Division of Child and Family Services
Treatment Plan Goal Status Review Aggregate Report

I. Introduction

The more efficient and effective the delivery of our services, the greater our opportunity for realizing positive treatment outcomes for the children and the families we are all committed to serve. Therefore, the overarching performance and quality improvement (PQI) goal of the Division of Child and Family Services (DCFS) and its partners is to assess the quality of services and care coordination provided to children and youth in order to improve practice and service delivery, and increase collaboration as we continue to build our system of care.

PQI is a process that continually monitors program performance. When a quality issue is identified, PQI drives the development of an informed and modified approach to address the issue and then monitors the implementation and success of the modified approach. The process includes involvement at all stages by all organizations and all stakeholders affected by the issue and/or involved in implementing the modified approach.

The Treatment Plan Goal Status Review conducted by the DCFS Planning and Evaluation Unit (PEU) is one of three initiatives identified in the 2008 DCFS-PEU Performance and Quality Improvement Plan; this plan was disseminated to all treatment home service providers in early 2008. The other two initiatives are: developing the Youth Profile; and, developing ongoing data collection and analysis of risk measures. The data and feedback received from these three initiatives will enable providers to acknowledge and build upon the strengths of their program, address the challenges and needs of their program, and facilitate collaboration with all system partners for improved child and family outcomes.

II. Treatment Plan Goal Status Review Process

The goal of the Treatment Plan Goal Status Review is to track youths' treatment status toward achieving measurable goals as indicated on the treatment plan and subsequent reviews of the treatment plan. In order to achieve this goal, the DCFS-PEU developed a methodology which included identifying a target population and subject selection, developing a data collection tool and process, and conducting data analysis and a report protocol for distribution to participating providers and other identified stakeholders.

The target population consisted of all children/youth in public agency custody that has been in an out-of-home placement with the provider agency for at least six months. This longitudinal perspective was chosen in order to allow a full analysis of treatment planning over time. Providers were asked to provide the PEU with the Medicaid numbers of the children/youth who met these selection criteria.

The PEU then determined a random sampling methodology from which the sampling frame was developed to allow for a review of 50% of treatment plans or a minimum of 10 treatment plans, whichever was greater. If a provider agency submitted less than 10 Medicaid numbers, the PEU reviewed all treatment plans submitted from that agency. Of the treatment plans selected from the sampling frame, those reviewed were from the four most recent 90-day review periods.

A total of 30 treatment home provider agencies participated in this review; of these, 14 were in the south, 15 were in the north, and one was in the rural region of the state. A total of 13 provider agencies did not meet the selection criteria for various reasons (i.e., they were not providing treatment level care, they did not have children placed for the requisite amount of time, they did not have children placed during the survey period, or they do not accept public custody children for placement); four of these agencies were in the north and nine were in the south.

A total of 259 treatment plans and charts were reviewed throughout the state. In the north, 137 children/youth were identified as meeting the selection criteria; of those, 98 were randomly selected for review. In the south, 199 children/youth were identified as meeting the selection criteria; of those, 154 were randomly selected for review. In the rural region, seven children/youth were identified as meeting the selection criteria; all seven were reviewed.

The data collection process started on March 7, 2008 and concluded on May 7, 2008. A data collection tool entitled "Treatment Plan Goal Status Review Form" was used to document all relevant data for each treatment plan selected for review. Goal status codes were developed by the PEU in order to ensure consistent comparison across all provider agencies and to allow for a standardized reporting format. These codes are as follows:

1 = Deteriorating/ Regressed/ Regression
2 = Unchanged/ No Progress
3 = Making progress toward goal/ Progressing/ Continuing/ Progress made
4 = Achieved/ Resolved/ Met
5 = Goal Revised/ Deferred/ Deleted/ New Goal
6 = Unable to score

In several instances, preliminary feedback was provided to agency staff by PEU staff in an exit interview format.

III. Individual Provider Results

There were 259 treatment plan reviews conducted with treatment home agencies. The following is the descriptive summary from the reviews.

