Division of Child and Family Services
Risk Measures and Departure Conditions
2012 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 2012 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 2012 report is the fifth year of data collection for risk measures and departure conditions. This report is an analysis of risk measures and departure conditions collected from January 2012 through December 2012.

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 incidents goes unreported or under-reported. Although data analysis limitations continue as a result of provider self-reporting, beginning in late 2009 and throughout 2012, 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. 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 CONDTIONS

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 (CFT) decision-making

The following is the data and analysis of the five risk areas and departure conditions based on data collected from January 2012 through December 2012.

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. The average monthly bed capacity and the number of youth served for the 2009, 2010, 2011 and 2012 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	
2012	34.71	2012	21.62
	Range: 0 to 236		Range: 0 to 195
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 9 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:

Bountiful Family Services
DCFS Adolescent Treatment Center
DCFS Oasis On-Campus Treatment Homes
Eagle Quest of Nevada
Etxea Services
Father Flanagan's Boys Town
Hope Healthcare Services
Majestic Community Services
SAFY

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
2012	9	19
2011	5	13
2010	11	18
2009	8	16
2008	6	14

There were a total of 19 reports of suicide attempts with the following descriptive information:

- 11 (57.89%) were female and 8 (42.11%) were male
- Average age was 14.53, ranging from age 7 to 18 years
- Race
  - 16 (84.21%) were Caucasian
  - 1 (5.26%) was African-American

  - 1 (5.26%) was American Indian/ Alaskan Native
  - 1 (5.6%) was Other
- 2 (10.53%) were of Hispanic origin
- Custody Status
  - 9 (47.37%) were in Child Welfare custody
  - 4 (21.05%) were in DCFS Youth Parole
  - 3 (15.79%) were in Parental custody and on Probation
  - 2 (10.53%) were in Parental custody and not on Probation
  - 1 (5.26) was in Tribal custody

Clinical and suicide attempt information:

- The 2 most frequent diagnoses were Dissociative Identity DO and Bipolar II DO
- Attempted suicide means reported were incidents of using a knife 5 (26.32%), cutting 3 (15.79%), overdose 3 (15.79%), hanging 2 (10.53 %), and 6 (31.58%) were categorized as "other"
- 15 (78.95%) children were reported as having previous suicide attempts
- Following the suicide attempts, 17 (89.47%) were admitted to a psychiatric hospital, 1 (5.26%) resulted in emergency hospital medical procedures, and 1 (5.26%) was categorized as "other"
- 17 (89.47%) agencies implemented a suicide protocol
- 18 (94.74%) were incidents where staff had received suicide awareness and prevention training
- 17 (89.47%) were incidents where staff received the required annual refresher training for suicide awareness and prevention

The reports of suicide attempts are separated for the northern/rural region and the southern region. Table 3 shows the providers who reported suicide attempts in each region.

Table 3

Providers	
North/Rural	**South**
DCFS ATC	Bountiful Family Services
Etxea Services	DCFS Oasis
Hope Healthcare Services	Eagle Quest of Nevada
	Father Flanagan's Boys Town
	Majestic Community Services
	SAFY

Table 4 shows demographic and descriptive information by region for suicide attempts.

Table 4

	North/Rural	**South**
Total	4	15
<u>Gender:</u> Male Female	 1 3	 7 8
Average Age	17	13.87

Race:		
Caucasian	4	12
African-American	-	1
American Indian/Alaskan Native	-	1
Other	-	1
Hispanic	-	2
Custody		
Child welfare	3	6
DCFS youth parole	-	4
Parental/no probation	1	1
Parental/on probation	-	3
Tribal	-	1
Most frequent diagnosis	Bipolar II & Bipolar I	Dissociative Identity Disorder
Attempted Suicide Means		
Knife	1	4
Cutting	-	3
Hanging	-	2
Overdose	2	1
Other	1	5
Previous Suicide Attempts	4	11
Attempted Suicide Outcomes		
Admitted to a psychiatric hospital	3	12
Emergency hospital medical procedures	1	-
Other	-	3
Implemented Suicide Protocol	2	15
Staff received training	3	15
Staff received annual refresher training	3	14

Highlights:

- Most agencies that reported a suicide attempt have a suicide protocol in place.
- Most agencies that reported a suicide attempt had staff receive suicide awareness and prevention training.
- Most agencies that reported a suicide attempt had staff complete an annual refresher for suicide awareness and prevention.
- There have been no completed suicides.

Practice Guidelines and 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, 31 Specialized Foster Care providers reported 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:

A Brighter Day Family Services
Apple Grove
Bountiful Family Services
Briarwood North
Daybreak Equestrian Center
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest of Nevada
Etxea Services
Father Flanagan's Boys Town
Golla Homes
Hand Up Homes
JC Family Services
Koinonia
London Family and Children's Services
Maple Star-North
Maple Star-South
Mile High Foster Family Agency
Mountain Circle Family Services
My Home
Nova
Olive Crest Foster Family Agency
Quest House
R House Community Treatment Center
Reagan Home
Rite of Passage
SAFY
St. Jude's Ranch for Children
Transformations Therapy
Unity Family Services

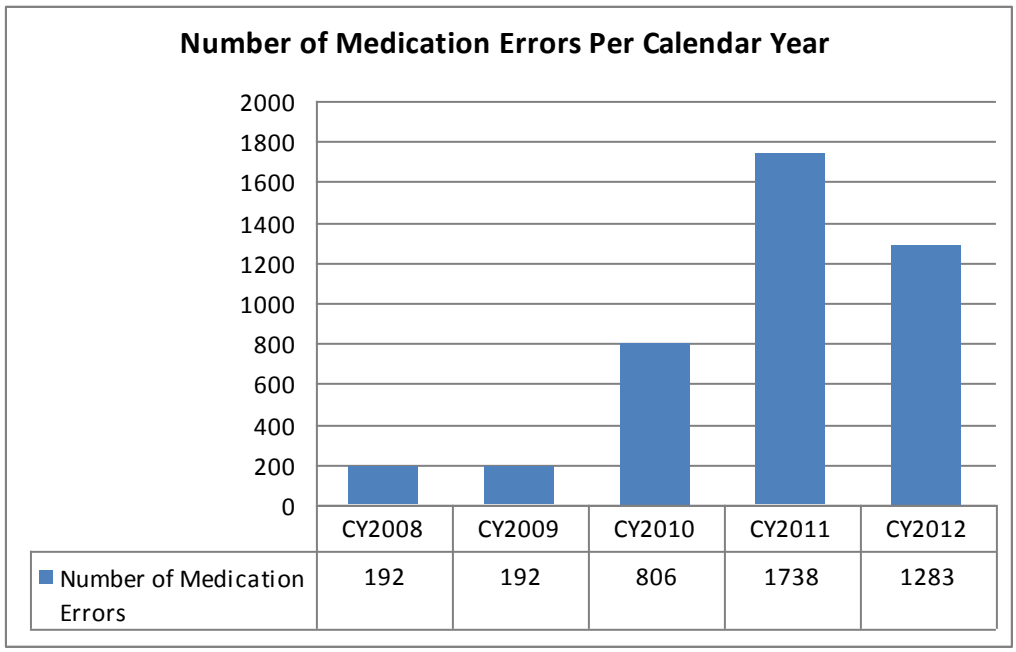
Table 5 shows the number of agencies reporting medication errors for each reporting period.

Table 5

MEDICATION ERRORS	
Reporting Period	Number of agencies reporting
2012	31
2011	32
2010	29
2009	19
2008	15

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

Graph 1



The incidents of medication errors reflect the following information.

