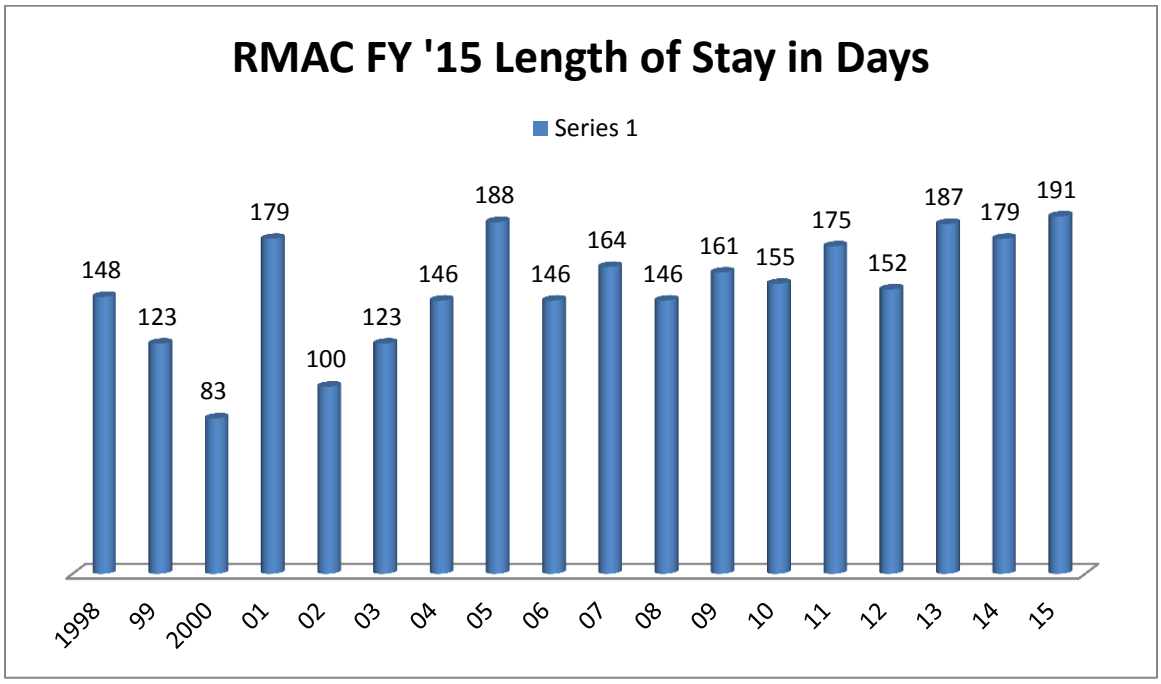
Fiscal Year 2015 RMAC Annual Analysis

Fiscal Year 2015 (FY'15) brought many challenges for the Ruth Meiers Adolescent Center (RMAC) and the youth served. Fewer admissions, longer stays, fewer youth discharged directly home, higher acuity in youth served, more incident reports, and increased private placements were just some of the factors impacting the youth served and the program as a whole. This report will analyze these factors and other data to tell the story of those served and of those providing the service in our 10 bed Psychiatric Residential Treatment Facility (PRTF).

LENGTH OF STAY (LOS)

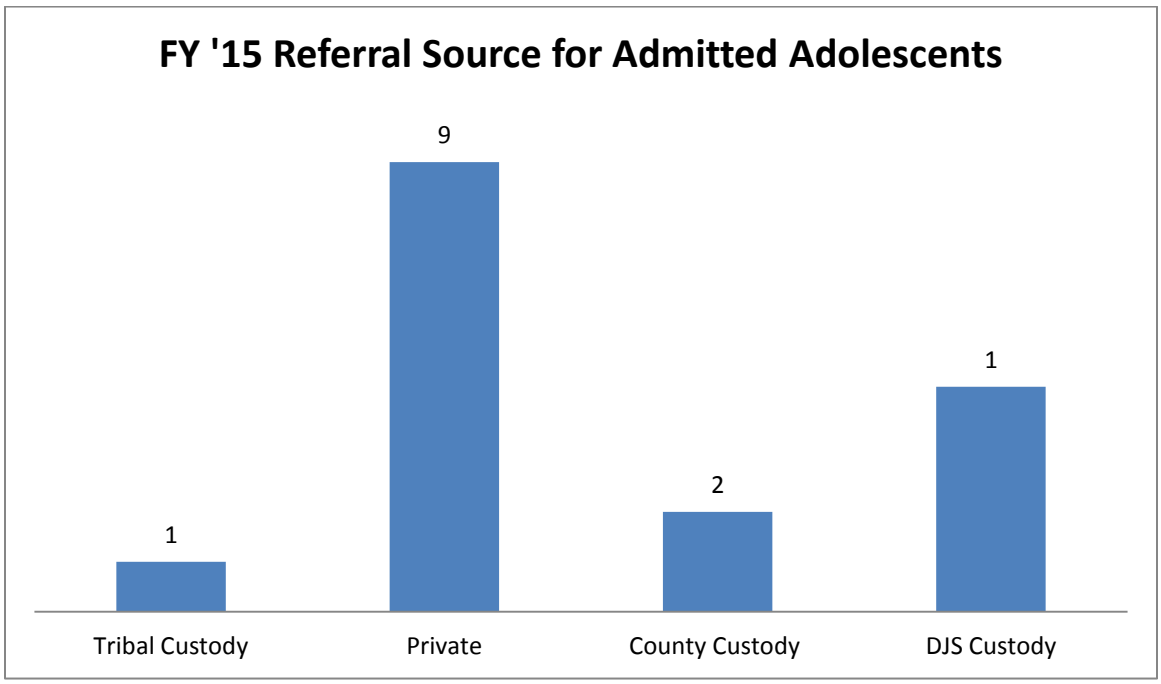
A national study in 2012 (James et al.) found the average length of stay (LOS) in residential care to be approximately 270 days. Though RMAC's LOS is significantly lower than that number, an 18 year high of 191 days is more than a month greater than the 18 year average of 160 days. The complexity of issues facing the adolescent, family, custodians and the facility all play a role in how long an adolescent is in care. As a result, many moving parts make pinpointing a specific reason for the high number of days in care very difficult, which ultimately is likely a combination of various factors. This will be explored in greater detail elsewhere in this report. An important goal for the program is to work towards minimizing the length of time an adolescent is in care while assuring that the treatment process is successful before discharging the adolescent. Nothing is worse for a treatment program than to discharge an adolescent before they are ready, only to have them reenter care at a later time.



As can be seen in the above chart, there is a fluctuation from year to year, though recent years has seen a slight increase in the number of days an adolescent is in care. Trying to maintain the status quo and/or reduce the length of time a child is in treatment is a significant challenge as the acuity of the adolescents admitted to the program continues to be greater often leading to a need of longer stays, not shorter.

REFERRAL SOURCES OF ADOLESCENTS ADMITTED TO RMAC

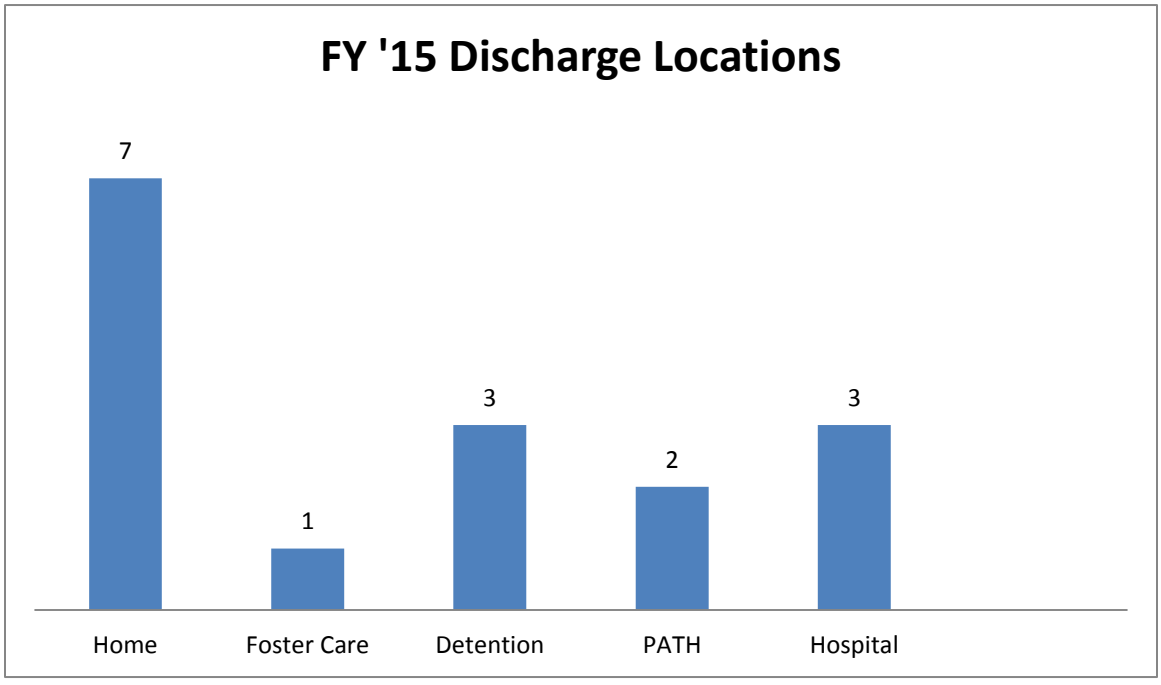
Where do the children in care come from? More than ever before youth were placed at RMAC directly by their parents or other custodial family members. Only 4 of 13 youth placed at RMAC in FY ’15 came from a tribal or county social service or DJS. This is a transformation from the historical data where upwards of 90% of youth were placed by a custodial agency. Though it is a step forward in that parents are able to access PRTF level of care for their child, issues related to insurance and keeping families engaged in the treatment process can be a challenge.



Compare this to the first year this data was collected, 1998, when 100% of the 25 youth placed at RMAC were placed by either County Social Service or the Division of Juvenile Services. Though the specific reasons are unclear, private placements began to noticeably increase beginning in 2010. An ongoing goal of the RMAC program is to engage parents into the treatment process with their child. Long recognized as one of the primary factors in successful treatment outcomes for youth in care, family involvement/engagement is not only desired but crucial for the young adult in care.