Demographics of Client Population Reviewed

Gender		
Males	152	(58.7%)
Females	107	(41.3%)

Age Range		
0 -5 year old	21	(8.1%)
6 -12 year old	88	(34.0%)
13 -18+ year old	150	(57.9%)

Average Age
13.0 years

Child and Adolescent Service Intensity Instrument (CASII) and the Nevada Early Childhood Services Eligibility Tool (NECSET)

The CASII (American Academy of Child and Adolescent Psychiatry, 2007) level of service intensity scores start with Level 0 which is for basic services for prevention and maintenance. Level 1 is for recovery maintenance and health management. Level 2 indicates a need for outpatient services. At a Level 3 more intensive outpatient services are indicated. Case management services begin at a Level 3. Level 4 indicates that there are multiple needs that require collaboration among services and providers. Levels 4 and 5 services are most commonly provided in a treatment home environment. Level 6 indicates a need for a secure environment that can provide medical and mental health services at the required intensity.

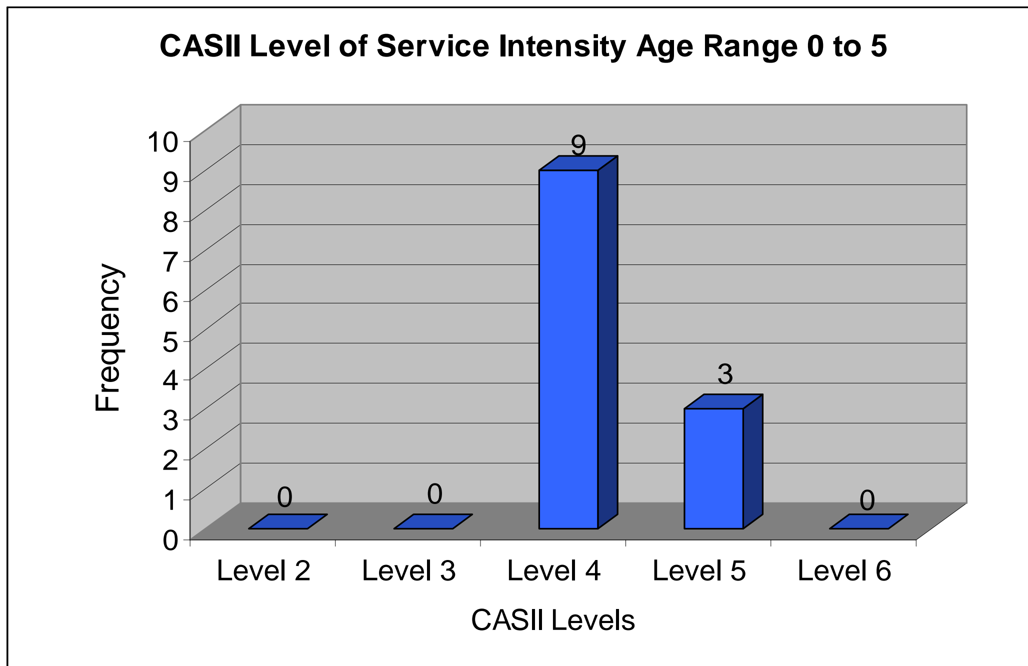
The NECSET was developed by DCFS Early Childhood Mental Health Services for use in scoring service intensity needs of children under six years old. Not all community providers have been trained on this instrument therefore, some community providers use the CASII to score young children. The American Association of Child and Adolescent Psychiatry is developing an Early Childhood Service Intensity Instrument (ECSII) for use with young children and their parents/caregivers but this instrument is currently still in development.

