 to 4239 days (or 11.61 years); the median length of stay is 186 days

Clinical and departure information:

- The most frequent diagnoses at admission were:
 - 148 (15.81%) Posttraumatic Stress Disorder
 - 88 (9.40%) Mood Disorder NOS
 - 67 (7.16%) Attention Deficit/Hyperactivity Disorder
 - 51 (5.45%) Depressive Disorder NOS
 - 50 (5.34%) Oppositional Defiant Disorder
- The most frequent diagnoses at discharge were:
 - 158 (16.88%) Posttraumatic Stress Disorder
 - 84 (8.97%) Mood Disorder NOS
 - 79 (8.44%) Attention Deficit/Hyperactivity Disorder
 - 53 (5.66%) Oppositional Defiant Disorder
 - 53 (5.66%) Depressive Disorder NOS
- The average CASII composite score at admission was 22.99
- The average CASII composite score at departure was 22.02
- The average ECSII composite score at admission was 21.10
- The average ECSII composite score at discharge was 20.67
- Reason for departure
 - 271 (28.92%) were reunified with biological family
 - 76 (8.11%) were adopted
 - 48 (5.12%) were placed with a relative
 - 23 (2.45%) were placed in independent living
 - 20 (2.13%) were emancipated or reached age 18 (aged out)
 - 65 (6.94%) were placed in a less restrictive setting (e.g. family foster care)
 - 173 (18.46%) were placed in a more restrictive environment (e.g. RTC, acute psychiatric hospital, juvenile detention, etc.)
 - 91 (9.71%) were AWOL (runaway) from placement
 - 75 (8.0%) were admitted to a new Specialized Foster Care home, different agency
 - 34 (3.63%) were admitted to another home within the same agency
 - 30 (3.20%) were removed by placing agency
 - 8 (2.99%) were other responses
 - 3 (0.32%) were missing
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 9.39, which equals the restrictiveness score of supervised independent living
 - 19 (2.03%) independent living by self
 - 7 (0.75%) independent living with friend
 - 40 (4.27%) home of parents for an 18-year-old
 - 281 (29.99%) home of parents for a child
 - 3 (0.32%) school dormitory
 - 64 (6.83%) home of relative
 - 25 (2.67%) adoptive home
 - 9 (0.96%) home of a family friend
 - 19 (2.03%) supervised independent living
 - 44 (4.70%) regular foster care
 - 3 (0.32%) individual home emergency shelter
 - 107 (11.42%) family-based treatment home
 - 69 (7.36%) group treatment home
 - 4 (0.43%) residential job corps center
 - 27 (2.88%) group emergency shelter

- 43 (4.59%) residential treatment center
- 14 (1.49%) medical hospital
- 1 (0.11%) drug-alcohol rehabilitation center
- 48 (5.12%) youth correction center
- 28 (2.99%) county detention center
- 16 (1.71%) state and private mental hospital
- 10 (1.07%) jail
- 56 (5.98%) unknown, e.g. AWOL
- 306 (32.69%) completed treatment
- 310 (33.44%) youth achieved treatment goals prior to discharge
- In the provider's opinion was the transition plan appropriate?
 - 794 (86.02%) yes
- Did the provider agree that the discharge was appropriate?
 - 819 (88.06%) yes
- Who recommended departure
 - 441 (47.07%) child and family team
 - 123 (13.13%) provider agency
 - 106 (11.31%) child welfare case manager
 - 80 (8.54%) child went AWOL
 - 79 (8.43%) judge or hearing master
 - 38 (4.06%) parole/probation officer
 - 17 (1.81%) parent
 - 13 (1.39%) child's mental health practitioner
 - 3 (0.32%) relative guardian
 - 2 (0.21%) CASA
 - 35 (3.74%) other

Highlights:

- Using the ROLES, 42.15% of children and adolescents achieved or returned to a permanent placement upon discharge (i.e. reunified with family, adopted, or relative placement).
- Upon departure, 55% 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).
- 47.07% of discharges from treatment homes were recommended by Child and Family Teams. In 2010, 55.9% were recommended by Child and Family Teams, in 2009 it was 48.4%, and in 2008 it was 39.3%.
- Of the 306 children and adolescents who completed treatment, 233 (76.1%) of the discharges were recommended by the Child and Family Team. In 2010, 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 (86%) and that the discharge was appropriate (88%).