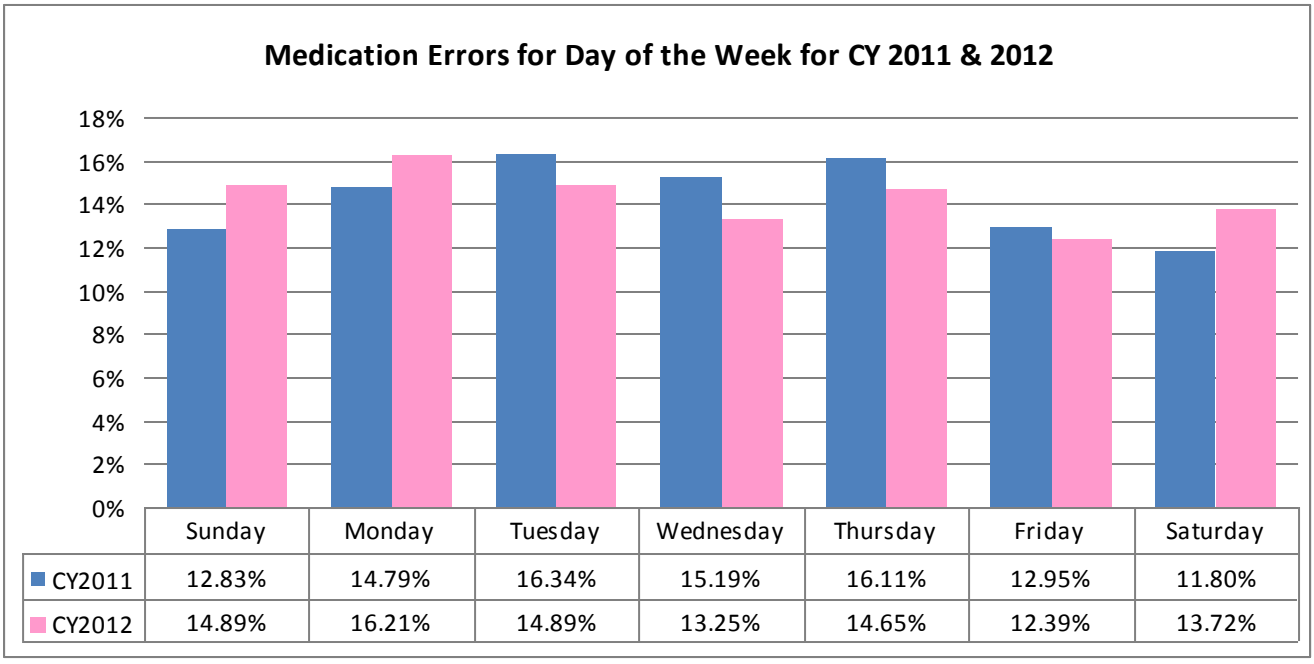
Clinical and medication error information:

- Custody Status
  - 676 (52.69%) Child welfare
  - 308 (24.01%) Parent and on probation
  - 203 (15.82%) Parent and not on probation
  - 95 (7.40%) DCFS youth parole
  - 1 (0.08%) Tribal
- The following Axis I diagnoses account for 47.6% of all diagnostic categories reported under medication errors
  - 301 (23.46%) Posttraumatic Stress Disorder
  - 198 (15.43%) Mood Disorder NOS
  - 112 (8.73%) Attention Deficit/Hyperactivity Disorder
- Type of medication error
  - 363 (28.29%) omission errors
  - 67 (5.22%) wrong time errors
  - 55 (4.29%) prescribing errors
  - 25 (1.95%) unauthorized drug administration errors
  - 4 (0.31%) improper dose errors
  - 4 (0.31%) deteriorated drug
  - 765 (59.63%) other medication errors
    - 48 (6.27%) Pharmacy error
    - 82 (10.72%) Documentation errors; e.g., administering the medication but staff failing to initial the block on the Medication Administration Record (MAR), failure to document a child's refusal to take the medication, etc.
    - 15 (1.96%) Administering medications without legal consent

- 0 (0%) Finding the youth's medication in an inappropriate area; e.g., in the child or youth's clothing, on the floor, packaged with a meal, in a non-secure area, in an unmarked open container or dish, or mixed together in a container, etc.
- 173 (22.61%) Failing to ensure that an adequate supply of medication is available or that new prescriptions are obtained within a reasonable time
- 79 (10.33%) Inability to obtain prior authorization from third party payer
- 128 (16.73%) Inability to obtain legal consent;
- 4 (0.52%) Security/storage safeguards are not followed

- 1271 (99.06%) of the medication errors were with psychotropic medication, 12 (0.94%) were non-psychotropic medication errors
- The graph below shows the percentage of medications for the days of the week for 2011 and 2012.

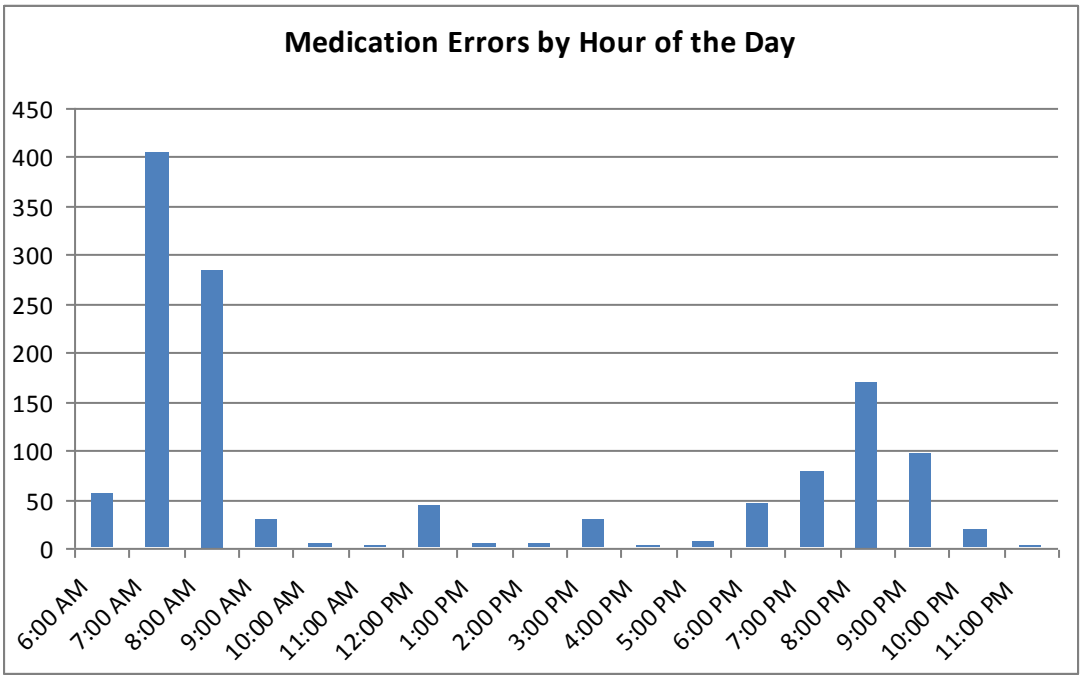
Graph 2



	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
CY2011	12.83%	14.79%	16.34%	15.19%	16.11%	12.95%	11.80%
CY2012	14.89%	16.21%	14.89%	13.25%	14.65%	12.39%	13.72%

- The most common time of day for errors was the 7:00 a.m. hour, with 404 (31.49%) of the errors occurring at this time. The morning hours of 7:00 a.m. and 8:00 a.m. had 688 errors or nearly 54% of all medication errors. The morning hours of 7:00 and 8:00 a.m. and the evening hour of 8 p.m. are consistently the highest hours for medication errors. This was also found in the 2011 report. These hours of the day are, of course, the primary times for medication administration when treatment foster parents or staff are especially busy with meals, transitioning to school or to bed, and administering medication.

Graph 3



- Medication error outcome
  - 1142 (89.01%) were errors that reached the client but did not cause the client harm
  - 135 (10.52%) were errors that did not reach the client
  - 5 (0.39%) 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
  - 1 (0.08%) errors occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
- 1283 (100%) of incidents involved staff who received medication administration training
- 1116 (86.98%) of incidents involved staff who received annual refresher training on medication management

The reports of the medication errors are separated for the northern/rural region and the southern region. Table 6 shows the providers who reported medication errors in each region.

Table 6

Providers	
North/Rural	**South**
Briarwood-North	A Brighter Day Family Services
Daybreak Equestrian Center	Apple Grove
DCFS Adolescent Treatment Center	Bountiful Family Services
DCFS Family Learning Homes	DCFS Oasis
Etxea Services	Eagle Quest of Nevada
Golla Home	Father Flanagan's Boys Town
Hand Up Homes	London Family & Children's Services
JC Family Services	Maple Star Nevada-South

Koinonia	Mile High Foster Family Agency
Maple Star Nevada-North	Olive Crest Foster Family Agency
Mountain Circle Family Services	SAFY
My Home	St. Jude's Ranch for Children
Nova	Unity Family Services
Quest House	
R House Community Treatment Center	
Reagan Homes	
Rite of Passage	
Transformations Therapy	

Table 7 shows demographic and descriptive information by region for medication errors.