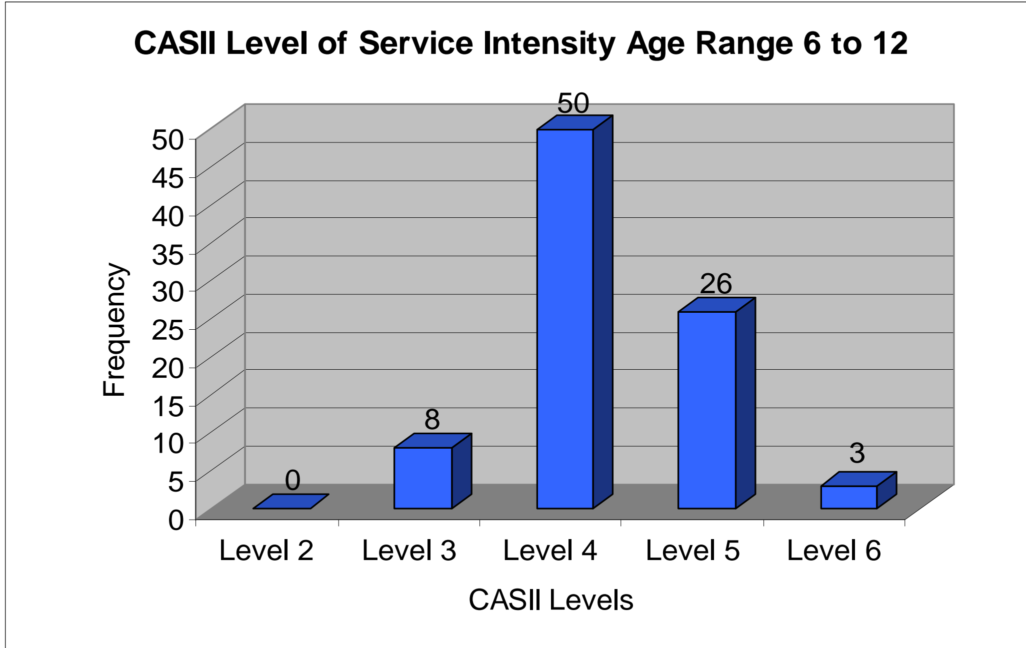
The CASII is used to match the mental health service needs of children and youth with treatment resources. The treatment plan goal review identified 244 CASII scores. The average CASII composite score was 22.26. CASII composite scores ranged from 16 (Level 2) to 32 (Level 6). NECSET scores were used in 7 treatment plans. The average NECSET composite score was 18.43. NECSET composite scores ranged from 16 to 22. CASII and NECSET scores were obtained primarily from the intake assessment or from the First Health FH-11A payment authorization request form.

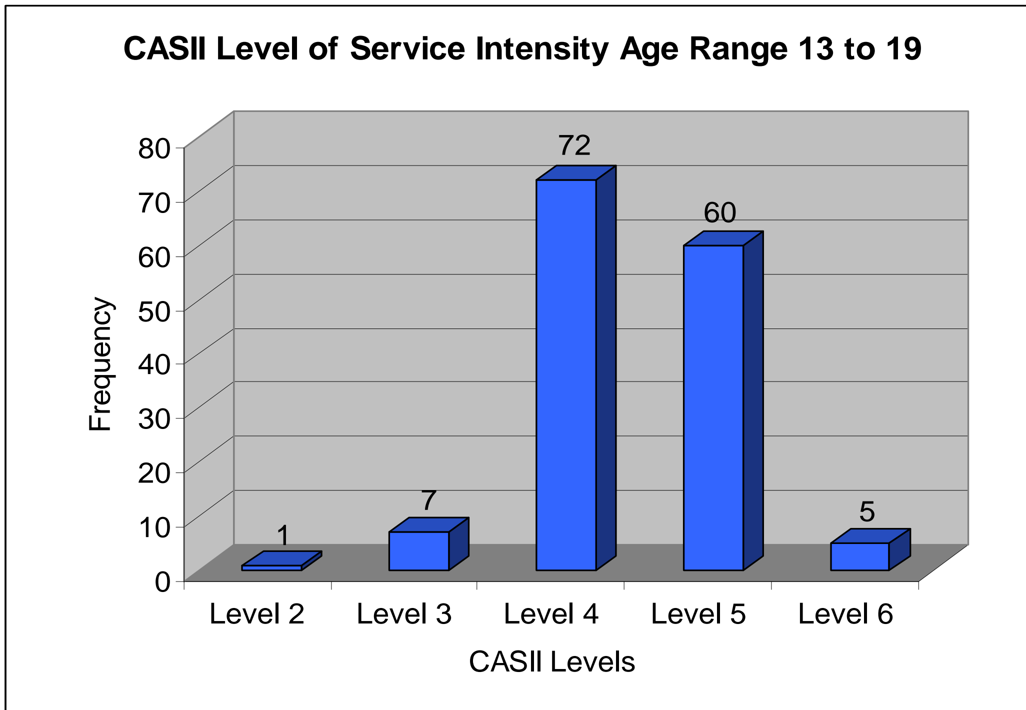
The table below presents the number and percentage of CASII level of intensity scores by each age range. Almost all children (90.2%) are rated at CASII Levels 4 and 5. This is consistent with the types of services provided in a treatment home environment.