Opportunities for improvement:

- Table 11 below shows treatment completion status by custody type.

Table 11

<u>Custody Type</u>	<u>Yes</u>	<u>No</u>	<u>Missing</u>
Child Welfare	113 (20.29%)	444 (79.71%)	-
Parental on probation	109 (59.24%)	74 (40.22%)	1 (0.54%)
Youth Parole	30 (31.91%)	64 (68.09%)	-
Tribal	3 (30.00%)	7 (70.00%)	-
Parental	51 (55.43%)	41 (44.57%)	-
<u>Total</u>	306 (32.66%)	630 (67.24%)	1 (0.1%)

- Upon departure, 32.7% of children and adolescents had completed services in the treatment home. In 2010, 40.3% of children and adolescents had completed services; in 2009, 42% of children and adolescents completed treatment, and 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.
- In examining the 306 children and adolescents that completed treatment we find the following demographic and clinical characteristics:
 - 62.4% were Caucasian
 - 35.6% were in parental custody on probation
 - 13.1% were diagnosed with Posttraumatic Stress Disorder
 - 71.6% returned to a permanent placement upon discharge (i.e., reunified with family, adopted, or relative placement) – 71.6%
 - 76.1% of discharges were recommended by the Child and Family Team
 - 95.1% of providers agreed that the transition plan was appropriate
 - 92.5% of the youth achieved treatment goals prior to discharge according to providers
 A closer examination of what works in Specialized Foster Care may help guide providers, policy makers, and advocates to implement approaches that work and ensure consistent application.

Children and Adolescents in Child Welfare Custody

Of the 937 departures reported in 2011, 557 or 59.45% of the children and adolescents were in the custody of a child welfare agency. The 557 child welfare custody departures reflect the following descriptive information.

- 307 (55.12%) were male and 250 (44.88%) were female
- Average age at departure was 12.69, ranging from less than 1 year of age to 19 years
- Race
 - 278 (49.91%) were Caucasian
 - 193 (34.65%) were Black/African-American
 - 6 (1.08%) were American Indian/Alaskan Native
 - 6 (1.08%) were Asian
 - 5 (0.9%) were Native Hawaiian/Other Pacific Islander
 - 52 (9.34%) were of mixed race
 - 17 (3.05%) were unknown
- 91 (16.34%) were of Hispanic origin

- 554 (99.46%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 342.24 days with a range of 1 to 4239 days (or 11.61 years); the median length of stay is 186 days

Clinical and departure information:

- The most frequent diagnoses at admission were:
 - 113 (20.29%) Posttraumatic Stress Disorder
 - 53 (9.52%) Mood Disorder NOS
 - 50 (8.98%) Attention Deficit/Hyperactivity Disorder
 - 36 (6.46%) Oppositional Defiant Disorder
 - 33 (5.92%) Conduct Disorder
- The most frequent diagnoses at discharge were:
 - 121 (21.72%) Posttraumatic Stress Disorder
 - 60 (10.77%) Attention Deficit/Hyperactivity Disorder
 - 46 (8.26%) Mood Disorder NOS
 - 37 (6.64%) Oppositional Defiant Disorder
 - 31 (5.57%) Conduct Disorder
- The average CASII composite score at admission was 22.30
- The average CASII composite score at departure was 21.79
- The average ECSII composite score at admission was 20.80
- The average ECSII composite score at departure was 21.00
- Reason for departure
 - 100 (17.95%) were reunified with biological family
 - 68 (12.21%) were adopted
 - 35 (6.28%) were placed with a relative
 - 17 (3.05%) were placed in independent living
 - 13 (2.33%) were emancipated or reached age 18 (aged out)
 - 41 (7.36%) were placed in a less restrictive setting (e.g. family foster care)
 - 77 (13.82%) were placed in a more restrictive environment (e.g. RTC, acute psychiatric hospital, juvenile detention, etc.)
 - 56 (10.05%) were AWOL (runaway) from placement
 - 70 (12.57%) were admitted to a new Specialized Foster Care home, different agency
 - 25 (4.49%) were removed by placing agency
 - 28 (5.03%) were admitted to another home within the same agency
 - 24 (4.31%) were other responses
 - 3 (0.54%) were missing
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 9.34, which equals the restrictiveness score of a regular foster home
 - 16 (2.87%) independent living by self
 - 6 (1.08%) independent living with friend
 - 8 (1.44%) home of natural parents for an 18-year-old
 - 132 (23.70%) home of natural parents for a child
 - 2 (0.36%) school dormitory
 - 36 (6.46%) home of relative
 - 22 (3.95%) adoptive home
 - 5 (0.90%) home of a family friend
 - 12 (2.15%) supervised independent living
 - 40 (7.18%) regular foster care
 - 3 (0.54%) individual home emergency shelter