Table 7

	North/Rural	**South**
Total	996	287
Custody		
Child welfare	456 (45.78%)	220 (76.66%)
Parental/on probation	255 (25.60%)	53 (18.47%)
Parental/no probation	195 (19.58%)	8 (2.79%)
DCFS youth parole	89 (8.94%)	6 (2.09%)
Tribal	1 (0.10%)	-
Most frequent diagnosis	Posttraumatic Stress Disorder (24.60%) Mood Disorder NOS (12.65%)	Mood Disorder NOS (25.09%) Posttraumatic Stress Disorder (19.51%)
Medication Error Type		
Omission or missed dose	210 (21.08%)	153 (53.31%)
Wrong time	60 (6.02%)	7 (2.44%)
Prescribing error	55 (5.52%)	-
Unauthorized drug	5 (0.50%)	20 (6.97%)
Improper/wrong dose	3 (0.30	1 (0.35%)
Deteriorated drug	2 (0.20%)	2 (0.70%)
Other medication error	661 (66.37%)	104 (36.24%)
Psychotropic Medication	984 (98.80%)	287 (100%)
Medication Error Outcomes		
Error did not reach the client	871 (87.45%)	13 (4.53%)
Error reached the client but did not cause client harm	122 (12.25%)	271 (94.43%)
Errors that reached the client and required monitoring	2 (0.20%)	3 (1.05%)
Errors occurred that may have contributed to or resulted in temporary harm to the client	1 (0.10%)	-

Staff received medication administration training	996 (100%)	287 (100%)
Staff received annual refresher training on medication management	898 (90.16%)	218 (75.96%)

Highlights:

- Specialized Foster Care providers have continued their reporting of medication errors. The number of reported medication errors reflect a more valid and expected amount of medication errors in treatment homes. This continued high level of reporting medication errors may also reflect improved tracking and documenting of medication errors by the provider community.
- 31 of 43 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.
- All staff received the required training for medication administration and management.

Practice Guidelines and 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.
- Pre-service and annual training in medication administration and management is a requirement. Ensure staff/treatment parents receive annual medication management and administration training in order to minimize errors and provide ongoing safe administration and monitoring of clients on medication.
- Agencies need to maintain detailed individual training records which include the date and duration of training. Staff should be evaluated using the following checklist:
    1. Demonstrates proper storage of medication
    2. Sets up medication administration properly (i.e., clean, designated space with needed supplies available)
    3. Reads and follows directions on medicine labels
    4. Identifies the client by name
    5. Demonstrates clean technique for administering medications
    6. Observes as client takes medication
    7. Demonstrates correct recording of medication given
    8. Demonstrates correct recording of medications not given
    9. Demonstrates proper action to take if medication not taken or given, either by refusal/unavailable medication or other contraindications

10. Describes proper action to take if medication not taken or given
11. Describes resources to be used in an emergency or when problems arise
12. Describes procedure for medication errors

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 169 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
Apple Grove
Bountiful Family Services
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis On-Campus Treatment Homes
Eagle Quest
Etxea Services
Father Flanagan's Boy Town
Genesis
Hand Up Homes
Hope Healthcare Services
JC Family Services
Maple Star North
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
St. Jude's Ranch for Children
Transformations Therapy
Trinity Youth Services
Unity Village

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

Table 8

AWOL INCIDENTS		
Reporting Period	Number of agencies reporting	Number of AWOLs
2012	27	169
2011	27	181
2010	28	160
2009	28	166
2008	26	183

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

- 99 (58.58%) were male and 70 (41.42%) were female
- Average age was 15.88, ranging from age 11 to 18 years
- Race:
  - 78 (46.15%) were Caucasian
  - 51 (30.18%) were African-American
  - 20 (11.83%) were of mixed race
  - 3 (1.78%) were American Indian/Alaskan Native
  - 3 (1.78%) were Asian
  - 3 (1.78%) were Native Hawaiian
  - 8 (4.73%) were Other
  - 3 (1.78%) were Unknown
- 25 (14.79%) were of Hispanic origin
- Custody Status:
  - 103 (60.95%) child welfare
  - 30 (17.75%) DCFS youth parole
  - 30 (17.75%) parent and on probation
  - 4 (2.37%) parent and not on probation
  - 2 (1.18%) Tribal

Clinical and AWOL information:

- The following 5 Axis I diagnoses account for over 47% of all diagnostic categories reported under AWOLs:
  - 25 (14.79%) Posttraumatic Stress Disorder
  - 17 (10.06%) Mood Disorder NOS
  - 16 (9.47%) Oppositional Defiant Disorder
  - 12 (7.10%) Conduct Disorder
  - 10 (5.92%) Bipolar Disorder NOS
- Average length of absence was 4.27 days, with a range of 1 to 34 days
- 127 (75.15%) of children and adolescents absent for more than 24 hours had a history of AWOL
- Type of supervision at AWOL:
  - 59 (34.91%) left home during the day
  - 41 (24.26%) left from school or work
  - 33 (19.53%) left from treatment home at night – staff awake
  - 15 (8.88%) left from treatment home at night – staff asleep
  - 21 (12.43%) were other
- Behavior during AWOL
  - 134 (79.29%) unknown
  - 20 (11.83%) substance abuse
  - 3 (1.78%) assaultive to others
  - 2 (1.18%) sexual activity
  - 2 (1.18%) criminal activity
  - 8 (4.73%) other
- Outcome
  - 82 (48.52%) absent indefinitely – did not return to the home
  - 35 (20.71%) returned voluntarily to treatment home within 72 hours
  - 12 (7.10%) returned through juvenile detention or law enforcement
  - 5 (2.96%) placed in congregate care
  - 5 (2.96%) found with family and stayed with family
  - 4 (2.37%) found with family and returned to Specialized Foster Care home

- 3 (1.78%) returned involuntarily within 72 hours
- 23 (13.61%) other

The graph below shows the percentage of AWOLs for the days of the week for 2011 and 2012

Graph 4

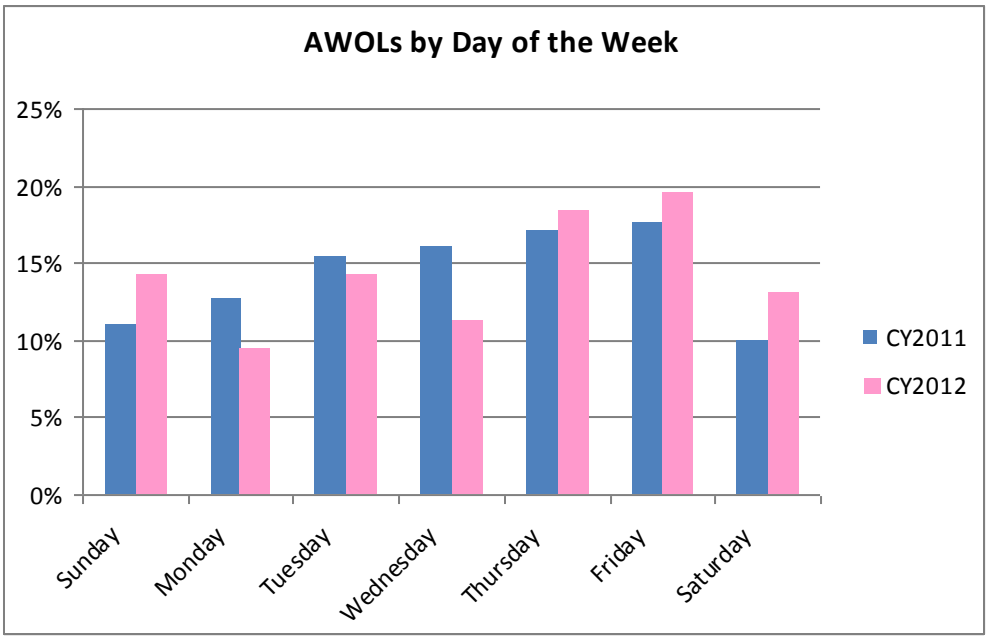


Table 9 compares the demographic information for AWOLs over the past five years.

Table 9

Demographics	2012	2011	2010	2009	2008
Gender:					
Male	99 (58.6%)	108 (59.7%)	87 (54.4%)	76 (45.8%)	73 (39.9%)
Female	70 (41.4%)	73 (40.3%)	73 (45.6%)	90 (54.2%)	110 (60.1%)
Average Age	15.88	15.78	15.32	15.82	15.65
Race:					
Caucasian	78 (46.2%)	104 (57.5%)	82 (51.3%)	87 (52.4%)	94 (51.4%)
African-American	51 (30.2%)	52 (28.7%)	47 (29.4%)	44 (26.5%)	54 (29.5%)
American Indian/Alaskan Native	3 (1.8%)	5 (2.8%)	6 (3.8%)	8 (4.8%)	11 (6%)
Asian	3 (1.8%)	2 (1.1%)	2 (1.3%)	1 (.6%)	-
Native Hawaiian/Other Pacific Islander	3 (1.8%)	2 (1.1%)	-	1 (.6%)	2 (1.1%)
Mixed Race	20 (11.8%)	12 (6.6%)	16 (10%)	19 (11.4%)	18 (9.8%)
Unknown	3 (1.8%)	4 (2.2%)	7 (4.4%)	6 (3.6%)	4 (2.1%)
Hispanic	25 (14.8%)	28 (15.5%)	29 (18.1%)	23 (13.9%)	22 (12.0%)
Total	169	181	160	166	183

The reports of the AWOLs are separated for the northern/rural region and the southern region. Table 10 shows the providers who reported AWOLs in each region.