CASII Level	Age Range 0-5	Age Range 6-12	Age Range 13-19	Total
Level 2	0	0	1 (.4%)	1 (.4%)
Level 3	0	8 (3.3%)	7 (2.9%)	15 (6.1%)
Level 4	9 (3.7%)	50 (20.5%)	72 (29.5%)	131 (53.7%)
Level 5	3 (1.2%)	26 (10.7%)	60 (24.6%)	89 (36.5%)
Level 6	0	3 (1.2%)	5 (2.0%)	8 (3.3%)
Total	12 (4.9%)	87 (35.7%)	145 (59.4%)	244 (100%)

The three graphs below show the CASII scores by each age range.







Most CASII scores for all age groups were found to fall within Level 4 and Level 5.

Diagnosis

The three most frequent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) and Diagnostic Classification of

Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3R) (Zero to Three, 2005) Axis I diagnosis by age range were determined from all diagnoses collected on each child. Diagnoses were obtained primarily from the intake assessment or from the First Health FH-11A form.

For children in age range 0 through 5 the following are the three most frequent diagnoses:

1. Reactive Attachment Disorder (RAD)
2. Neglect of Child/Maltreatment
3. Posttraumatic Stress Disorder (PTSD)

For children in age range 6 through 12 the following are the three most frequent diagnoses:

1. PTSD
2. Attention Deficit/Hyperactivity Disorder (ADHD)
3. RAD

For children in age range 13 through 19 the following are the three most frequent diagnoses:

1. PTSD
2. ADHD
3. Depressive Disorder NOS

PTSD appears in each of the three age groups as a frequent diagnostic category for children in this review. Children were selected for this review based on their public agency custody status. Oftentimes, these children are brought to the attention of authorities due to child maltreatment issues. Some of these children, as a result of their exposure to highly traumatic stressors develop symptoms of PTSD. It is noteworthy that the children served in a treatment home environment are diagnosed with this disorder as it is the first step toward receiving appropriate treatment. With appropriate treatment, children diagnosed with PTSD can achieve full recovery.

Children receiving rehabilitative services in a treatment home environment must meet criteria for a determination of severe emotional disturbance (SED). An indication of the multiple and complex needs of these children is the severity and number of diagnoses that they receive. Approximately 68% of children in this review had at least two DSM-IV-TR or DC: 0-3R Axis I diagnoses.

<u>Children with a Dual Diagnosis of a Mental Health Condition and a Developmental Delay</u>

Children dually diagnosed with a mental health condition and a developmental delay can pose a special challenge to mental health and other helping professionals. One of the challenges is the combination of a lower intelligence and a mental health disorder which may not be responsive to usual treatment approaches. Another challenge is the lack of verbal communication and the tendency to express emotion through behavior. Although it is not uncommon for children to "act out" their emotions, children with a developmental delay may struggle with this more. The needs of children with a dual diagnosis may

