

Specialty Services

(SPEC)

Service Description

Specialty Intensity of Service (SPEC IOS) provides highly supervised, 24-hour care within a community-based out-of-home treatment setting for youth who manifest significant emotional and/or behavioral challenges which require specialized clinical intervention. Specialty Services are, by definition, uniquely tailored to particular needs in a manner extending beyond the usual expectations of individualized care. Specific behaviors that may qualify for specialty treatment services include extreme aggression/assault, fire setting, problematic sexual behavior, and animal cruelty. The purpose of SPEC IOS is to engage the youth in addressing clearly identified behavioral health challenges and to stabilize symptomology in preparing the youth for a less restrictive environment. Treatment practices include trauma-informed care, which focuses on the individual's safety and well-being through engagement and an emphasis on de-escalation techniques and eliminating the use of any type of physical restraint practices. The individualized focus should implement therapeutic principles which are directly focused on the etiology of each individual's prescribed need. Examples of therapeutic modalities include, but are not limited to, the Sanctuary Model, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), and Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET). Comprehensive services are multidisciplinary, multimodal therapies that include, but are not limited to, the following:

- A. Individual, group, and family therapy which are facilitated by an independently licensed clinician (or, at minimum, must be within three years of clinical licensure and under the supervision of an independently clinically licensed practitioner per applicable board regulations);
- B. Psychiatric treatment, consultation, and medication monitoring services, including psychiatric diagnostic evaluations, which are completed by a licensed Psychiatrist and/or Advanced Practicing Nurse (APN);
- C. Comprehensive and collaborative treatment and transition plan meetings that include all members of the Child Family Team;
- D. Crisis prevention, stabilization, and interventions that are reflective of CSOC's commitment to the Nurtured Heart Approach and Six Core Strategies to Reduce Seclusion and Restraints;
- E. Recreational activities that build on the youth's strengths and interests;
- F. Allied therapeutic services that are participatory in nature and focus on developing daily living skills and vocational skills;
- G. Activities designed to engage and encourage the youth's abilities to integrate into the community and in preparation for return to his/her own home/community or an independent living arrangement, as deemed appropriate;
- H. Nursing services to monitor physical health needs;
- I. Coordination with the Division of Child Protection and Permanency (DCP&P), when applicable.

Access to other services (such as psycho-education, vocational counseling, and medical services) is arranged to meet each individual's needs. Assessment of school performance and functioning in the community is a

fundamental component of treatment planning as is involvement with school personnel to monitor the ongoing impact of treatment and to facilitate constructive ways of working with the youth. All interventions must be directly related to the goals and objectives established in the youth's care plan. Treatment includes regular and ongoing family involvement, when clinically appropriate. Parent/caregiver/guardian involvement from the beginning of treatment is essential and, unless contraindicated, should occur at least once a month (or more frequently as determined in the care plan). When there is no active family involvement, the DCF case/care management entities will act as (or develop) a surrogate family and are responsible for participating in all treatment team meetings.

All care plans must be individualized and should focus on transitioning the youth home or to a non-clinical setting whenever possible. Length of stay is individualized based on each youth's needs. The length of stay will be based on individual treatment needs and closely monitored by CSOC's Contracted Systems Administrator (CSA) via the Joint Care Review (JCR) process. Specialty services are available Statewide and are managed on a no eject/no reject basis. Services are all-inclusive. Programs are encouraged to have bilingual capacity.

Criteria

Admission Criteria

The youth meets all of criteria A through G:

- A. The youth is between the ages of 5 and 21. Eligibility for services is in place until the young adult's 21st birthday;
- B. The youth presents symptoms consistent with a DSM-5 behavioral health disorder and requires intensive out-of-home therapeutic intervention;
- C. The youth is in need of 24-hour supervision due to emotional and/or behavioral challenges in the home and/or community to such extent that the youth has been (or is) not able to safely function in a regular community, home, or school activities due to significant symptoms and/or behaviors;
- D. The CSOC Assessment and other relevant information indicate that the youth requires Specialty Intensity of Service (IOS);
- E. The youth's cognitive and/or adaptive functioning is in mildly impaired range or higher. If the youth is diagnosed with a developmental/intellectual disability, he/she demonstrates symptoms consistent with a co-occurring DSM-5 mental health disorder, which interferes with his/her ability to adequately function in significant life domains: family, school, social or recreational/vocational activities. The presenting behaviors seem directly correlated with a behavioral or an emotional disorder, independent of the intellectual/developmental disability, and it is clearly evident that the youth's presenting behaviors indicate a change from their baseline functioning which could benefit from the provision of therapeutic- behavioral services, which are rehabilitative in quality;
- F. The parent/caregiver/guardian (or young adult if age 18 and older) must consent for treatment;