- 100 (17.95%) family-based treatment home
- 50 (8.98%) group treatment home
- 2 (0.36%) residential job corps center
- 27 (4.85%) group emergency shelter
- 16 (2.87%) residential treatment center
- 8 (1.44%) medical hospital
- 1 (0.18%) drug-alcohol rehabilitation center
- 7 (1.26%) youth correction center
- 11 (1.97%) county detention center
- 13 (2.33%) state and private mental hospital
- 1 (0.18%) jail
- 39 (7.0%) unknown, e.g. AWOL
- 113 (20.29%) completed treatment
- 128 (22.98%) youth achieved treatment goals prior to discharge
- In the provider's opinion was the transition plan appropriate?
 - 471 (84.56%) yes
- Did the provider agree that the discharge was appropriate?
 - 485 (87.07%) yes
- Who recommended departure
 - 237 (42.55%) child and family team
 - 95 (17.06%) child welfare case manager
 - 77 (13.82%) provider agency
 - 50 (8.98%) child went AWOL
 - 49 (8.80%) judge or hearing master
 - 10 (1.80%) child's mental health practitioner
 - 3 (0.54%) parole/probation officer
 - 3 (0.54%) parent
 - 2 (0.36%) CASA
 - 1 (0.18%) relative guardian
 - 30 (5.39%) other

Highlights for child welfare:

- Using the ROLES, 36% 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 9.34 for all discharged children and adolescents in child welfare custody is equal to the restrictiveness of supervised independent living.
- Of the 113 children and adolescents in child welfare custody that completed treatment 84 (74.33%) were discharged as recommended by their Child and Family Team.
- Upon departure, 48% 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 will have a restraint and manual guidance policy that emphasizes the use of restraint and manual guidance only when a child is of danger to themselves or others.
- 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
 - Parent and family involvement in all aspects of the child and adolescent's treatment

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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**Attachment A
PARTICIPATING PROVIDER LIST**

	PROVIDER NAME	# of Provider Reporting Periods	# of Provider Reports Submitted	% of Reports Completed
1.	A Brighter Day	12	12	100%
2.	Apple Grove	12	12	100%
3.	Bountiful Family Services	12	12	100%
4.	Briarwood - North	12	12	100%
5.	Briarwood – South - CLOSED	7	7	100%
6.	Daybreak Equestrian Center	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.	JC Family Services - NEW	6	6	100%
18.	Kids First	12	9	75%
19.	KidsPeace - NEW	9	9	100%
20.	Koinonia	12	12	100%
21.	London Family & Children’s Services	12	12	100%
22.	Majestic Community Services - NEW	5	5	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.	Nova	6	6	100%
31.	Olive Crest Foster Family Agency	12	12	100%
32.	R House Community Treatment Center	12	12	100%
33.	Reagan Home	12	12	100%
34.	Rite of Passage	12	12	100%
35.	SAFY	12	12	100%
36.	Sankofa Group	12	12	100%
37.	St. Jude’s Ranch for Children	12	12	100%
38.	Transformations Therapy	12	12	100%
39.	Trinity Youth Services	12	12	100%
40.	Unity Family Services	12	12	100%
41.	Unity Village	12	12	100%