Table 10

Providers	
North/Rural	**South**
DCFS Adolescent Treatment Center	A Brighter Day Family Services
DCFS Family Learning Homes	Apple Grove
Etxea Services	Bountiful Family Services
Hand Up Homes	DCFS Oasis
Hope Healthcare Services	Eagle Quest of Nevada
JC Family Services	Father Flanagan's Boys Town
Maple Star Nevada-North	Genesis
Mountain Circle Family Services	Maple Star Nevada-South
My Home	Mile High Foster Family Agency
Reagan Homes	New Beginnings
Rite of Passage	Olive Crest Foster Family Agency
Transformations Therapy	SAFY
	St. Jude's Ranch for Children
	Trinity Youth Services
	Unity Village

Table 11 shows demographic and descriptive information by region for AWOLs.

Table 11

	North/Rural	**South**
Total	61	108
Gender:		
Male	39 (63.93%)	60 (55.56%)
Female	22 (36.07%)	48 (44.44%)
Average Age	16.38	15.60
Race:		
Caucasian	41 (67.21%)	37 (34.26%)
African-American	7 (11.48%)	44 (40.74%)
American Indian/Alaskan Native	3 (4.92%)	-
Asian	-	3 (2.78%)
Native Hawaiian/Other Pacific Islander	2 (3.28%)	1 (0.93%)
Mixed Race	8 (13.11%)	12 (11.11%)
Other	-	8 (7.41%)
Unknown	-	3 (2.78%)
Hispanic	8 (13.11%)	17 (15.74%)

Custody		
Child welfare	29 (47.54%)	74 (68.52%)
DCFS youth parole	16 (26.23%)	14 (12.96%)
Parental/no probation	3 (4.92%)	1 (0.93%)
Parental/on probation	11 (18.03%)	19 (17.59%)
Tribal	2 (3.28%)	-
Most Frequent Diagnosis	Posttraumatic Stress Disorder (22.95%)	Posttraumatic Stress Disorder (10.19%) Mood Disorder NOS (10.19%) Oppositional Defiant Disorder (10.19%) Conduct Disorder (10.19%)
Average Length of Absence	5.67 days	3.50 days
History of AWOL	48 (78.69%)	79 (73.15%)
Type of Supervision At AWOL		
Left home during the day	15 (24.59%)	44 (40.74%)
Left from school or work	20 (32.79%)	21 (19.44%)
Left from treatment home at night – staff awake	10 (16.39%)	23 (21.30%)
Left from treatment home at night – staff asleep	5 (8.20%)	10 (9.26%)
Other	11 (18.03%)	10 (9.26%)
Behavior While on AWOL		
Unknown	48 (78.69%)	86 (79.63%)
Substance abuse	10 (16.39%)	10 (9.26%)
Assaultive to others	-	3 (2.78%)
Sexual activity	2 (3.28%)	-
Criminal activity	-	2 (1.85%)
Other	1 (1.64%)	7 (6.48%)
AWOL Outcome		
Absent indefinitely – did not return to the home	37 (60.66%)	45 (41.67%)
Returned voluntarily to treatment home within 72 hours	15 (24.59%)	20 (18.52%)
Returned through juvenile detention or law enforcement	4 (6.56%)	8 (7.41%)
Placed in congregate care	2 (3.28%)	3 (2.78%)
Found with family and stayed with family	-	5 (4.63%)
Found with family and returned to Specialized Foster Care home	1 (1.64%)	3 (2.78%)
Returned involuntarily within 72 hours	-	3 (2.78%)
Other	2 (3.28%)	21 (19.44%)

Practice Guidelines and Opportunities for Improvement:

- Identify predictors of runaway behavior in youth such as substance use, history of running away, and multiple placements to use in developing crisis plans at admission (Courtney, Skyles, Miranda, Zinn, Howard, and George, 2005).
- 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, 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 15 Specialized Foster Care providers reported a total of 208 incidents of restraints or manual guidance:

DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis On-Campus Treatment Homes
Eagle Quest
Etxea Services
Father Flanagan's Boys Town
Genesis
Koinonia
London Family and Children's Services
Maple Star North
Maple Star South
Mountain Circle Family Services
My Home
Rite of Passage
SAFY

Table 12 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 12

RESTRAINT AND MANUAL GUIDANCE		
Reporting Period	Number of agencies reporting	Number of Restraints
2012	15	208
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 (CPAR)
- Crisis Prevention Institute **(**CPI**)**
- Jireh Escort/Jireh Standing/Jireh Seated
- Therapeutic Crisis Intervention **(**TCI**)**
- David Mandt System

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

- 112 (53.85%) were male and 96 (46.15%) were female
- Average age was 9.85, ranging in age from 5 to 17 years
- Race
  - 150 (72.12%) were Caucasian
  - 36 (17.31%) were Black/African American
  - 9 (4.33%) were American Indian/Alaskan Native
  - 4 (1.92%) were of mixed race
  - 4 (1.92%) were Other
  - 3 (1.44%) were Native Hawaiian/Other Pacific Islander
  - 2 (0.96) were Asian
- 47 (22.60%) were of Hispanic origin
- Custody Status:
  - 158 (75.96%) child welfare
  - 40 (19.23%) parent and not on probation
  - 9 (4.33%) parent and on probation
  - 1 (0.48%) DCFS youth parole

Clinical and restraint and manual guidance information:

- The following 4 Axis I diagnoses account for over 67% of all diagnostic categories reported under Restraints and Manual Guidance:
  - 70 (33.65%) Mood Disorder NOS
  - 31 (14.90%) Posttraumatic Stress Disorder
  - 20 (9.62%) Attention Deficit/Hyperactivity Disorder
  - 19 (9.13%) Bipolar Disorder NOS
- 177 (85.10%) of children and adolescents had a restraint or manual guidance used on them previously
- Average length of restraints or manual guidance was 11.46 minutes, ranging from 1 to 135 minutes
- Type of supervision prior to use of restraint or manual guidance
  - 79 (37.98%) group of 2 or 3
  - 64 (30.77%) one-on-one

- 56 (26.92%) group – 4 or more
- 8 (3.85%) line of sight
- 1 (0.48%) other

- Precipitating event
  - 91 (43.75%) physically assaultive toward adult
  - 37 (17.79%) physically assaultive toward another youth
  - 34 (16.35%) youth putting self at "risk" of harm
  - 18 (8.65%) youth putting others at "risk" of harm
  - 18 (8.65%) other
  - 5 (2.40%) youth running away
  - 5 (2.40%) property destruction
- Injury report
  - 168 (80.77%) no one injured
  - 32 (15.38%) client injured
  - 7 (3.37%) staff injured
  - 1 (0.48%) peer injured
- 208 (100%) incidents involved staff who received training on restraint and manual guidance while 206 (99.04%) of incidents involved staff who received annual refresher training

Graph 5 below shows the frequency of restraints by the hour of the day; 35.6% of restraints occur from 5:00 p.m. to 7:00 p.m.

Graph 5

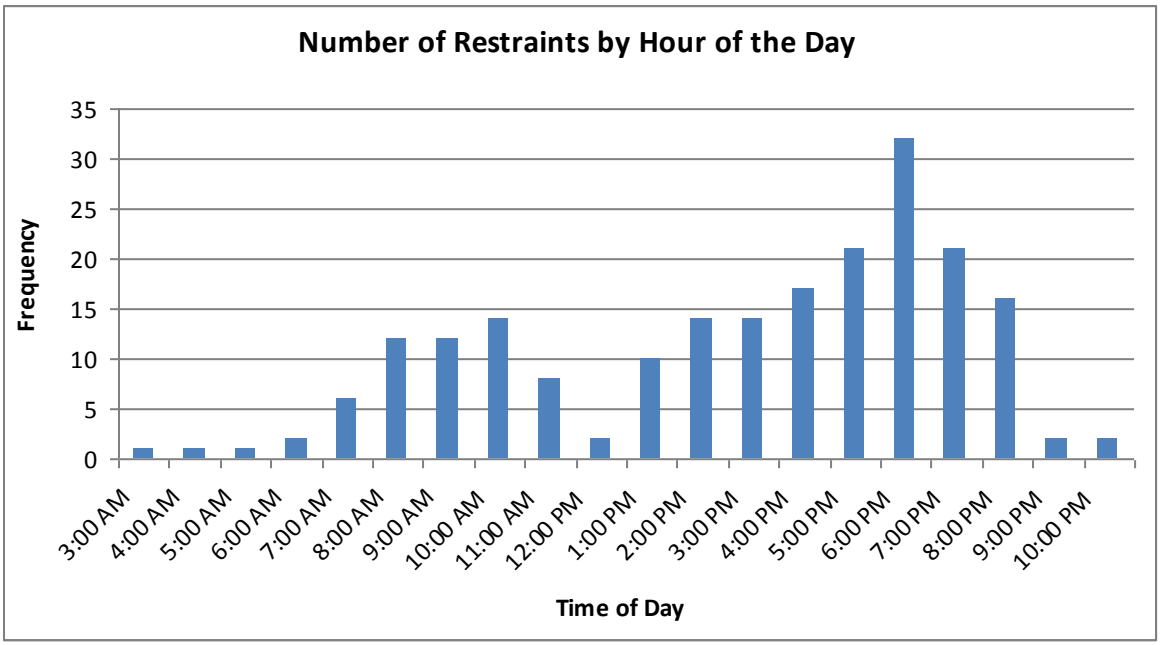


Table 13 reflects the demographics for restraint and manual guidance over the past five years. In 2012 the number of restraints for African-American children and youth decreased to 17.31%. There is an overall reduction in restraints and manual guidance in 2012. Improvement strategies are needed to maintain reduced number of restraints for all children and adolescents.