DISCHARGE LOCATION INFORMATION

When an adolescent is done with their treatment at RMAC, where do they go? This is an extremely important question. The answer has a significant impact on the treatment process and outcome. One of the first things that happen when an adolescent enters treatment is to establish the discharge plan. Where will they be going when they are done? When will they be done? Does everyone agree with the plan? If the parent and or family need to work on issues do they do so willingly and in a timely manner? Are services available when and where needed? All of these factors play a role in how well the adolescent does in treatment, though the adolescent doesn't control most of those factors directly. What if the parents can't take the child home? Is there a family member or foster home available in the child's home town? What if the child is not making progress in treatment – where do they go? Where ever they go, will they be safe? Are services available at the discharge location? Can the parents or custodians follow through on discharge recommendations? Is cost and money a factor? If siblings are involved, are they ready for their brother/sister to return? Finding answers to these questions is sometimes as difficult as providing treatment to the adolescent. Many times an adolescent is making good progress in the program only to have one or more of the above factors still unanswered and problematic. Some of the factors are so important that, if left unanswered, success for the adolescent after discharge is unlikely.



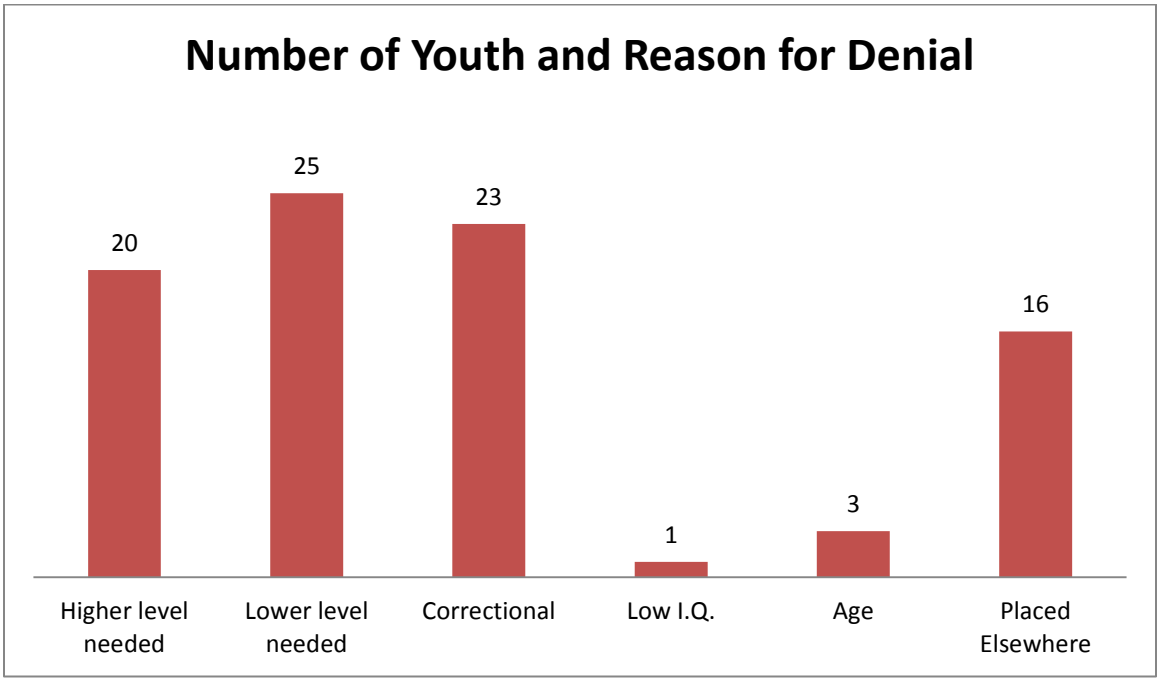
In most situations, where the adolescent is returning to their home, family work is necessary. This important process can be complicated given that many of the adolescents in the program are from locations far away from Grand Forks and RMAC. New efforts were made this past year to engage regional Human Service Centers (HSC) to provide family therapy to those families from their region, given that RMAC is part of the state HSC system. This process allows for therapy to begin more quickly and just as importantly, continue on in the child's home area after discharge. We are still working the kinks out with this process but initial results are encouraging. Ultimately the program goal is for the child to be discharged to a location where they can be happy, healthy and successful, where ever that may be.

FACT: In FY '15 females were in the program for 201 days, whereas males averaged 185 days.

Youth placed by County Social Service agencies averaged 213 days in placement; DJS placements, 86 days and Tribal placements, 92 days.

OVERALL REFERRALS TO THE RMAC PROGRAM

During FY'15, 120 referral applications were formally reviewed by the Admissions and Discharge team, 19 were accepted of which 13 (68.4%) were ultimately admitted and placed into the program. This, breaks down to 15.8% of all referrals to the program were accepted and 10.8% of all referrals actually entered the program. Why do only 10.8% of the referrals to the program end up entering the program? This is a great question and one that is more difficult to answer than one would think. The following chart shows the number of applicants reviewed and the various reasons for their denial.

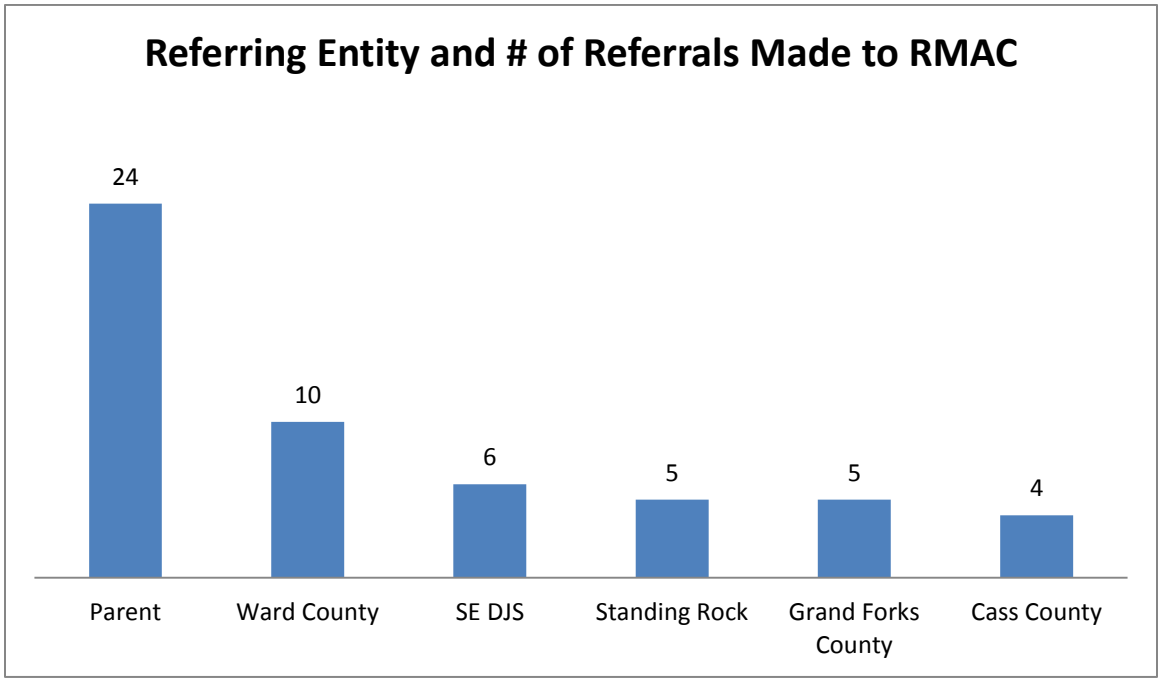


Those denied because a "lower level of care needed" make up the largest number and percentage (20.8%) of all reasons for denial. The Admissions team places a heavy emphasis on making sure youth are served in the least restrictive environment. If, after reviewing the referral information, the team determines that an adolescent's needs do not rise to the PRTF level, a recommendation to a less restrictive (lower) level of care is made. This past year found 23 (19.1%) referrals denied as a result of the team determining that a correctional setting may be more appropriate. These referrals are often difficult for the team in that the adolescent does likely have psychiatric issues that are appropriate for a PRTF but often the behaviors of the adolescent (aggressive, assaultive, AWOL risk, etc…) would be better served in a more secure type setting. Additionally, 16.6% (20) of the denied referrals were the result of the team believing that a higher/different level of care was needed. This could include the need for more security than RMAC can provide or that the current issues for the adolescent (suicidal, homicidal, active A&D issues, sexual offending, assaultive behavior etc.) were more acute than appropriate for RMAC.

During FY ’15, RMAC received referrals from 38 different entities including:

- County Social Service Offices
- Tribal Social Services
- Division of Juvenile Services
- Hospitals
- Human Service Centers
- Parents

The following chart shows the 5 entities with the most referrals to the RMAC program.



Similar to the data of youth *admitted* to the program the number one source of all adolescents *referred* to the program is parent’s – 24 youth or 20% of all referrals. If individual county social service referrals were combined they would total 43%, which would surpass parental referrals.