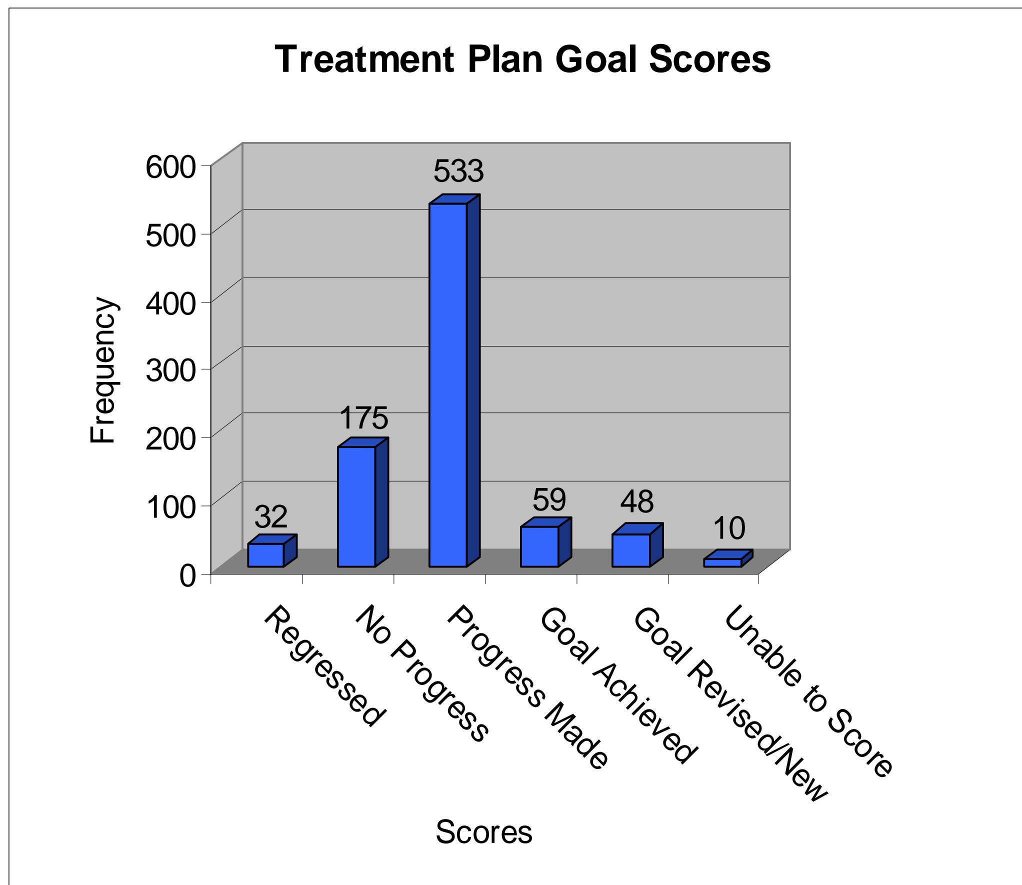
require specifically designed methods of intervention. Of the 259 treatment plans reviewed 35 children (13.5%) were dually diagnosed with a mental health disorder and a developmental delay.

<u>Treatment Goal Results</u>

Treatment plan goal score results were derived by taking the last score for each identified goal. For example, when there were four 90-day reviews for one goal the last score was used to chart the results in order to measure the progress (or lack of) made on the stated goal.

There were 896 goals identified in the treatment plan review. The majority (59.5%) indicated that progress was made and that 6.6% of goals were achieved. Results showed that 19.5% of the goals indicated no progress while 3.6% showed regression. Some goals (5.4%) were new or revised and 1.1% of the goals could not be scored. There were some goals (4.4%) that were not scored because of missing data.

The graph below shows the treatment plan goals by score.



Treatment Plan Goals Related to Diagnosis

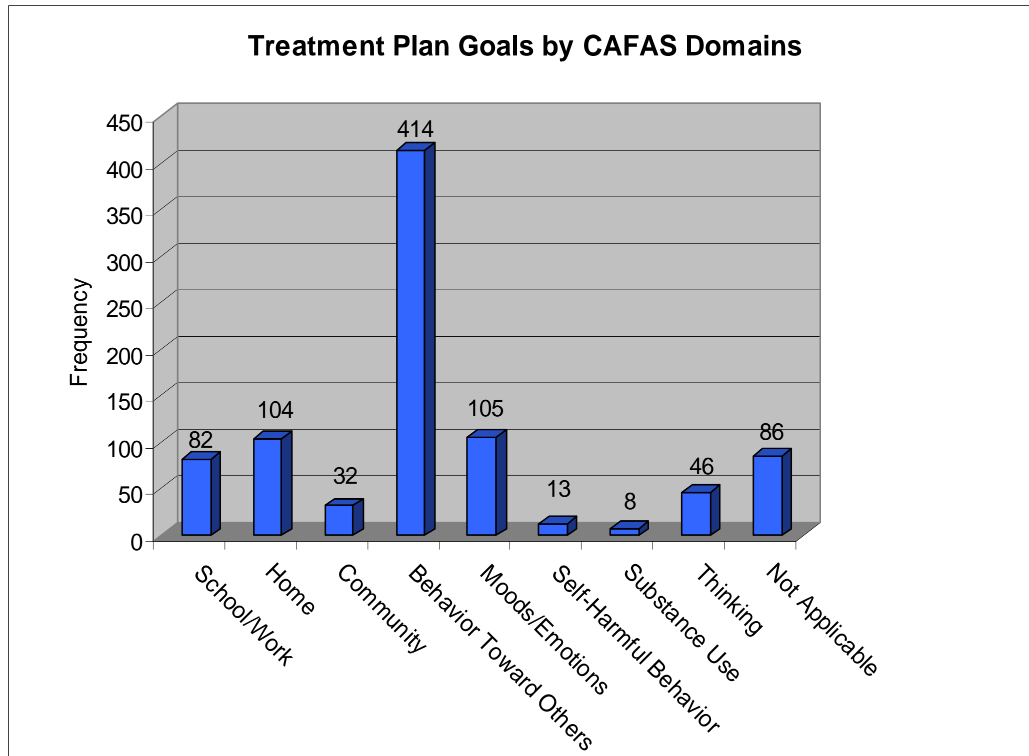
A diagnosis is one part of a comprehensive clinical assessment process that guides the clinician in the development of a treatment plan. The treatment plan reviews included a data collection item that asked whether the treatment plan goals were related to the diagnoses and assessment. Reviewers ascertained if the goal addressed a therapeutic need of the child addressed in the assessment and diagnoses. Of the 896 treatment goals 84.5% were found to relate to the diagnoses and assessment. In most cases in which the reviewers determined the treatment goal did not relate to the diagnosis and assessment, it was clear the goal(s) were relevant to the child's ability to successfully master activities of daily living in the treatment home setting.