Table 13

Demographics	2012	2011	2010	2009	2008
Gender:					
Male	112 (53.85%)	178 (76.7%)	257 (73.2%)	94 (56%)	102 (66.2%)
Female	96 (46.15%)	54 (23.3%)	94 (26.8%)	74 (44%)	52 (33.8%)
Average Age	9.85	10.67	10.93	10.88	12.59
Race:					
Caucasian	150 (72.12%)	127 (54.7%)	108 (30.8%)	84 (50%)	103 (66.9%)
African-American	36 (17.31%)	78 (33.6%)	151 (43%)	66 (39.3%)	40 (26%)
American Indian/Alaskan Native	9 (4.33%)	3 (1.29%)	7 (2%)	6 (3.6%)	1 (.6%)
Asian	2 (0.96%)	-	2 (.6%)	-	-
Native Hawaiian/Other Pacific Islander	3 (1.44%)	2 (.9%)	1 (.3%)	1 (.6%)	-
Mixed Race	4 (1.92%)	13 (5.6%)	64 (18.2%)	11 (6.5%)	10 (6.5%)
Unknown	-	9 (3.9%)	18 (5.1%)	-	-
Other	4 (1.92%)	-	-	-	-
Hispanic	47 (22.60%)	33 (14.9%)	69 (19.7%)	16 (9.5%)	6 (3.9%)
Total	208	232	351	168	154

The reports of the use of restraint and manual guidance are separated for the northern/rural region and the southern region. Table 14 shows the providers who reported restraints and manual guidance in each region.

Table 14

Providers	
North/Rural	**South**
DCFS Adolescent Treatment Center	DCFS Oasis
DCFS Family Learning Homes	Eagle Quest of Nevada
Etxea Services	Father Flanagan's Boys Town
Koinonia	Genesis
Maple Star Nevada-North	London Family & Children's Services
Mountain Circle Family Services	Maple Star Nevada-South
My Home	SAFY
Rite of Passage	

Table 15 shows demographic and descriptive information by region for restraints and manual guidance.

Table 15

	North/Rural	South
Total	97	111
Gender:		
Male	54 (55.67%)	58 (52.25%)
Female	43 (44.33%)	53 (47.75%)
Average Age	9.87	9.83

Race:		
Caucasian	80 (82.47%)	70 (63.06%)
African-American	5 (5.15%)	31 (27.93%)
American Indian/Alaskan Native	7 (7.22%)	2 (1.80%)
Asian	-	2 (1.80%)
Native Hawaiian/Other Pacific Islander	3 (3.09%)	-
Mixed Race	1 (1.03%)	3 (2.70%)
Other	1 (1.03%)	3 (2.70%)
Hispanic	31 (31.96%)	16 (14.41%)
Custody		
Child welfare	77 (79.38%)	81 (72.97%)
DCFS youth parole	-	1 (0.90%)
Parental/no probation	13 (13.40%)	27 (24.32%)
Parental/on probation	7 (7.22%)	2 (1.80%)
Most frequent diagnosis	Posttraumatic Stress Disorder (28.87%) Attention Deficit/ Hyperactivity Disorder (20.63%)	Mood Disorder NOS (52.25%)
Restraint Method		
CPAR	71 (73.20%)	90 (81.08%)
CPI	19 (19.59%)	18 (16.22%)
Jireh	7 (7.22%)	-
TCI	-	1 (0.90%)
Mandt	-	1 (0.90%)
Other	-	1 (0.90%)
Restraint or manual guidance used previously	77 (79.38%)	100 (90.09%)
Average length of restraint or manual guidance in minutes	8.99	13.61
Type of supervision		
Group of 4 or more	17 (17.53%)	39 (35.14%)
Group of 2 or 3	17 (17.53%)	62 (55.86%)
One-on-one	55 (56.70%)	9 (8.11%)
Line of sight	8 (8.25%)	-
Other	-	1 (0.90%)
Precipitating event		
Physically assaultive toward adult	52 (53.61%)	39 (35.14%)
Physically assaultive toward another youth	26 (26.80%)	11 (9.91%)
Youth putting self at “risk” of harm	11 (11.34%)	23 (20.72%)
Youth putting others at “risk” of harm	8 (8.25%)	10 (9.01%)
Property destruction	-	5 (4.50%)
Youth running away	-	5 (4.50%)
Other	-	18 (16.22%)

Injury report		
No one injured	91 (93.81%)	77 (69.37%)
Client injured	3 (3.09%)	29 (26.13%)
Staff injured	3 (3.09%)	4 (3.60%)
Peer injured	-	1 (0.90%)
Staff received training	97 (100%)	111 (100%)
Staff received annual refresher training	97 (100%)	109 (98.20%)

Highlights:

- All staff received initial training and 99% received refresher training
- Over one-third of restraints occur during the dinner hour/early evening from 5 pm through 7 pm.

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 restraint 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 should 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
    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 two 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 22 Specialized Foster Care providers reported a total of child on child physical and/or sexual incidents:

A Brighter Day Family Services
Bountiful Family Services
DCFS Family Learning Homes
Eagle Quest of Nevada
Father Flanagan's Boys Town
Golla Homes
JC Family Services
KidsPeace
Koinonia
London Family and Children's Services
Majestic Community Services
Maple Star Nevada - South
Mile High Foster Family Agency
Mountain Circle Family Services
My Home
New Beginnings
Quest Hours
R House Community Treatment Center
Rite of Passage
SAFY
St. Jude's Ranch for Children
Transformations Therapy

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

- Victim
  - 98 (74.24%) were male, 31 (23.48%) were female, and 3 (2.27%) were missing data
  - Average age was 11.91 with an age range of 1 to 17 years
  - 82 (62.12%) were child welfare custody, 12 (9.09%) were parental custody not on probation, 22 (16.67%) were parental custody on probation, 8 (6.06%) were DCFS youth parole, 2 (1.52%) were Tribal custody, and 6 (4.55%) were missing data
- Initiator
  - 99 (75%) were male and 33 (25%) were female
  - Average age was 12.57 with an age range of 3 to 18 years
  - 94 (71.21%) were child welfare custody, 19 (14.73%) were parental custody on probation, 10 (7.58%) were DCFS youth parole, 4 (3.03%) were Tribal custody, 2 (1.52%) were parental custody not on probation, and 3 (2.27%) were missing

Clinical and physical and/or sexual incident (child on child) information:

- The most frequent diagnoses were
  - Attention Deficit/Hyperactivity Disorder (13.39 % of youth) and Oppositional Defiant Disorder (12.60% of youth) for the victim
  - Posttraumatic Stress Disorder (14.84 % of youth) and Oppositional Defiant Disorder (13.28% of youth) for the initiator

- Physical and/or sexual incident
  - 115 (87.12%) were physical incidents
  - 17 (12.88%) were sexual incidents
- History of physical or sexual incidents
  - 80 (60.61%) of the victims
  - 92 (69.70%) of the initiators
- 95 (71.97%) of the initiator youth had a history of initiating against other children
- Type of supervision for the incident
  - 77 (58.33%) occurred in the home during the day, staff awake
  - 21 (15.91%) occurred in the home at night, staff awake
  - 8 (6.06%) occurred in the community during a supervised outing
  - 4 (3.03%) occurred in the home at night, staff asleep
  - 19 (14.39%) at school
  - 2 (1.52%) during unsupervised family visit
  - 1 (0.76%) other
- 128 (96.97%) of the incidents were reported to the legal guardian
- 30 (22.73%) of the incidents were reported to child protective services

The reports of child on child incidents are separated for the northern/rural region and the southern region. Table 16 shows the providers who reported child on child incidents in each region.