PROFILE OF AN ADOLESCENT REFERRED TO RMAC

- *15 years old*
- *Current location of adolescent at time of referral:*
    - *Correctional setting – 21.4%*
    - *Home – 17.7%*
    - *Inpatient Psychiatric Facilities – 14%*
    - *Other PRTF/RCCF – 12.1%*
    - *Mother's home – 9.3%*

PROFILE OF AN ADOLESCENT ADMITTED TO RMAC IN FY'15

- *14 years old*
- *38% have experienced sexual abuse*
- *61% Caucasian, 31% Native American, 8% Hispanic*
- *Average GAF score of 47 upon admittance*
- *69% were private placements*
- *54% female, 46% male*
- *Average length of time from when a referral is received until it is reviewed by the Admissions team is 7 days*
- *Those completing the program averaged 8 home passes for a total of 17 days*
- *Most of the adolescents attended the on-site school classroom*
- *7 times during FY'15 adolescents went to detention for a total of 28 days*
- *10 times adolescents went to the hospital for a total of 74 days*

Top 5 Diagnosis of Adolescent's Admitted to RMAC in FY'15

Depression with Psychotic Features

Disruptive Mood Disorder

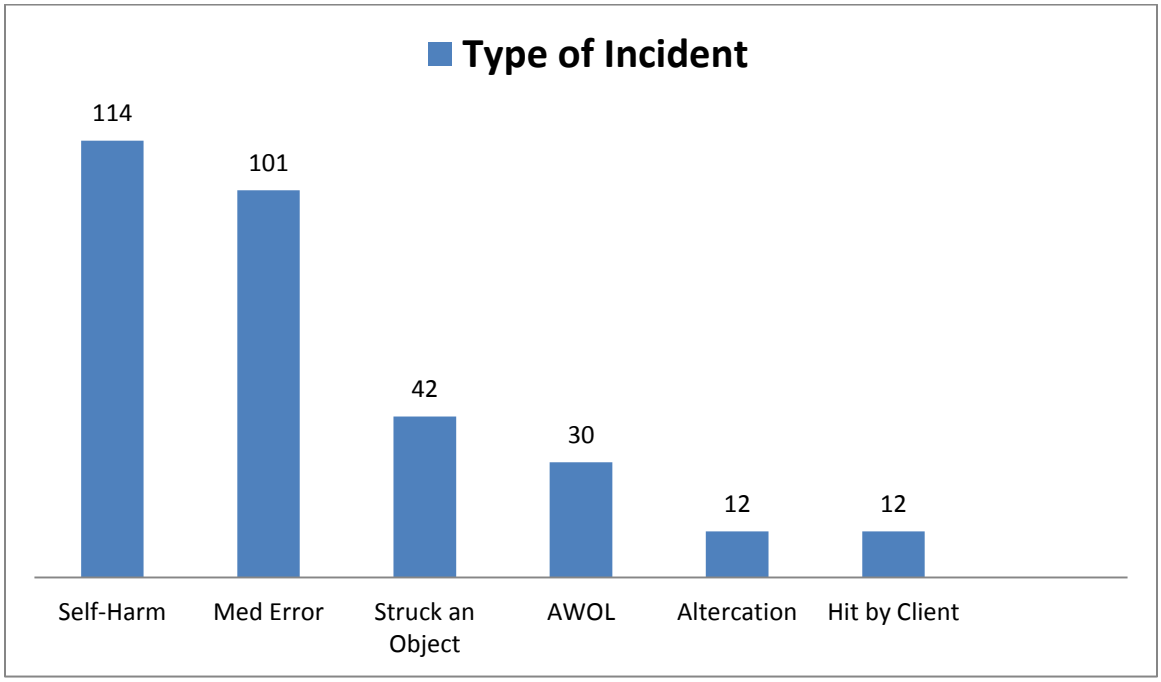
Oppositional Defiance Disorder

Post-Traumatic Stress Disorder

Depression

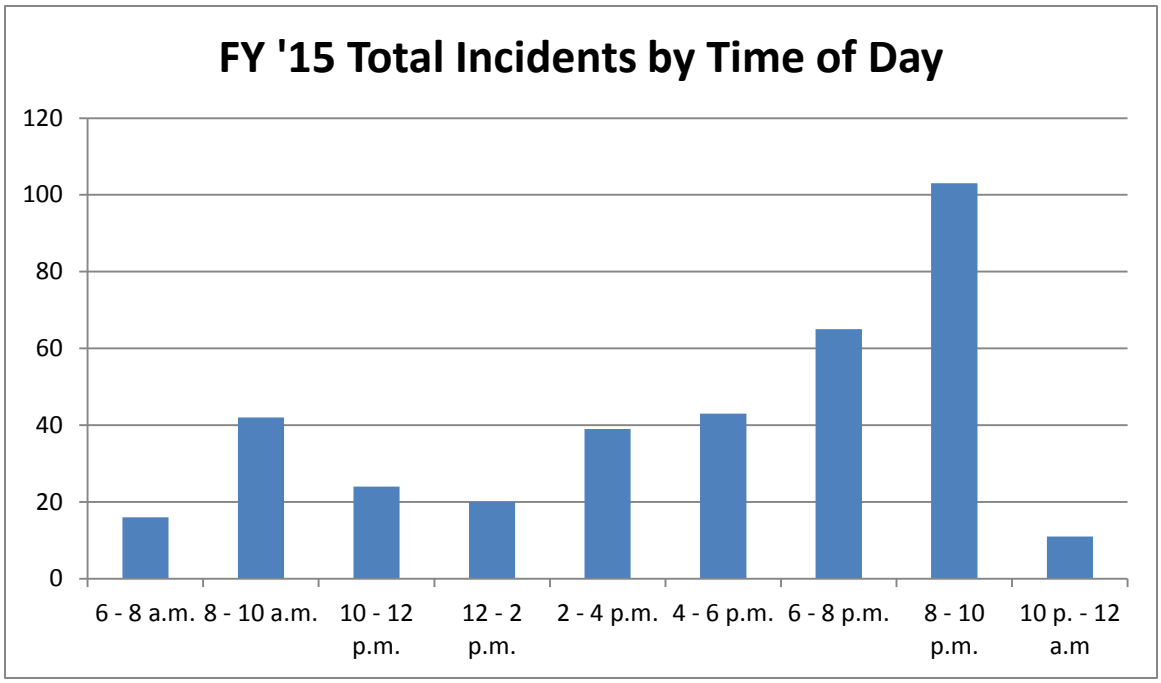
Safety

A top program priority is the safety of the adolescents and staff that work with them. Direct Care Associates (DCA's) are trained to work with adolescents that exhibit a wide range of behaviors. Add significant psychiatric issues to the mix and things can become very complicated quite quickly. DCA's are trained in the philosophy of not using physical interventions, including restraints and escorts, unless safety is an immediate issue. Significant effort is given to document and evaluate all risk management issues that occur with RMAC youth and staff. This is accomplished by staff completing required paperwork when certain types of incidents occur. A review of incident data creates an awareness of and understanding of the most prevalent safety issues and concerns.



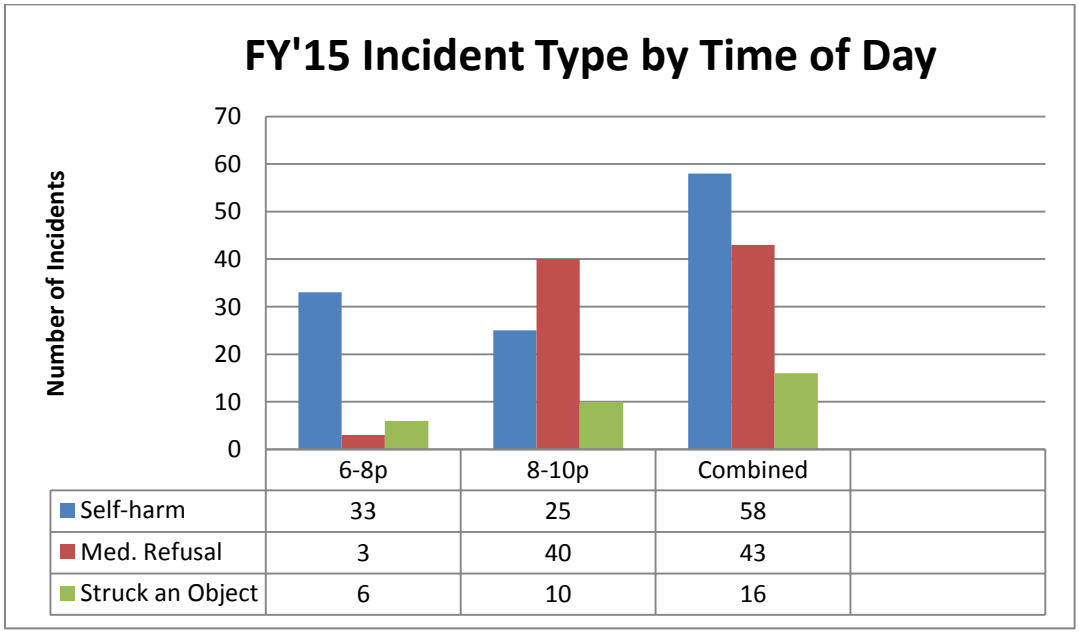
The most obvious incidents that are reflected in the chart above is that of Self-harm and Med Errors. Self-harm incidents include things like cutting or scratching, punching a wall, banging one's head, and suicide gesture/attempts. Though direct care staff attempt to intervene with youth prior to these type of incidents occurring, often staff react to keep the youth from further harming themselves. For example, if an adolescent begins to self-harm by using a pencil eraser to rub/burn a mark on their arm, staff attempt to have them stop on their own but will ultimately remove the pencil to prevent further scratching. Another example would be an adolescent that when angry, bangs their head against a wall. Often staff can't intervene fast enough to stop the initial behavior but are then able to respond and place their hand between the wall and the adolescents head, preventing further harm. For many adolescents these types of behavioral actions occur often, while for others, infrequently. Many have exhibited the behaviors for months and even years prior to arriving at RMAC for treatment. The first order of business is to keep the adolescent safe and then work with them to identify why they respond the way they do. The goal is to help them learn new skills to manage a variety of situations in a healthier manner in the future. Towards that end, the program is very successful in reducing the most severe behaviors, but not without a lot of hard work by the adolescent and RMAC staff.