	<p>G. The youth is a resident of New Jersey. For minors under 18 years of age, the legal residency of the parent or legal guardian shall determine the residence of the minor.</p> <p>In addition, the youth must meet at least any one of H through L:</p> <p>H. The youth has a history or pattern of fire setting behaviors, with the most recent fire setting incident occurring in the past two (2) year period. A fire setting evaluation with documented risk level must be completed within 12 months of the referral for out-of-home treatment, and the youth's risk to re-engage in fire setting behaviors must be moderate or higher;</p> <p>I. The youth has a history or pattern of assaultive behaviors as evidenced by a significant assaultive behavior which has occurred within the past twelve (12) month period, either with or without a weapon. The assaultive behavior resulted in a medical injury that required the need for medical treatment for either the victim or the youth; there may or may not be legal charges related to the assaultive behavior;</p> <p>J. The youth manifests a pattern of problematic sexual behavior which may or may not have resulted in legal charges, with the most recent incident occurring within the past two (2) year period. A psychosexual evaluation with documented risk level must be completed within 12 months of the referral for out-of-home treatment, and the youth's risk to re-engage in problematic sexual behavior must be moderate or higher. Youth may be Tier I or II under Megan's Law;</p> <p>K. The youth exhibits a history or pattern of aggressive or cruel behaviors directed towards animals. The most recent incident of animal cruelty behavior must be within twelve (12) months of the referral for out-of-home treatment;</p> <p>L. The youth meets DSM-5 criteria for Trauma and Stress Related Disorders, including Post Traumatic Stress Disorder (PTSD) and Reactive Attachment Disorder as evidenced by trauma victimization, which may include, but not limited to, physical, sexual, or emotional abuse, natural disaster, domestic violence, violent crime victimization, or profound neglect. The youth's presenting behaviors require intensive supervision and specialized clinical interventions that cannot be provided at a higher or lower intensity of service. In addition, the youth may also have a history of the following:</p> <ul style="list-style-type: none"> • Multiple foster home/kinship home placements. • Multiple out-of-home treatment settings. • Juvenile Court/Juvenile Justice involvement.
Exclusion Criteria	Any of the following is sufficient for exclusion from this intensity of service:

	<p>A. The parent/caregiver/guardian (or young adult if age 18 and older) does not voluntarily consent to admission or treatment and/or there is no court order requiring such treatment;</p> <p>B. The youth is not a resident of New Jersey. For minors under 18 years of age, the legal residency of the parent or legal guardian shall determine the residence of the minor;</p> <p>C. CSOC Assessment Tools and other relevant clinical information indicate that the youth requires a different intensity of service.;</p> <p>D. The youth is at imminent risk of causing serious harm to self or others, and inpatient psychiatric hospitalization is indicated;</p> <p>E. The youth's presenting challenges compromise the safety of the current environment;</p> <p>F. The youth's level of cognitive and/or adaptive functioning falls below a mildly impaired range, which does not allow him/her to actively participate in this type of milieu and therapeutic intervention. This would also include the following:</p> <ul style="list-style-type: none"> • The youth has a sole diagnosis of autism spectrum disorder and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM-5 behavioral health diagnosis. • The youth has a sole diagnosis of Intellectual/Developmental Disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM-5 behavioral health diagnosis. • The youth has a diagnosis of autism spectrum disorder and an Intellectual/Developmental Disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM-5 behavioral health diagnosis. <p>G. The youth's symptomology of trauma and/or other clinical needs can be adequately maintained and effectively treated at a lower intensity of service or may require a different clinical focus based on clinical review;</p> <p>H. The youth is a Tier III under Megan's Law;</p> <p>I. The youth has a medical condition that would prevent participation in services and that require daily care that is beyond the capability of this setting;</p> <p>J. The youth is diagnosed with a substance use disorder and whose substance use needs require specialized treatment intervention;</p> <p>K. The youth is not in agreement with the Child Family Team's (CFT) plan for out of home treatment. There is evidence of multiple attempts by the CFT to engage the youth in the plan;</p> <p>L. The youth is engaging in a recent pattern of violent behavior that compromises the safety of the youth and others in the out of home program.</p>
Continued Stay Criteria	<p>All of the following criteria are necessary for continuing treatment at this intensity of service:</p> <p>A. The severity of the youth's psychiatric/behavioral/emotional challenges continue to meet the criteria for this intensity of service;</p> <p>B. The CSOC Assessment and other relevant information indicate that the youth continues to require the SPEC Intensity of Service;</p>