Table 16

Providers	
North/Rural	**South**
DCFS Family Learning Homes	A Brighter Day Family Services
Golla Home	Bountiful Family Services
JC Family Services	Eagle Quest of Nevada
Koinonia	Father Flanagan’s Boys Town
Mountain Circle Family Services	KidsPeace
My Home	London Family & Children's Services
Quest House	Majestic Community Services
R House Community Treatment Center	Maple Star Nevada-South
Rite of Passage	Mile High Foster Family Agency
Transformations Therapy	New Beginnings
	SAFY
	St. Jude’s Ranch for Children

Table 17 shows demographic and descriptive information by region for child on child incidents.

Table 17

	North/Rural	South
Total	35	97
Gender: Victim		
Male	31 (88.57%)	67 (69.07%)
Female	4 (11.43%)	27 (27.84%)
Missing	-	3 (3.09%)
Gender: Initiator		
Male	31 (88.57%)	68 (70.10%)
Female	4 (11.43%)	29 (29.90%)
Average Age		
Victim	11.66	12.01
Initiator	12.86	12.47
Custody: Victim		
Child welfare	26 (74.29%)	56 (57.73%)
DCFS youth parole	3 (8.57%)	5 (5.15%)
Parental/no probation	3 (8.57%)	9 (9.28%)
Parental/on probation	2 (5.71%)	20 (20.62%)
Tribal	1 (2.86%)	1 (1.03%)
Missing	-	6 (6.19%)
Custody: Initiator		
Child welfare	29 (82.86%)	65 (67.01%)
DCFS youth parole	2 (5.71%)	8 (8.25%)
Parental/no probation	2 (5.71%)	-
Parental/on probation	1 (2.86%)	18 (18.57%)
Tribal	1 (2.68%)	3 (3.09%)
Missing	-	3 (3.09%)
Most frequent diagnosis: Victim	Posttraumatic Stress Disorder (22.86%) Attention Deficit/ Hyperactivity Disorder (11.43%)	Attention Deficit/ Hyperactivity Disorder (16.30%) Oppositional Defiant Disorder (14.13%)
Most frequent diagnosis: Initiator	Posttraumatic Stress Disorder (28.57%) Mood Disorder NOS (17.14%)	Oppositional Defiant Disorder (15.05%) Mood Disorder NOS (10.75%)
Physical and/or sexual incident		
Physical incidents	32 (91.43%)	83 (85.57%)
Sexual incidents	3 (8.57%)	14 (14.43%)
History of physical or sexual incidents		
Of the victims	28 (80.00%)	52 (53.61%)
Of the initiators	29 (82.86%)	63 (64.95%)
Initiator youth had a history of initiating against other children	30 (85.71%)	65 (67.01%)
Type of supervision for the incident		

Occurred in the home during the day, staff awake	21 (60.00%)	56 (57.73%)
Occurred in the home at night, staff awake	12 (34.29%)	9 (9.28%)
Occurred in the community during a supervised outing	-	8 (8.25%)
Occurred in the home at night, staff asleep	-	4 (4.12%)
At school	2 (5.71%)	17 (17.53%)
During unsupervised family visit	-	2 (2.06%)
Other		1 (1.03%)
Incidents were reported to the legal guardian	32 (91.43%)	96 (98.97%)
Incidents were reported to child protective services	26 (74.29%)	21 (21.65%)

Practice Guidelines and 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 42 Specialized Foster Care providers reported a total of 918 departures.

A Brighter Day
Apple Grove
Art Homes
Bountiful Family Services
London Family and Children's Services
Majestic Community Services
Maple Star North
Maple Star Rural

Briarwood North
Daybreak Equestrian Center
DCFS Adolescent Treatment Center
DCFS Family Learning Homes
DCFS Oasis
Eagle Quest
Etxea Services
Father Flanagan's Boys Town
Genesis
Golla Home
Hand Up Homes
Hope Healthcare Services
Northwest Academy
JC Family Services
Kids First
KidsPeace
Koinonia
Maple Star South
Mile High Foster Family Agency
Mountain Circle Family Services
My Home
New Beginnings
Nova
Olive Crest Foster Family Agency
Quest House
R House Community Treatment Center
Reagan Home
Rite of Passage
SAFY
St. Jude's Ranch for Children
Transformations Therapy
Trinity Youth Services
Unity Family Services
Unity Village

Table 18 shows the number of agencies reporting departures and the total number of departures for each reporting period.

Table 18

DEPARTURES		
Reporting Period	Number of agencies reporting	Number of Departures
2012	42	918
2011	41	937
2010	42	940
2009	39	907
Sept – Dec 2008	30	351

Departures reflect the following descriptive information:

- 553 (60.24%) were male and 365 (39.76%) were female
- Average age at departure was 13.48, ranging from 1 year of age to 20 years
- Race:
  - 494 (53.81%) were Caucasian
  - 219 (23.86%) were Black/African-American
  - 100 (10.89%) were of mixed race
  - 26 (2.83%) were American Indian/Alaskan Native
  - 8 (0.87%) were Native Hawaiian/Other Pacific Islander
  - 6 (0.65%) were Asian
  - 59 (6.43%) were other
  - 6 (0.65%) were unknown
- 178 (19.39%) were of Hispanic origin
- Custody Status
  - 540 (58.82%) were in child welfare custody
  - 183 (19.93%) were in parental custody and on probation
  - 88 (9.59%) were in custody of youth parole

  - 88 (9.59%) were in parental custody no probation
  - 19 (2.07%) were in Tribal custody
- 895 (97.49%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 242.42 days with a range of 1 to 5332 days (or 14.61 years); the median length of stay is 156 days

Clinical and departure information:

- The most frequent diagnoses at admission were:
  - 154 (16.83%) Posttraumatic Stress Disorder
  - 70 (7.65%) Mood Disorder NOS
  - 69 (7.54%) Attention Deficit/Hyperactivity Disorder
  - 64 (6.99%) Oppositional Defiant Disorder
- The most frequent diagnoses at discharge were:
  - 157 (17.16%) Posttraumatic Stress Disorder
  - 76 (8.31%) Mood Disorder NOS
  - 69 (7.54%) Oppositional Defiant Disorder
  - 61 (6.67%) Attention Deficit/Hyperactivity Disorder
- The average CASII composite score at admission was 22.61
- The average CASII composite score at departure was 21.67
- The average ECSII composite score at admission was 19.58
- The average ECSII composite score at discharge was 19.21
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.08, which equals the restrictiveness score of regular foster care
  - 13 (1.42%) independent living by self
  - 8 (0.87%) independent living with friend
  - 49 (5.34%) home of parents for an 18-year-old
  - 258 (28.10%) home of parents for a child
  - 5 (0.54%) school dormitory
  - 68 (7.41%) home of relative
  - 33 (3.59%) adoptive home
  - 6 (0.65%) home of a family friend
  - 18 (1.96%) supervised independent living
  - 35 (3.81%) regular foster care
  - 1 (0.11%) individual home emergency shelter
  - 98 (10.68%) family-based treatment home
  - 61 (6.64%) group treatment home
  - 37 (4.03%) group emergency shelter
  - 34 (3.70%) residential treatment center
  - 15 (1.63%) medical hospital
  - 44 (4.79%) youth correction center
  - 37 (4.03%) county detention center
  - 24 (2.61%) state and private mental hospital
  - 6 (0.65%) jail
  - 68 (7.41%) unknown, e.g. AWOL
- 304 (33.15%) completed treatment
- 109 (11.87%) the provider gave notice; of these 78 (71.56%) were 14 calendar days' notice
- In the provider's opinion was the transition plan appropriate?
  - 784 (85.40%) yes

- Did the provider agree that the discharge was appropriate?
  - 838 (91.29%) yes
- Who recommended departure
  - 424 (46.19%) child and family team
  - 109 (11.87%) provider agency
  - 89 (9.69%) child went AWOL
  - 77 (8.39%) child welfare case manager
  - 64 (6.97%) judge or hearing master
  - 59 (6.43%) parole/probation officer
  - 21 (2.29%) child's mental health practitioner
  - 18 (1.96%) parent
  - 6 (0.65%) relative guardian
  - 1 (0.11%) child's attorney
  - 50 (5.45%) other

Highlights:

- Using the ROLES, 44.44% of children and adolescents achieved or returned to a permanent placement upon discharge (i.e. reunified with family, adopted, or relative placement).
- Upon departure, 53.81% 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).
- Table 19 below shows the percentage of discharges from treatment homes that were recommended by CFT across reporting periods.