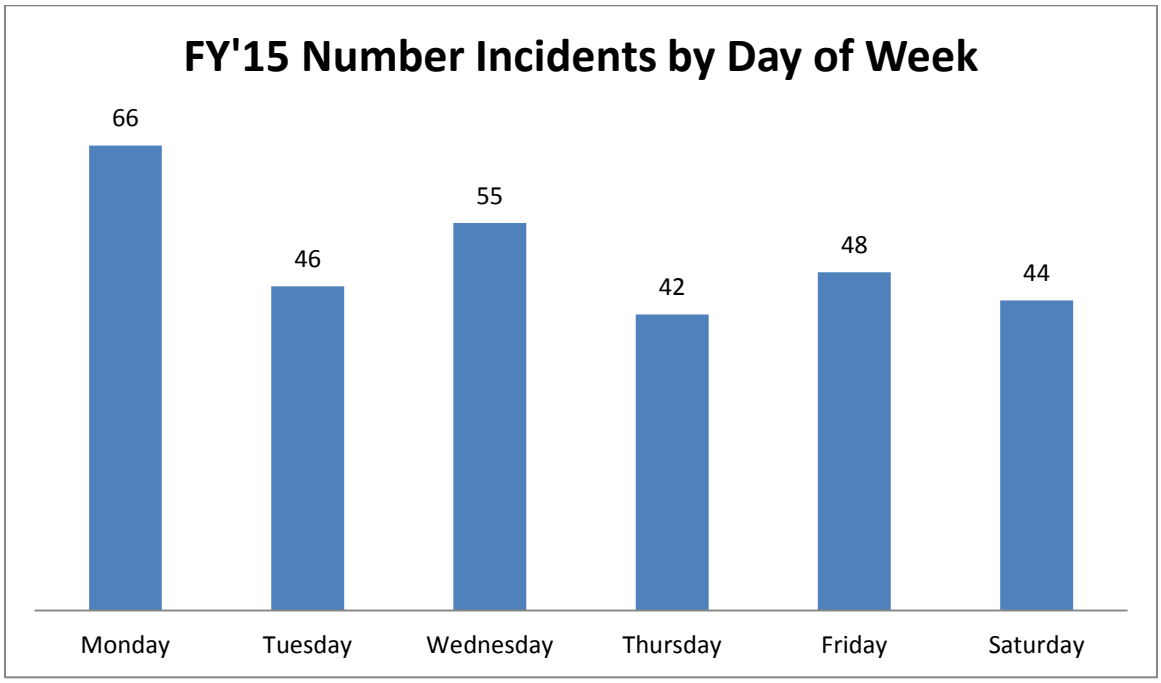
MISCELLANEOUS INCIDENT REPORT DATA



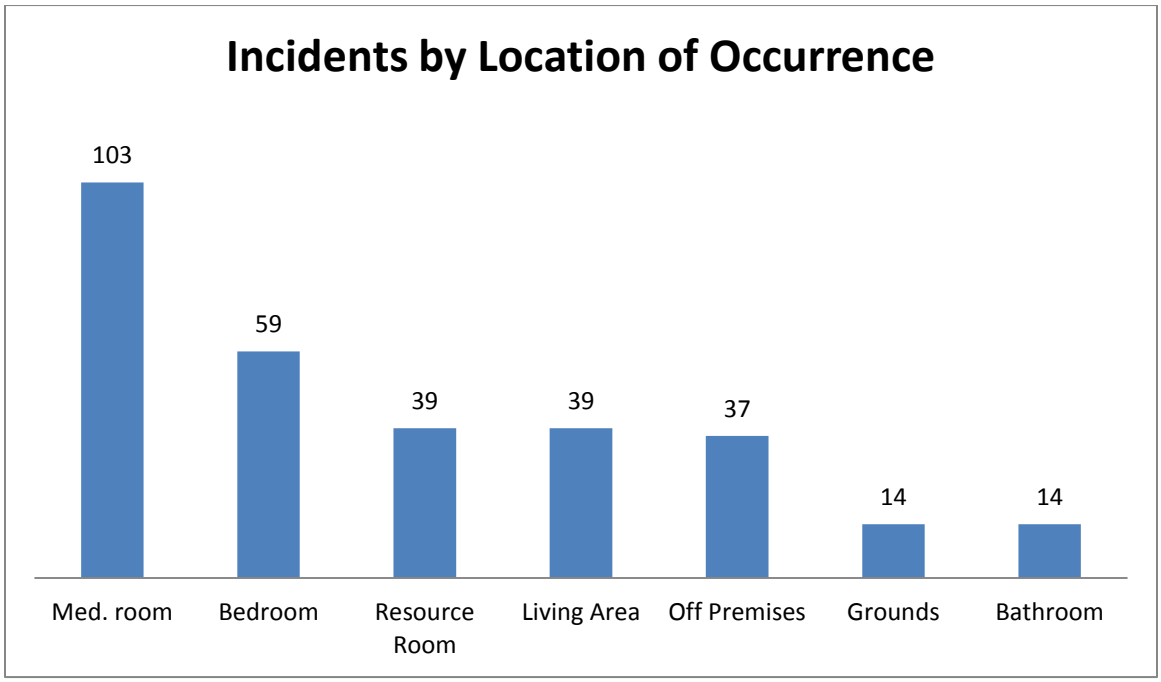
Tracking when incidents occur allows us to focus in on what factors may or may not be contributing to incidents. This past year found 46% of all incidents occurring between 6:00 and 10:00 p.m. Possible factors contributing to incidents during this timeframe include:

- Medication distribution
- Study time
- Returning from off-site passes
- Individual activities
- Group activities
- Bed time/evening routine
- Evening phone calls





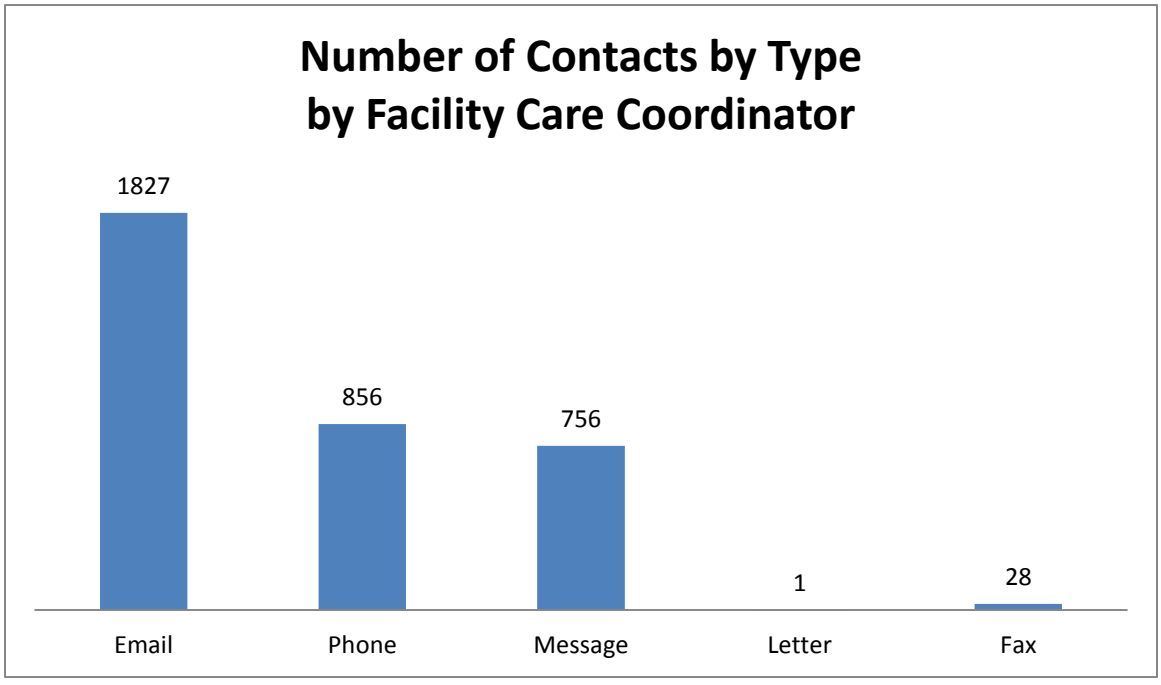
Monday has the most incidents occurring, though the distribution is similar across the entire week. The distribution is analyzed to determine what specific causes might be impacting the specific day of the week. For example, using the above data, one might speculate why more incidents occur on Monday's. The transition back to the program from weekends at home, can be difficult. Returning to school and study time, are other Monday variables. For those adolescents that struggle academically, school incidents are not unusual.



Given earlier data, regarding medication errors, it is not surprising that the Medication Room had the most incidents. Equally interesting is that 59 (16%), of all incidents, occur in the adolescents bedroom. Reasons? Self-harm injury, such as scratching on an arm or leg, or refusing to come out of a bedroom, would be considered an incident and can often occur in the bedroom.

FAMILY/CUSTODIAN ENGAGEMENT

As a program RMAC makes a concerted effort to involve parents and custodians in the treatment process. Treatment Review meetings are usually conducted every two weeks for each adolescent in care. Parents, custodians and others working with the youth and family are invited to attend this meeting. It is an opportunity for everyone to get on the same page as to the progress being made with the adolescent. The meeting is led by the adolescent with input from the care coordinator, nurse, individual therapist, family therapist, clinical director, activity coordinator, school teacher and direct care staff. The facility RN is in contact with parents/custodians related to anything medical – appointments, medication changes or just general medical concerns or issues. Direct Care Associates are in contact with parents when they are at RMAC and when they contact them regarding an incident that may have occurred. The Clinical Director works with the parents/custodian to facilitate the placement of the adolescent and develop the treatment plan for the child and family. Parents/custodians also have both on-site and off-site visitation with their adolescent. Adolescents and parents are encouraged to have telephone contact, which can occur daily or even multiple times daily. Much of the contact with family occurs via the facility Care Coordinator. The Care Coordinator functions as the case manager for each of the adolescents in the program. A significant amount of the Care Coordinators time is spent in making contact with parents and custodians, as the following chart shows.



That is 3468 contacts made in one year by the Care Coordinator alone, which is an average of 13.3 contacts every work day. Add to this the number of contacts made by the facility nurse and clinical director and other staff and you can see that keeping parents and custodians involved with their adolescent and their treatment is a priority.

One option for more contact that has been discussed, though not currently used at RMAC, is an opportunity for family members to come together periodically with other family members, whether for education or to simply be with others going through the treatment process with their child. The Program Committee is considering this as it plans for future programming. A

possible barrier to this initiative is distance as many families live 50-200 miles away from RMAC. To bridge that mileage gap may require creative use of technology to keep parents/families involved with their child.

QUALITY ASSURANCE

How does RMAC know how they are doing? What do people think of the program? How do we work with parents and custodians? How do parents feel about their role in meetings? These and many other questions are addressed through a facility satisfaction questionnaire that is distributed to parents, custodians and adolescents at different points in time during the treatment process. These questionnaires are reviewed regularly by the Program Director and then again in the Program Committee meeting and the monthly all staff meeting. The questionnaires, which are completed voluntarily, are then analyzed in aggregate. The questionnaires provide insight and are a tool that provides time sensitive feedback.

A second tool, and the most prominent data that the program uses to address program improvement, is the Community Based Standards (CbS) surveys. This evidence-based tool collects data from parents, adolescents and staff at two different points each year. This data is then entered into the national data base for similar type programs resulting in program specific as well as national baseline data. Not only is the program able to look at specific program issues but the data allows us to compare to other like facilities across the country. This tool collects the most extensive data reflecting all aspects of our programming. Once the data is reviewed the program develops an improvement plan that hopefully addresses the identified issue.