	<ul style="list-style-type: none"> C. Specialty services continue to be required to support reintegration of the youth into a less restrictive environment; D. The care plan is appropriate to the youth's changing condition with realistic and specific goals and objectives that include target dates for accomplishment; E. The youth's parent/caregiver/legal guardian has been actively invested in treatment, as evidenced by regular attendance of treatment team meetings, active participation in family therapy, on-site visitation/therapeutic leave, and involvement with transition planning; F. Individualized services and treatment are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice; G. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments in the care plan include strategies for achieving these unmet goals; H. When clinically necessary, an appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored; I. Collaboration between all Child Family Team (CFT) members, which may include, but not limited to, CMO, DCP&P, parent/legal guardian, youth, and treating provider is clearly document in the care plan; J. There is documented evidence of active, individualized transition planning; K. The youth is actively participating in treatment, is regularly attending treatment team meetings, and is adhering to program rules and guidelines.
Transitional Joint Care Review (TJCR) - Transition Request Criteria	<p>If the Child Family Team (CFT) is requesting transition to a different CSOC out-of-home treatment setting via TJCR, ALL of the additional following criteria must be met:</p> <p>The CSOC Assessment and other relevant information indicate that the youth requires a different clinical treatment focus within a different OOH treatment setting. This documentation must include the following:</p> <ul style="list-style-type: none"> A. Treatment needs that were addressed in current episode of care and any previous episodes of OOH treatment; B. Treatment interventions that were successful and/or unsuccessful in current episode of care and any previous episodes of OOH treatment; C. Behaviors/needs that warrant a different OOH intensity of service; D. The youth and family's perspective on proposed transition and the position of the Child Family Team; E. Justification as to why another OOH treatment episode is in the youth's and family's best interest; F. Barriers for the reintegrating the youth to the community at this time; G. Community reintegration plan for youth.
Transition Criteria	Any of the following criteria is sufficient for transition from this Intensity of Service:

	<ul style="list-style-type: none">A. The youth's documented care plan goals and objectives for this Intensity of Service have been substantially met;B. After making adjustments to the youth's care plan to include alternate strategies for achieving unmet goals, the youth's ability to acquire, retain, improve, and/or generalize the behavioral and adaptive skills plateaus and there is no reasonable expectation of progress at this intensity of service. The treating agency is responsible for continued care until a more appropriate clinical setting is secured. Before proceeding to transition a youth for this reason, the treating provider must first collaborate with the CSOC Specialized Residential Treatment Unit (SRTU) as per No Eject/No Reject protocol;C. Consent for treatment is withdrawn by the parent/caregiver/guardian or young adult if age 18 and older, and there is no court order requiring such placement;D. Support systems, which allow the youth to be maintained in a less restrictive intensity of service, have been secured and established;E. A transition plan with follow-up appointments and an appropriate living arrangement is in place. The first follow-up appointment will take place within 10 calendar days of transition. The CFT and parent/guardian/caregiver will be responsible for assuring that the youth attends these appointments;F. The youth is engaging in a documented recent pattern of violent behavior that is compromising the safety of the youth and others in the out of home program;G. The child/youth and/or the parent/guardian/caregiver are available but not participating in treatment or noncompliant with the treatment program's rules and regulations. The lack of participation or noncompliance is significant enough to negatively impact the overall treatment course and compromises the child/youth's ability to have a successful, positive response to treatment.
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