Table 19

Discharges Recommended by Child and Family Team	
Reporting Period	Percent of Discharges Recommended by Child and Family Team
2012	46.19%
2011	47.07%
2010	55.90%
2009	48.40%
2008	39.30%

In the past two years there appears to be a downward trend in discharges recommended by the CFT after a higher percentage in 2010.

- Table 20 below shows the number of children and adolescents who completed treatment whose discharge was recommended by the CFT across reporting periods.

Table 20

Treatment Completers' Discharges Recommended by Child and Family Team	
Reporting Period	**Number of Discharges Recommended by Child and Family Team**
2012	229 (75.33%)
2011	233 (76.10%)
2010	308 (81.30%)
2009	290 (77.30%)

2008	138 (39.30%)

- There is a high degree of agreement by the providers that the transition plan was appropriate (85.40%) and that the discharge was appropriate (91.29%).

Opportunities for improvement:

- Table 21 below shows treatment completion status by custody type.

Table 21

Custody Type	Complete	Incomplete	Missing
Child Welfare	114 (12.43%)	425 (46.35%)	1 (0.11%)
Parental on probation	108 (11.78%)	75 (8.18%)	
Youth Parole	33 (3.60%)	55 (6.00%)	
Parental	45 (4.91%)	43 (4.69%)	
Tribal	4 (0.44%)	15 (1.64%)	
Total	304 (33.12%)	613 (66.78%)	1 (0.11%)

- Table 22 below shows the percent of treatment completers by reporting periods.

Treatment Completers by Year	
Reporting Period	Percent
2012	33.1%
2011	32.7%
2010	40.3%
2009	42.0%
2008	39.3%

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.

The reports of the departures are separated for the northern/rural region and the southern region. Table 23 shows the providers who reported departures in each region.

Table 23

Providers	
North/Rural	**South**
Briarwood-North	A Brighter Day Family Services
Daybreak Equestrian Center	Apple Grove
DCFS ATC	ART Homes
DCFS FLH	Bountiful Family Services
Etxea Services	DCFS Oasis

Golla Home	Eagle Quest of Nevada
Hand Up Homes	Father Flanagan's Boys Town
Hope Healthcare Services	Genesis
Northwest Academy	London Family & Children's Services
JC Family Services	Majestic Community Services
Kids First	Maple Star Nevada-South
Koinonia	Mile High Foster Family Agency
Maple Star Nevada-North	New Beginnings
Maple Star Nevada-Rural	Olive Crest Foster Family Agency
Mountain Circle Family Services	SAFY
My Home	St. Jude's Ranch for Children
Nova	Trinity Youth Services
Quest House	Unity Family Services
R House Community Treatment Center	Unity Village
Reagan Homes	
Rite of Passage	
Transformations Therapy	

Table 24 shows demographic and descriptive information by region for departures.

Table 24

	North/Rural	South
Total	315	603
Gender:		
Male	212 (67.30%)	341 (56.55%)
Female	103 (32.70%)	262 (43.45%)
Average Age	15.28	12.54
Race:		
Caucasian	214 (67.94%)	280 (46.43%)
African-American	45 (14.29%)	174 (28.86%)
American Indian/Alaskan Native	16 (5.08%)	10 (1.66%)
Asian	1 (0.32%)	5 (0.83%)
Native Hawaiian/Other Pacific Islander	2 (0.63%)	6 (1.00%)
Mixed Race	25 (7.94%)	75 (12.44%)
Other	12 (3.81%)	47 (7.97%)
Unknown	-	6 (1.00%)
Hispanic	59 (18.73%)	119 (19.73%)
Custody		
Child welfare	94 (29.84%)	446 (73.96%)
DCFS youth parole	54 (17.14%)	34 (5.64%)
Parental/no probation	53 (16.83%)	35 (5.80%)
Parental/on probation	97 (30.79%)	86 (14.26%)
Tribal	17 (5.40%)	2 (0.33%)

Most frequent diagnosis		
Admission	Posttraumatic Stress Disorder (17.14%) Dysthymic Disorder (9.21%)	Posttraumatic Stress Disorder (16.67%) Oppositional Defiant Disorder (9.17%) ADHD (8.50%)
Discharge	Posttraumatic Stress Disorder (16.83%) Dysthymic Disorder (10.48%)	Posttraumatic Stress Disorder (17.33%) Oppositional Defiant Disorder (9.50%) Mood Disorder NOS (9.17%)
Average CASII/ECSII Score		
CASII Admission	23.97	21.85
CASII Discharge	22.37	21.28
ECSII Admission	25.00 (1 child)	19.41
ECSII Discharge	25.00 (1 child)	19.03
Average Length of Stay	244.69	241.23
Average ROLES Score	9.21	10.53
Children and Adolescents that Achieved or Returned to a Permanent Placement	51.75%	40.63%
Children and Adolescents Going to a Less Restrictive Setting to Live	59.37%	50.91%
Completed Treatment	175 (55.56%)	129 (21.43%)
Transition Plan Appropriate	277 (87.94%)	507 (84.08%)
Discharge Appropriate	278 (88.25%)	560 (92.87%)
Who Recommended Departure?		
Child and Family Team	192 (60.95%)	232 (38.47%)
Child Welfare Case Manager	6 (1.90%)	71 (11.77%)
Provider Agency	46 (14.60%)	63 (10.45%)
Child Went AWOL	28 (8.89%)	61 (10.12%)
Judge or Hearing Master	7 (2.22%)	57 (9.45%)
Child's Mental Health Practitioner	3 (0.95%)	18 (2.99%)
Parent	8 (2.54%)	10 (1.66%)
Relative Guardian	1 (0.32%)	5 (0.83%)
Parole/Probation Officer	14 (4.44%)	45 (7.46%)
Child's Attorney	-	1 (0.17%)
Other	10 (3.17%)	40 (6.63%)

Children and Adolescents in Child Welfare Custody

Of the 918 departures reported in 2012, 540 or 58.82% of the children and adolescents were in the custody of a child welfare agency. The 540 child welfare custody departures reflect the following descriptive information.

- 293 (54.26%) were male and 247 (45.74%) were female
- Average age at departure was 12.34 , ranging from 2 years of age to 19 years
- Race

  - 273 (50.56%) were Caucasian
  - 140 (25.93%) were Black/African-American
  - 70 (12.96%) were of mixed race
  - 11 (2.04%) were American Indian/Alaskan Native
  - 4 (0.74%) were Asian
  - 1 (0.19%) was Native Hawaiian/Other Pacific Islander
  - 35 (6.48%) were other
  - 6 (1.11%) were unknown
- 108 (20.0%) were of Hispanic origin
- 538 (99.63%) were Medicaid or SCHIP recipients
- Average length of stay at departure is 263.69 days with a range of 1 to 5332 days (or 14.61 years); the median length of stay is 149.5 days

Clinical and departure information:

- The most frequent diagnoses at admission were:
  - 116 (21.52%) Posttraumatic Stress Disorder
  - 46 (8.53%) Attention Deficit/Hyperactivity Disorder
  - 43 (7.98%) Mood Disorder NOS
  - 43 (7.98%) Oppositional Defiant Disorder
- The most frequent diagnoses at discharge were:
  - 121 (22.45%) Posttraumatic Stress Disorder
  - 49 (9.09%) Mood Disorder NOS
  - 43 (7.98%) Attention Deficit/Hyperactivity Disorder
  - 42 (7.79%) Oppositional Defiant Disorder
- The average CASII composite score at admission was 21.88
- The average CASII composite score at departure was 21.31
- The average ECSII composite score at admission was 19.74
- The average ECSII composite score at departure was 19.34
- Setting child/adolescent will live – The Restrictiveness of Living Environment Scale (ROLES) (Hawkins, Almeida, Fabry & Reitz, 1992) resulted in an average score of 10.21, which equals the restrictiveness score of a regular foster home
  - 10 (1.85%) independent living by self
  - 6 (1.11%) independent living with friend
  - 16 (2.96%) home of natural parents for an 18-year-old
  - 123 (22.78%) home of natural parents for a child
  - 1 (0.19%) school dormitory
  - 36 (6.67%) home of relative
  - 27 (5.00%) adoptive home
  - 3 (0.56%) home of a family friend
  - 14 (2.59%) supervised independent living
  - 26 (4.81%) regular foster care
  - 1 (0.19%) individual home emergency shelter
  - 84 (15.56%) family-based treatment home
  - 45 (8.33%) group treatment home
  - 33 (6.11%) group emergency shelter
  - 20 (3.70%) residential treatment center
  - 14 (2.59%) medical hospital
  - 13 (2.41%) youth correction center
  - 6 (1.11%) county detention center

  - 15 (2.78%) state and private mental hospital
  - 47 (8.70%) unknown, e.g. AWOL
- 114 (21.15%) completed treatment
- In the provider's opinion was the transition plan appropriate?
  - 447 (82.78%) yes
- Did the provider agree that the discharge was appropriate?
  - 496 (91.85%) yes
- Who recommended departure
  - 241 (44.63%) child and family team
  - 73 (13.52%) child welfare case manager
  - 58 (10.74%) provider agency
  - 54 (10.00%) child went AWOL
  - 42 (7.78%) judge or hearing master
  - 13 (2.41%) child's mental health practitioner
  - 8 (1.48%) parole/probation officer
  - 8 (1.48%) parent
  - 3 (0.56%) relative guardian
  - 40 (7.41%) other

Highlights for child welfare:

- Using the ROLES, 202 (37.41%) 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 10.21 for all discharged children and adolescents in child welfare custody is equal to the restrictiveness of a regular foster care home.
- Upon departure, 263 (48.70%) 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).
- Of the 114 children and adolescents in child welfare custody that completed treatment 86 (75.44%) were discharged as recommended by their CFT.