Finally, RMAC collects much data relevant to admissions and discharge. Examples of this data can be found in earlier sections of this report. The following highlights information gleaned from the internal RMAC Satisfaction Questionnaires.

- **Regarding the Intake Process:**
    - 86% of parents and custodians gave an *excellent* rating to their overall intake experience.
    - 100% of parents and custodians responding agreed or strongly agreed that RMAC had provided reliable contact with them from their initial contact until the intake appointment.
    - 100% of parents and custodians responding to the questionnaire felt staff' were friendly and professional.
    - 100% of parents and custodians felt RMAC would provide individualized care for their child.
- **Regarding Treatment Review Meetings:**
    - 100% of parents and custodians responding to the questionnaire agreed or strongly agreed that "team members listen and respond to my concerns, ideas and questions."

- 60% strongly agreed and 40% agreed that "I feel that I am an active member of the team, not just a listener."
- 90% strongly agree that "team members are sensitive and respectful."
- 90% of parents and custodians responding to the questionnaire strongly agree that, "I am comfortable with my child's placement at RMAC."
- 100% of respondents say "I would feel comfortable referring others to the RMAC facility.
- 60% strongly agree and 40% agree "I feel that I am an active member of the team, not just a listener."
- 80% strongly agree and 20% agree "I have the support I need from RMAC."

- **Regarding Discharge from the Program:**
  - 79% of parents and custodians responding felt "the quality of care my adolescent received while in placement at RMAC," was *excellent*, with another 14% finding that the care was *good*.
  - Regarding the "degree of improvement my adolescent gained in treatment at RMAC," 36% responded *excellent*, 29% *good*, 14% *average*, 14% *poor* and 7% *unacceptable*. It should be noted that the data reflects all scenarios for youth that were discharged from the program. In some instances an adolescent is discharged from the program unsuccessfully, often because they need a higher or more secure level of care than RMAC can provide.
  - 93% of parents and custodians responded *excellent* to "how you feel you personally were treated by RMAC staff."
  - 100% felt that communication with RMAC staff was excellent or good.
  - Good or excellent is how 85% of parents and custodians responding described the RMAC discharge process.

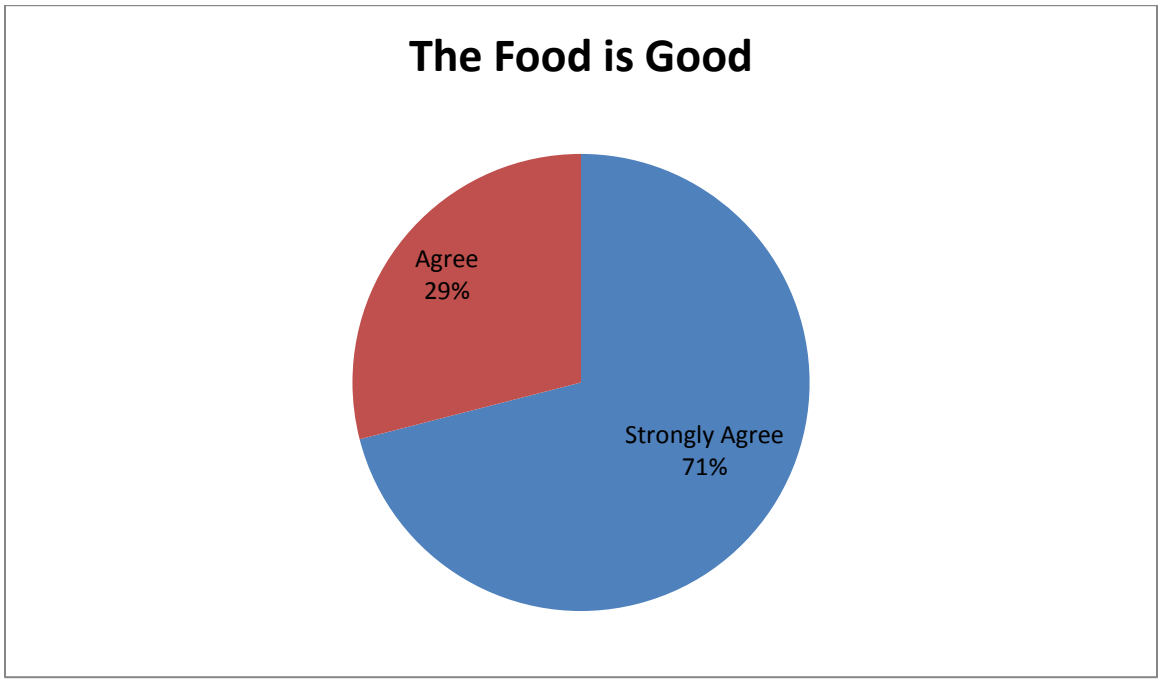
- **Adolescent Post Discharge Follow-up:**

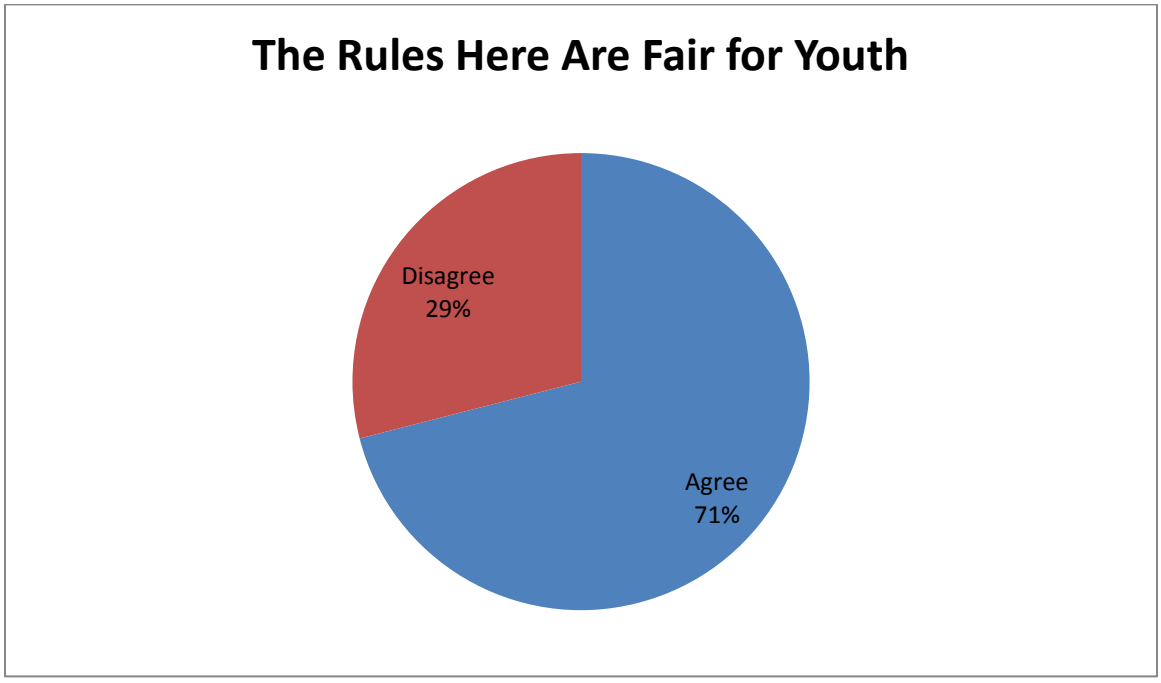
  The sample size of data for adolescents was very small this past year with just 3 of 16 (19%) adolescents returning questionnaires. A number of variables may have an impact the number of questionnaires returned, for example: a resident was discharged unsuccessfully and RMAC did not have a specific address to send the questionnaire; the adolescent may have moved from their discharge location and the questionnaire is not forwarded on to their new address or they turned 18 and their where-a-bouts was unknown

  - 100% of the adolescent responses said the "Admission Process," was *average*.
  - 2 of 3 adolescents responded that "Food/Nutrition," was *excellent*.
  - 100% of those responding found activities *good* or *excellent*.

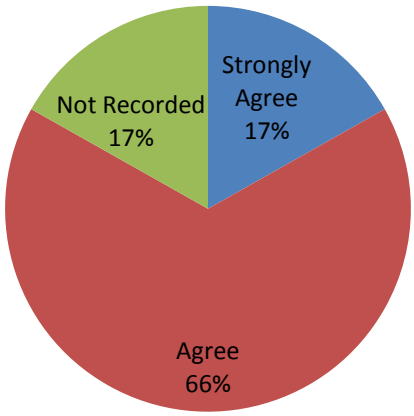
- 3 of 3 found "Groups," *good* or *excellent*.
- Regarding rating on-site school: 1 – excellent, 1 – average, 1 poor

The following reflects summary data from the CbS project. This project generates a significant amount of data impacting a wide range of program areas. This data is gathered twice annually and analyzed in depth after each collection period. The CbS data has become the primary Quality Assurance tool/data used by the RMAC facility. Responses to questions on the Youth Climate Survey include:

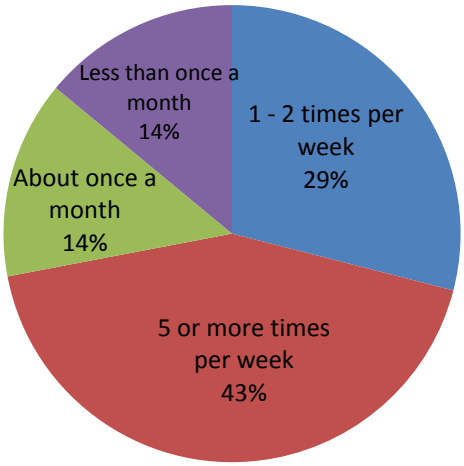




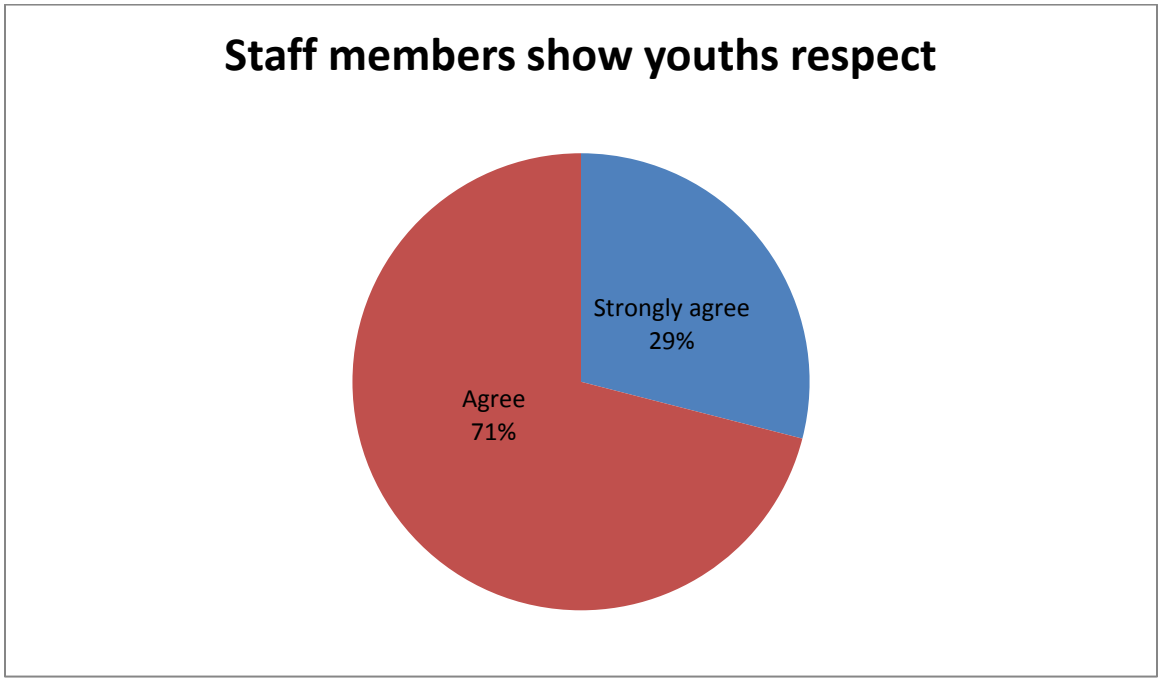
I was able to give my opinion about my individual service plan goals

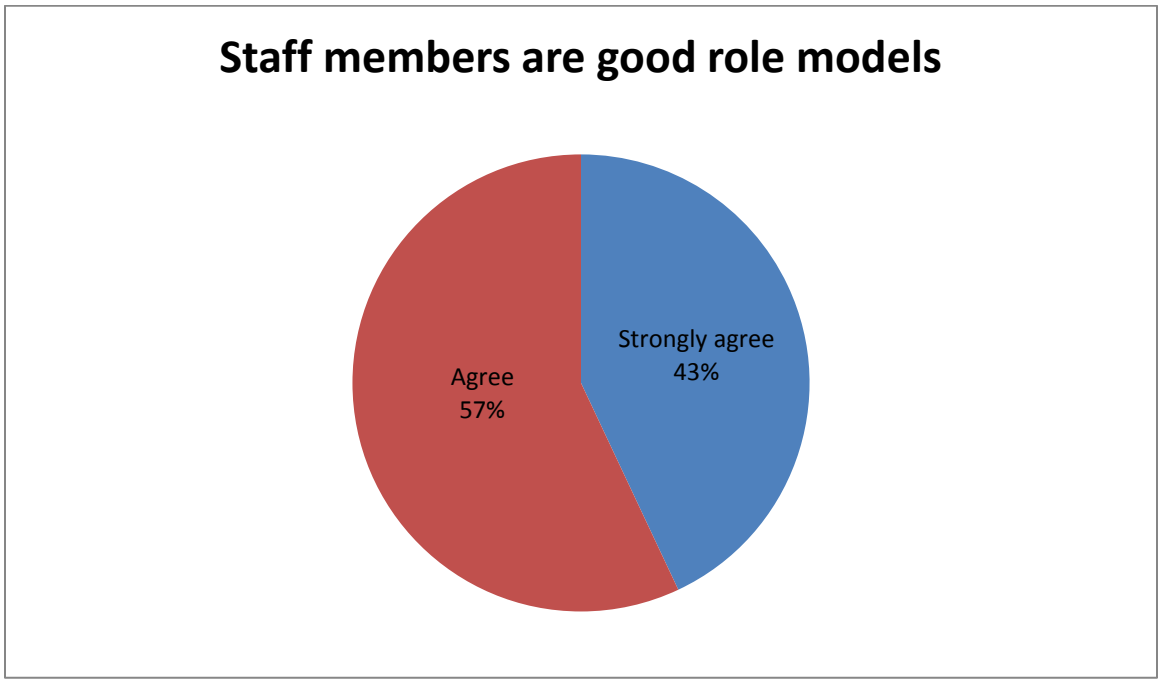


I usually talk with my parent of guardian:

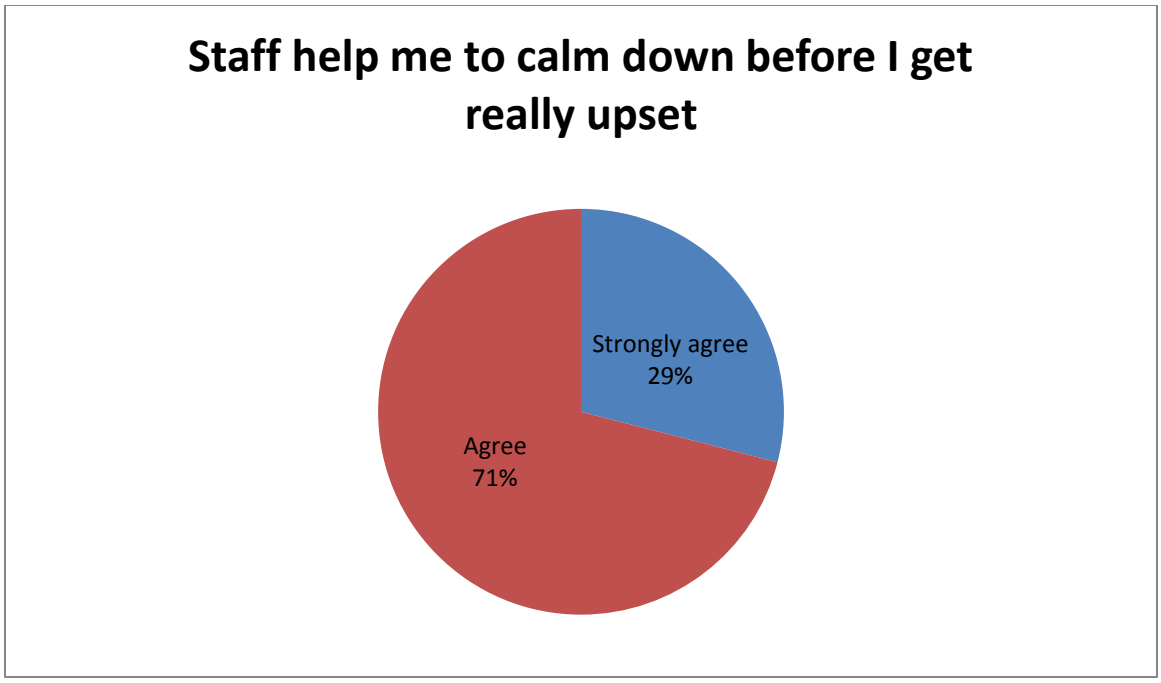


Adolescents are working on very difficult issues while in the RMAC treatment program. Many of the adolescents have had or currently have adversarial relationships with different adults in their lives - parents, teachers, authority figures, relatives and even staff members. RMAC strives to develop positive professional relationships with the adolescents served so they can feel comfortable addressing very difficult and personal issues. Toward that end, the last CbS data found youth responding:

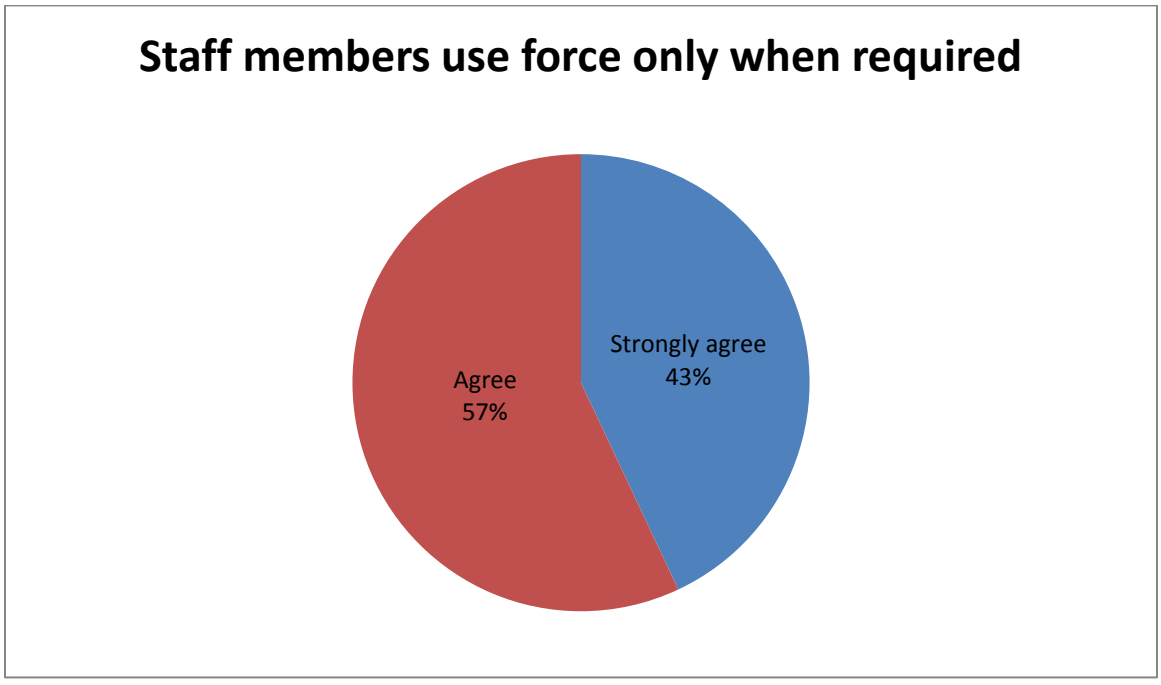




These findings help to reinforce that even though staff often find themselves in difficult situations with youth, when handled correctly, youth, will still view them in a respected manner. What if an adolescent is really upset or escalated?