Type of Goals

The total number of goals identified in the treatment plan review (896) required a method of clustering the data in order to better understand the impact on children's functioning. The Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 2005), a standardized tool that measures the degree to which impairment affects child functioning, was used to rate each treatment plan goal. The CAFAS has eight life domains which are: School/Work, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking.

The CAFAS is commonly used to assess impairment in children and youth with emotional, behavioral, or psychological needs (Hodges, 2005). The scale can be used to manage the progress in treatment and for organizing a treatment plan for clients in outpatient and residential settings. It is also used to track clinical outcomes for individual clients and for evaluation purposes. The CAFAS domains reflect areas of real-life functioning for children and youth. The CAFAS domains were used to rate the type of goal identified for each child.

The following graph shows the CAFAS domains for treatment plan goals.



The Behavior Toward Others domain assesses the appropriateness of youth's daily behavior in interacting with peers and adults. Behavior Toward Others was the most frequently rated domain at 46.2%. This domain addresses how a child relates to others, how anger, disagreements, or aggression is expressed, peer interactions and relationships, and sexual behavior. For all treatment plan goals that were rated as making progress or goal achieved 31.3% fell into the Behavior Toward Others domain.

The Moods/Emotions domain received 11.7% of the ratings. This domain assesses the modulation of the child's emotional life. This domain addresses the management and expression of emotions such as fears, worries, sadness, anxieties and depression. For all treatment plan goals that were rated as making progress or goal achieved 8.1% fell into the Moods/Emotions domain.

The Home domain received 11.6%% of the ratings. The Home domain assesses the child's compliance with rules and expectations of the caregiver and the extent to which the child performs age appropriate tasks and engages in disruptive behaviors in the home. For all treatment plan goals that were rated as making progress or goal achieved 8.6% fell into the Home domain.

School/Work domain had 9.2% of the ratings. This domain assesses the ability to function in a group educational or work environment. For all treatment plan goals that were rated as making progress or goal achieved 7.2% fell into the School/Work domain.

The Thinking domain assesses the degree of impairment in thought processes. This domain received 5.1% of the ratings. For all treatment plan goals that were rated as making progress or goal achieved 3.1% fell into the Thinking domain.

The domains of Community, Self-Harmful Behavior, and Substance Use together received 6% of the goal ratings. The treatment plan goals that were rated as making progress or goal achieved for these remaining domains are included in the table below.

CAFAS Domains Rated As Making Progress or Goals Achieved

CAFAS Domain	*Number of Goals*	*Percent*
School/Work	61	7.2
Home	73	8.6
Community	23	2.7
Behavior Toward Others	267	31.3
Moods/Emotion	69	8.1
Self-Harmful Behavior	10	1.2
Substance Use	3	.3
Thinking	26	3.1

Domains that received few ratings should also be considered. The Community domain focuses on conformity to laws and the rights of others. Goals that specifically address delinquent behavior may be rated under this domain. The Self-Harmful Behavior domain's few ratings may indicate that children who exhibit serious self-harm are in need of immediate placement in more restrictive levels of care. The low frequency of ratings under the Substance Use domain may be indicative of the difficulties and challenges in assessing and treating substance abuse in mental health settings.