The reports of the child welfare departures are separated for the the northern/rural region and the southern region. Table 25 shows demographic and descriptive information by region for child welfare departures.

Table 25

	North/Rural	South
Total	94	446
Gender:		
Male	53 (56.38%)	240 (53.81%)
Female	41 (43.62%)	206 (46.19%)
Average Age	14.03	11.99

Race:		
Caucasian	65 (69.15%)	208 (46.64%)
African-American	11 (11.70%)	129 (28.92%)
American Indian/Alaskan Native	3 (3.19%)	8 (1.79%)
Asian	-	4 (0.90%)
Native Hawaiian/Other Pacific Islander	1 (1.06%)	-
Mixed Race	10 (10.64%)	60 (13.45%)
Other	4 (4.26%)	31 (6.95%)
Unknown	-	6 (1.35%)
Hispanic	17 (18.09%)	91 (20.40%)
Most frequent diagnosis		
Admission	Posttraumatic Stress Disorder (27.66%)	Posttraumatic Stress Disorder (20.22%) Oppositional Defiant Disorder (9.21%) ADHD (8.31%) Posttraumatic Stress Disorder (21.12%) Mood Disorder NOS (9.21%) Oppositional Defiant Disorder (8.76%)
Discharge	Posttraumatic Stress Disorder (28.72%)	
Average CASII/ECSII Score		
CASII Admission	23.34	21.54
CASII Discharge	22.24	21.10
ECSII Admission	25.00 (1 child)	19.57
ECSII Discharge	25.00 (1 child)	19.16
Average Length of Stay	292.49	257.62
Average ROLES Score	11.24	10.00
Children and Adolescents that Achieved or Returned to a Permanent Placement	25.53%	39.91%
Children and Adolescents Going to a Less Restrictive Setting to Live	39.36%	50.67%
Completed Treatment	42 (44.68%)	72 (16.18%)
Transition Plan Appropriate	79 (84.04%)	368 (82.51%)
Discharge Appropriate	82 (87.23%)	414 (92.83%)
Who Recommended Departure?		
Child and Family Team	59 (62.77%)	182 (40.81%)
Child Welfare Case Manager	5 (5.32%)	68 (15.25%)
Provider Agency	3 (3.19%)	55 (12.33%)
Child Went AWOL	12 (12.77%)	42 (9.42%)
Judge or Hearing Master	4 (4.26%)	38 (8.52%)
Child's Mental Health Practitioner	-	13 (2.91%)
Parent	2 (2.13%)	6 (1.35%)

Parole/Probation Officer	3 (3.19%)	5 (1.12%)
Relative Guardian	-	3 (0.67%)
Child's Attorney	-	-
Other	6 (6.38%)	34 (7.62%)

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 want to address medication errors that are systemic (i.e. inability to obtain prior authorization from a third party payer and inability to obtain legal consent) with system partners such as Nevada Medicaid and Child Welfare agencies.
- 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 and trauma informed care in its curriculum. Providers will have a restraint and manual guidance policy that emphasizes the use of restraint 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 CFT decision-making around client discharge as children and adolescents who completed treatment were more likely to have discharge recommended by the CFT
  - 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.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Society of Hospital Pharmacists. (1993). ASHP guidelines on preventing medication errors in hospitals. *American Journal of Hospital Pharmacy.* 50:305–14.

Bowlby, J. (1970). *Attachment and loss, Volume I: Attachment*. New York: Basic Press.

Child Welfare League of America. (2007). *Prevention of missing-from-care episodes.* Retrieved 10-14-09 from www.cwla.org/programs/fostercare/childmiss07.pdf

Children Missing From Care: Proceedings of Expert Panel Meeting. March 8 and 9, 2004.

Committee on Restraint and Crisis Intervention Techniques Final Report to the Governor and Legislature (2007). *Behavior support & management: Coordinated standards for children's systems of care.* Rensselaer, NY: Council on Children and Families.

Courtney, C. E., Skyles, A., Samuels, G. M., Zinn, A., Howard, E., & George, R. M. (2005) *Youth who run away from substitute care (CS-114)*. University of Chicago, Chapin Hall Center for Children.

Falhberg, V. (1991). *A child's journey through placement.* Indianapolis: Perspective Press.

Falhberg, V. and Staff of Forest Heights Lodge (1972). *Residential treatment: a tapestry of many therapies.* Indianapolis: Perspectives Press.

Haimowitz, S., Urff, J., & Huckshorn, K. (1992). *Restraint and seclusion: A risk management guide.* New York: Author.

Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry*, 43, 54-58.

Iowa Department of Human Services Employees' Manual, Title 3, Chapter E (2006). Restraint and Seclusion Policy for Mental Health Institutions. Iowa: Author

Jewett, C. (1982). *Helping children cope with separation and loss.* Massachusetts: Harvard Common Press.

Nevada Children's Behavioral Health Consortium. *Guidance for creating effective child and family team meetings.*

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide. *Model program's guide version 2.5.* Retrieved April 27, 2009 from http://www.dsgonline.com/mpg2.5/TitleV_MPG_Table_Ind_Rec.asp?ID=292

Stop It Now. (2010). *Prevent child sexual abuse: Facts about sexual abuse and hot to prevent it.* Retrieved February 14, 2012 from http://www.stopitnow.org/files/Prevent_Child_Sexual_Abuse.pdf

Title 39, Nevada Revised Statutes 433 § 5476 (1999).

United States General Accounting Office, GAO Report to Congress (1999). Mental health: Improper restraint or seclusion. People at risk. Washington, D.C. Author.

U.S. Pharmacopeia. (2000, December). *USP Medmarx data analyzed – first annual report provided.* Retrieved April 28, 2009 from http://www.usp.org/audiences/volunteers/members/private/memos/2000-12.html

U.S. Pharmacopeia. (1997, January). *Definition of medication errors.* Retrieved April 28, 2009 from http://www.usp.org/hqi/practitionerPrograms/newsletters/qualityReview/qr571997-01-01e.html

World Health Organization. (2006). *Preventing child maltreatment: a guide to taking action and generating evidence.* Retrieved 02-14-12 from http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf

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.	ART Homes - NEW	5	5	100%
4.	Bountiful Family Services	12	12	100%
5.	Briarwood – North - CLOSED	3	3	100%
6.	Daybreak Equestrian Center - CLOSED	5	5	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	9	75%
12.	Father Flanagan's Boys Town	12	12	100%
13.	Genesis (formally Sankofa)	12	12	100%
14.	Golla Home	12	12	100%
15.	Hand Up Homes	12	12	100%
16.	Hope Healthcare Services	12	12	100%
17.	JC Family Services	12	12	100%
18.	Kids First - CLOSED	1	1	100%
19.	KidsPeace	12	12	100%
20.	Koinonia	12	12	100%
21.	London Family & Children's Services	12	12	100%
22.	Majestic Community Services	12	12	100%
23.	Maple Star Nevada - North	12	12	100%
24.	Maple Star Nevada – Rural - CLOSED	7	7	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.	Northwest Academy (formally Horizon Academy)	12	12	100%
31.	Nova	12	12	100%
32.	Olive Crest Foster Family Agency	12	12	100%
33.	Pathways of Nevada - NEW	12	12	100%
34.	Quest House - NEW	6	6	100%
35.	R House Community Treatment Center	12	12	100%
36.	Reagan Home	12	12	100%
37.	Rite of Passage	12	12	100%
38.	SAFY	12	12	100%
39.	St. Jude's Ranch for Children	12	12	100%
40.	Transformations Therapy	12	12	100%
41.	Trinity Youth Services - CLOSED	7	7	100%
42.	Unity Family Services - CLOSED	6	6	100%
43.	Unity Village - CLOSED	7	7	100%