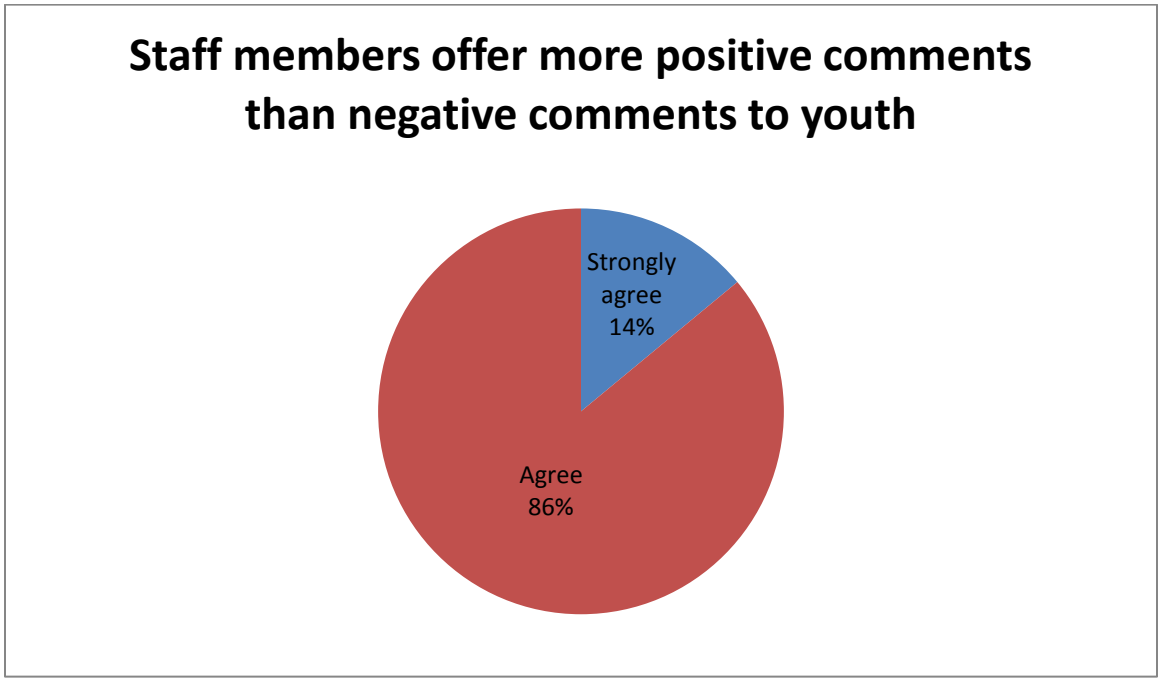


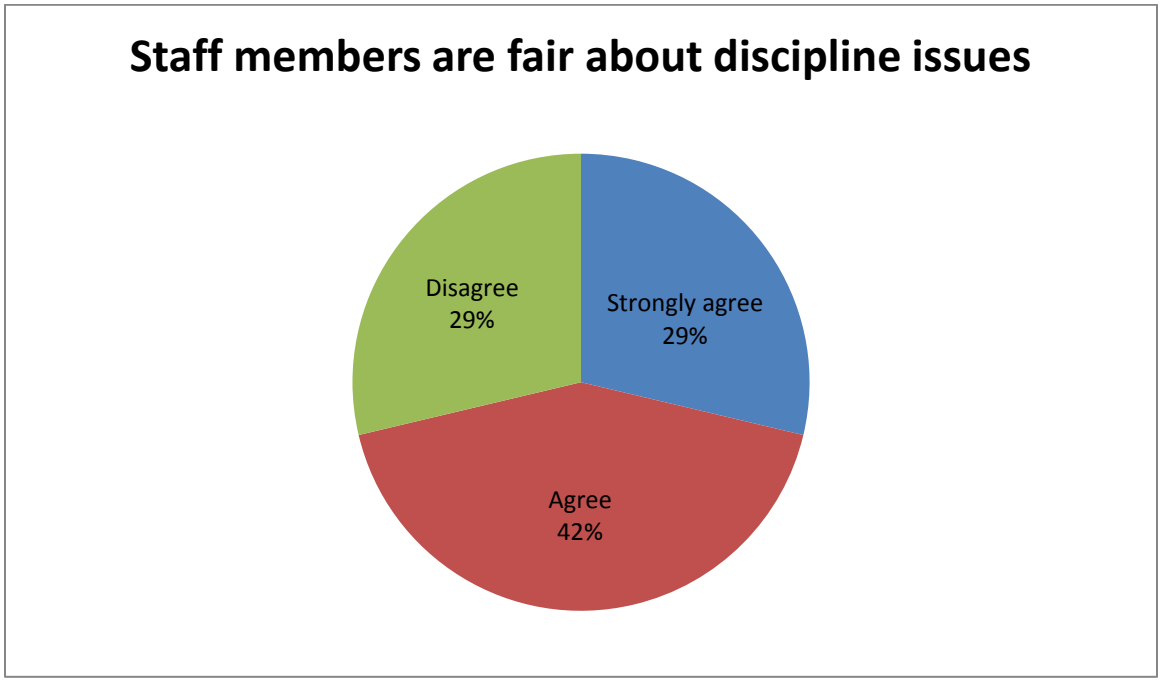
One of the more difficult challenges faced when working with adolescents is when they pose a danger to themselves or others. At what point, if at all, should staff use a physical intervention to keep people safe. RMAC philosophy is to not cause any additional trauma and not use any hands on interventions unless all other means have not been successful and harm is imminent. It is important that both staff members and adolescents/families understand this policy/philosophy.



The chart above reflects that 100% of the adolescent's strongly agree or agree that RMAC staff only use physical interventions if it is required. The goal is to never use a physical intervention but staff' at times are faced with difficult decisions, such as an adolescent attempting self-harm, or in extreme situations, attempting suicide. The good news is that adolescents indicate it is used only when required.

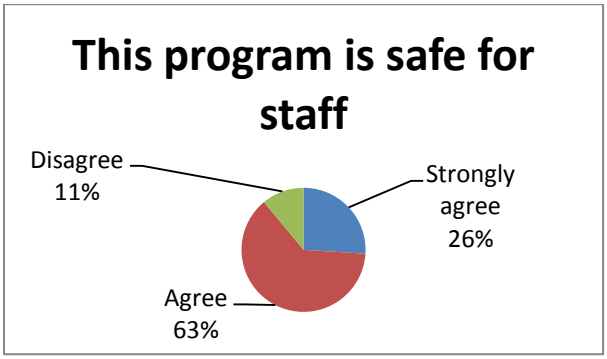
Given that much effort goes in to helping adolescents learn new ways to manage their behavior and be responsible and accountable for their actions, one could anticipate that the adolescents might have strong and even adversarial feelings toward staff. CbS data finds:

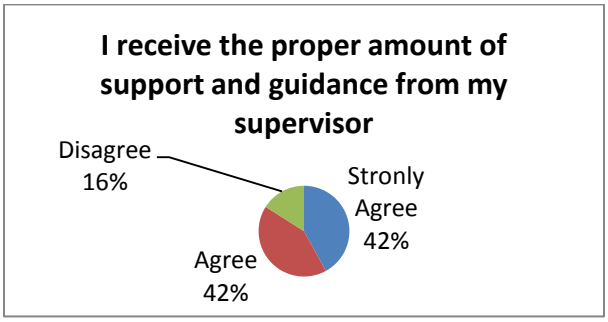


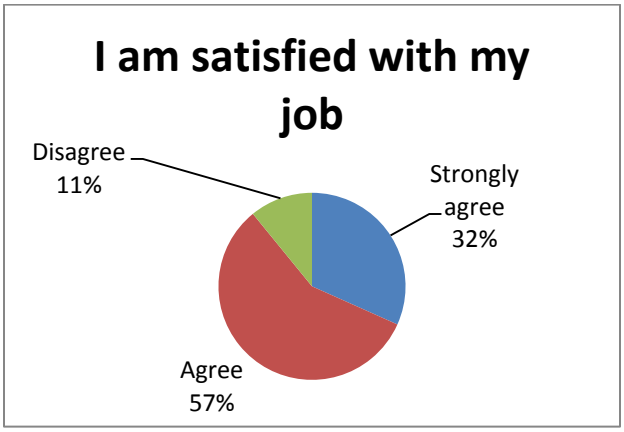


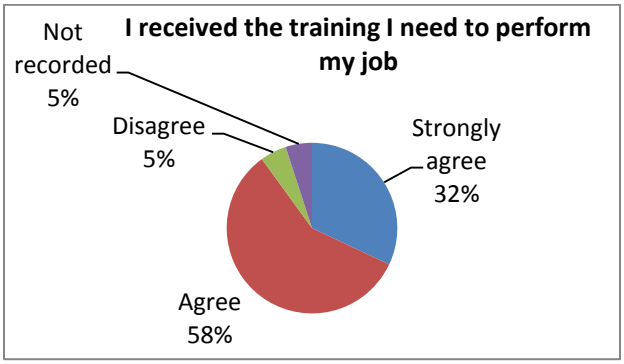
The above charts reflect that staff' are positive with the adolescent's, and that in general, adolescents feel that staff members are fair about discipline issues. This is no easy task in a residential program as youth have a wide variety of individual needs that staff' are responding to while attempting to maintain a consistent environment where adolescents understand expectations and consequences for actions. The above chart does show that 29% of the adolescents feel staff' are not fair about discipline issues. This finding, when analyzed by the program director becomes a topic point for staff' at the next all staff meeting. This finding shows the value of the CbS data and its goal of program improvement through informed data use.

Just as families and adolescents are surveyed for their input into the operation of the facility, staff' are asked for their input. The Staff Climate survey covers a wide range of program areas, from safety, training, cleanliness of facility, nutrition, rules, supervisor support, communication, job satisfaction, health services, orientation, respect, role modeling, to treating youth fairly. For example:









Safety is a top priority for staff and the adolescents. Feeling safe in the work environment is an important factor related to job satisfaction. As the chart to the left shows 89% of RMAC staff say the program is safe. Determining specific reasons as to why some staff disagree and rectifying them is an ongoing effort.

Serving a diverse group of professional staff in a difficult and fluid environment can be a challenge. Staff' have a variety of needs and meeting all those needs can be difficult. 84% of RMAC staff agree or strongly agree that they receive the proper amount of guidance and support from their supervisor. The goal is 100% and figuring out why some staff' feel less than satisfied is an ongoing effort.