Some goals were not rated (.7%) or were not applicable (9.6%) under the CAFAS domains. A few treatment agency providers focus on independent living. Their goals reflect a focus on independent living skills which address skill building activities that rely on a developmental process rather than problems or challenges that impact functional impairment and therefore, do not relate to the CAFAS domains.

IV. <u>Discussion and Recommendations</u>

The intent of this review was to track children's treatment status toward achieving measurable goals as identified on their treatment plans. The majority of treatment plan goals reviewed were rated as making progress (59.5%) or that the goal was achieved (6.6%) as represented on the most recent 90-day review. This indicates that two-thirds of the goals (66.1%) were being addressed in an effective manner.

In reviewing treatment plan goals reviewers noted that almost all providers had treatment plans that were reviewed every 90 days and that they had a method of determining whether the child was or was not progressing on each goal. Also, goals were stated in behavioral and measurable terms by most providers.

Children selected for this review mostly received a CASII level of intensity score of Level 4 or 5. Levels 4 and 5 are appropriate for a treatment home environment. Nearly all (90.2%) of the children received these level of intensity scores.

Eight (3.3%) children received a CASII level of intensity score of 6. Care should be taken when accepting a child at this level of intensity as it assumes the ability to provide psychiatric and medical supervision. It also indicates monitoring and observation on a 24-hour basis. Traditionally, a child that scores at a Level 6 receives services in a secure facility (AACAP, 2007). If a child is scored at a Level 6, best practices dictates the provider's ability to confirm on an ongoing basis whether the child is receiving the level of intensity of services that is needed for this score.

It is recommended that each provider consider the recommendations provided to them in their individual agency reports. It is also recommended that providers compare their findings with the aggregate findings described in this report. Comparing individual agency findings with the overall findings in this aggregate report will help agencies determine where they are in relation to all agencies. For example, where does the agency's CASII scores fall in comparison with the aggregate scores or what was the distribution of treatment plan goal scores for the agency in comparison to aggregate scores? This may help the agency to identify areas of strength or areas for improvement.

As with any study or review there are always limitations to be addressed. This treatment plan goal review did not use standardized instruments to measure improvement over time for each goal. Goals were not compared from the first treatment plan review to the last 90-day review. This review did not examine children from intake through the course of treatment at designated intervals. Therefore, comparisons could not be made among the treatment plan goal scores.

All 30 providers that were identified for the treatment plan goal status review participated. All 30 providers demonstrated responsiveness and willingness to have reviewers examine their charts.

References

American Academy of Child and Adolescent Psychiatry. (2007). *Child and adolescent service intensity instrument.* (version 3.0). Washington, DC: Author.

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Hodges, K. (2005). *CAFAS manual for training coordinators, clinical administrators, and data managers.* (3rd ed.). Ann Arbor, MI: Author.

Zero to Three. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood:* (revised edition). Washington, DC: Author.

TREATMENT PLAN GOAL STATUS REVIEW
Participating and Non-Participating Treatment Home Agencies

PARTICIPATING AGENCIES		
Northern	Southern	Rural
Bountiful Psychiatric/ Briarwood Golla Home Hand Up Homes Hope Healthcare Services Kathy's House Kids First Koinonia Foster Homes Maple Star Nevada (North) Mountain Circle Family Services My Home R House Community Treatment Centers Reagan Home Rite of Passage Shaw Foster Homes Ujima Youth Services	Apple Grove Agape Villa Bountiful Psychiatric/Briarwood Eagle Quest of Nevada Father Flanagan's Boys Town Foundation for the Stars Fresh Start Services Maple Star Nevada (South) Olive Crest Foster Family Agency REM SAFY St. Jude's Ranch for Children Trinity Youth Services Unity Village	Maple Star Nevada (Rural)
NON-PARTICIPATING AGENCIES*		
Center for Independent Living Commencements Honne B Care, Inc. Las Vegas Home Health-Our Kids Home New Beginnings WestCare, Inc. Nevada	Volunteers of America Rivendel Independent Living REM Nevada Inc. Eirlys House	

*Some agencies did not participate in the Treatment Plan Goals Status Review. This occurred for a variety of reasons such as the agency does not provide treatment level care, does not have children placed for the requisite amount of time, or they did not have children placed during the survey period, or they do not accept public custody children for placement. Four of these agencies were in the north and six were in the south. One agency, Rivendel Independent Living, did not respond to the request for agency participation in this review.