One measurement that is analyzed with each CbS data collection is that of staff job satisfaction. Retaining a committed staff that enjoys their job is a challenge. Though we are not completely there, 89% of RMAC staff either strongly agree or agree that they are satisfied with their job. Improving communication, involving all staff in having a say and promoting an in-house social committee are ways the program attempts to impact satisfaction.

Training, whether orientation for new staff', or ongoing training for regular staff, is a significant area within the program. Strict licensure and accreditation training standards impact all employees. Training needs are met through in-house, conferences and online training programs. 90% of the team indicates they receive the training they need to do their job.

THERAPY

Therapy at RMAC is ongoing and takes on many different shapes. As a Cognitive Behavioral based program several forms of traditional therapy are provided, including:

- **Individual –** all adolescents that enter the program work with an individual therapist. In most situations the adolescent works with the RMAC therapist. In some situations where the adolescent is a local youth and they are working with their own therapist arrangements are made for that therapeutic alliance to continue. The frequency of appointments with the individual therapist, are determined on an individual basis, and occur no less that once a week.

- **Family –** family therapy is coordinated between RMAC and the family. Youth in the program come from all across North Dakota, making family therapy a challenge given the long distances. Working with regional human service centers to provide the family therapy for youth from their regions is just now being put in place. Results of this approach are initially optimistic. Blending therapy to begin while the adolescent is in placement and have it continue when the adolescent returns home is a challenge, again, as home could be 200 miles away from RMAC.

- **Groups:** RMAC conducts approximately 365 groups (a group every day) a year. Groups cover a wide range of issues such as anger management, sexual abuse and neglect, coping skills, boy issues, girl issues, working together and nutrition. The following are groups conducted weekly:

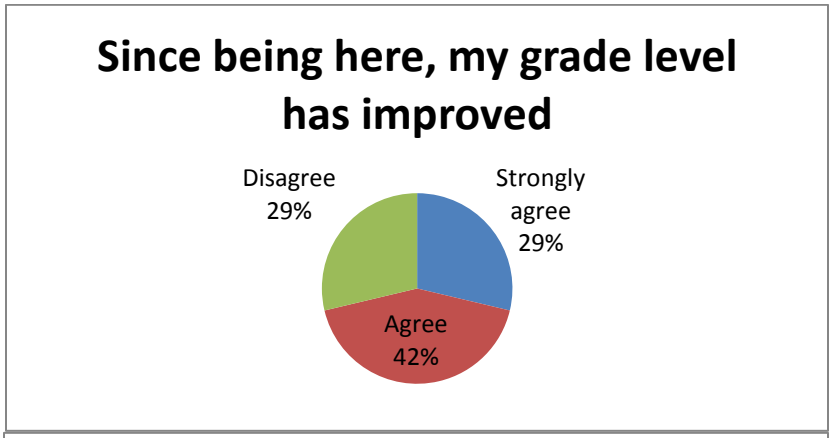
    - Boys and Girls Group
    - A & D Education Group
    - SPARCS Group
    - Nutrition Group
    - Weekly Planning Group
    - Community Group
    - Craft Group

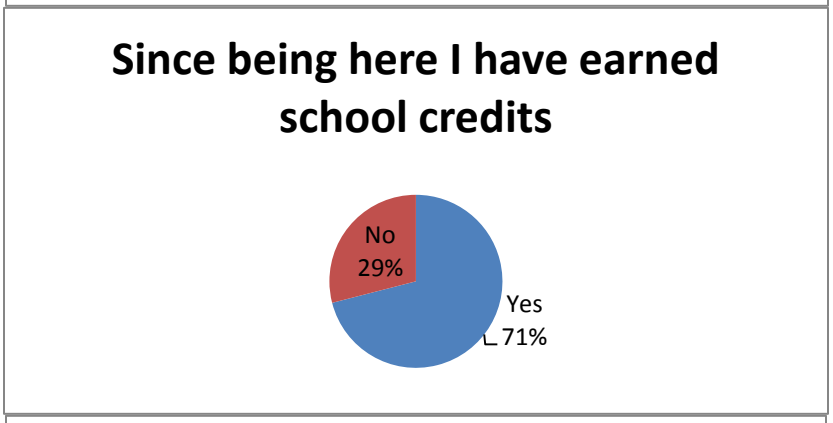
Technology and Treatment

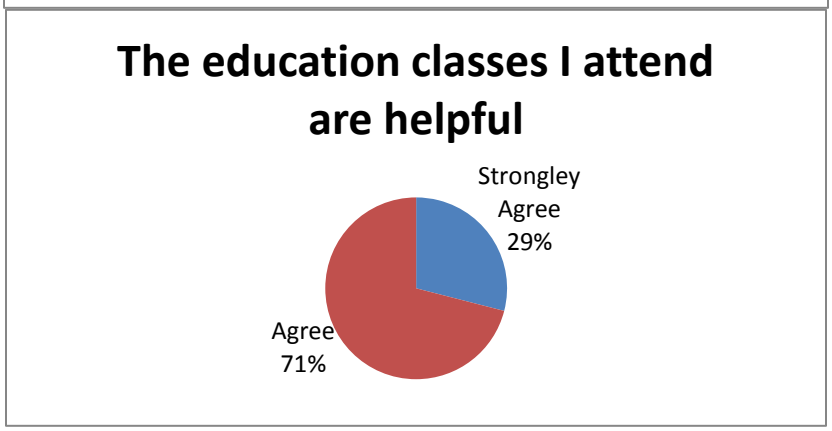
Always looking for ways to provide treatment in the most helpful and efficient manner possible, RMAC has embraced technology to help meet the needs of the adolescents served in the program. Video psychiatric consultations allow for the program to maintain a consistent provider for the youth even when the provider is unable to be at the facility in person. Use of video technology allows for youth to connect to therapists that may be located in another town or region, allowing for a therapeutic alliance to continue. Many parents/custodians attend weekly treatment reviews via the PolyCom system, since the distance may be great to attend a 30 minute meeting.

EDUCATION

RMAC works closely with the Grand Forks School District to provide educational services to the adolescent's at RMAC. When possible an adolescent attends off-site classes in mainstream school classrooms. For many of the youth school is initially attended on-site in the RMAC classroom. The classroom is led by a Special Education teacher and at least one para-professional. The small numbers in the classroom allow the adolescents to receive the individual attention they need and helps to accelerate the transition to public school. For many of the adolescent's school has been difficult. They have struggled academically and are significantly behind their peers. A program goal is to have the adolescent make enough progress in their treatment so they can attend off-site school either on a part-time or full-time basis. School related CbS survey questions found:







A long term goal for the on-site school program is to have a 1 or 2 classroom built either connected to or adjacent to the facility. The current onsite classroom environment, though

functional, could be improved by moving to a more modern and technology enhanced space. All major partners of the program agree that a new space would better serve our adolescents. Ongoing work continues to identify funding sources to help make this goal a reality. Success in school is an important indicator for future success. Many of the adolescents entering the RMAC program have significant educational issues when they arrive. Most see significant improvement in this critical area of their development and treatment.

EVIDENCE-BASED INITIATIVES

As a program, RMAC continues to develop it's programming to reflect the latest evidence-based treatment practices. Currently RMAC uses the following evidence-based practices as part of treatment programming;

- Trauma Informed Care
- Building Bridges
- Community-based Services (CbS)
- SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress)
- CPI (Crisis Prevention Intervention)
- Music Therapy
- CARF (Council on Accreditation of Rehabilitation Facilities)

The past 2 years have been very active with the *Trauma Informed Care* and *Building Bridges* initiatives. Significant staff training and implementation of these initiatives has occurred and continues at this time. Having a better understanding of the role trauma plays with the youth served and the impact it has on their behavior has been helpful for staff. Building Bridges has helped the program keep focus on the role of the family during the treatment process. The evidence-based *CbS* project has been in place since 2012 and yields significant data from which program improvement can be analyzed and improvements or enhancements made. The SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress) group curriculum continues to be an affective evidence-based group conducted by a certified trainer that addresses techniques to manage many of the stressors experienced by the adolescents in the program. Crisis Prevention Intervention (CPI) is the crisis response protocol used at the facility and is led by the Clinical Director, who is a certified instructor. Additionally the program has been using a Canine education group and Equine therapy to assist adolescents, particularly those identified with sensory related issues. Music therapy is also provided once a week with RMAC adolescents. CARF standards are adhered to and represent a wide range of best practices utilized by similar facilities from across the country. Maintaining a 3 year accreditation status is an ongoing practice, one that pushes the program to maintain the highest standards possible.

ACCOUNTABILITY

Ruth Meiers Psychiatric Residential Treatment Facility (RMAC) is a program of the Northeast Human Service Center and is licensed by the North Dakota Department of Human Services. Licensure involves complying with the ND Psychiatric Residential Treatment Facility administrative code chapter 75-03-17. This chapter involves a wide range of standards that must be met in order to maintain licensure.

RMAC is accredited by the Council on Accreditation of Rehabilitation Facilities (CARF). This national accreditation body has specific standards that RMAC must maintain in order to keep its accreditation status and remain licensed. The CARF standards reflect best practices used by facilities across the United States.

SUMMARY

Hopefully this report has provided you a glimpse inside the RMAC program. Hard work is being done every day by the adolescents and RMAC team. Because of the many challenges facing everyone involved, it is essential to have tools available to assess on a regular basis how everyone is doing. This report is one of those tools the program uses as it steps back and analyses many aspects of the program. The report highlights a variety of areas, but certainly not all. Additionally, areas such as training, staff recruitment, retention, policy, staff ratios, scheduling, and the physical plant are reviewed on an ongoing basis and issues are addressed as needed.

The Ruth Meiers Adolescent Treatment Center (RMAC), now in its 26th year of providing psychiatric mental health care to North Dakota adolescents, continues to adapt to the ever-changing needs of those served. Recent trends have more aggression and assaultive behavior being reported in referrals to the program. Adjusting programming to meet the needs of that type of behavior, which can be very disruptive to the treatment environment, is the challenge. Exploring new ideas and best practices may shed light on the new treatment approaches that are successful for adolescents with this profile. Looking at data to help us understand not only where we've been, but more importantly, where we are going, is our commitment to quality program improvement and development.

Bryon Novotny
Program Director
October 26, 2015