Specialty Services (SPEC)

Specialty Residential Services (SPEC) – Child/Youth/Young Adult

Definition

Specialty Services (SPEC) provide highly supervised, 24-hour care within a community-based out-of-home treatment setting for children, youth, and young adults 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 assault/aggression, fire setting, inappropriate sexual behavior, and animal cruelty.

Common to children/youth/young adults manifesting such behavior is a history of complex trauma. Traumatic events are severe and pervasive, such as emotional/physical/sexual abuse, natural disaster, domestic violence, violent crime victimization, and/or profound neglect. Specialty services assist the child/youth/young adult in processing their traumatic experiences and related behaviors in a healthy and holistic manner. Treatment is provided in a safe, consistent, and nurturing environment with a high degree of supervision, structure, and evidence-based clinical intervention.

Specialty services are available Statewide and are managed on a no eject/no reject basis. Services are all-inclusive. Treatment should include regular and ongoing family involvement, when clinically appropriate. When there is no active family involvement, the DCF case/care management entities should act as (or develop) a surrogate family and be responsible for participating in treatment team meetings. The individualized focus should implement therapeutic principles which are directly focused on the etiology of each individual's prescribed need. Examples of therapeutic modalities may 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 two years of clinical licensure and under the supervision of a clinically licensed practitioner);

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 discharge plan meetings that include all members of the Child Family Team;

D. Behavioral management;

E. Crisis intervention;

F. Structured recreational activities;

G. Allied therapeutic services that are participatory in nature and focus on developing daily living skills and vocational skills (MI/DD youth may receive a substitution for portion of the allotted allied time for behavioral support interventions and activities);

H. Activities designed to engage and encourage the child/youth/young adult's abilities to integrate into the community and in preparation for his/her return to own home/community or an independent living arrangement, as deemed appropriate;

I. Nursing services to monitor physical health needs;

J. Coordination with the Division of Child Protection and Permanency (DCP&P) and/or CSOC DD Consultants, when applicable.

Access to other services (such as psycho-educational testing, vocational counseling, and medical services) is arranged to meet each individual's needs. All interventions must be directly related to the goals and objectives established in the Child Family Team ISP/treatment plan. Parent/custodian/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 ISP/treatment plan). 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 ISP/treatment plans must be individualized and should focus on transition to a lower intensity of service (IOS) or return home. Programs are encouraged to have bilingual capacity.

Criteria	
Admission Criteria	*The youth meets **A, B C, D** and **E** and at least **ONE** from **F THROUGH J**.* A. The child/youth/young adult presents symptoms consistent with a DSM IV-TR or DSM V diagnosis and requires intensive out-of-home therapeutic intervention. B. The child/youth/young adult is between the ages of 5 and 21. Special consideration will be given to children under 11. Eligibility for services is in place until the young adult's 21st birthday. C. The CSOC Assessment and other relevant information indicate that the child/youth/young adult requires Specialty Intensity of Service (IOS). D. The child/youth/young adult must have cognitive functioning abilities in the moderately impaired range or higher, as

	evidenced by an IQ of 60 or higher. Special considerations will be made for IQ's between 55 - 60. E. The parent/custodian/guardian (or young adult if age 18 and older) must consent for treatment. The youth meets any **ONE** of the following: F. The child/youth/young adult has a history or pattern of fire setting behaviors, with the most recent fire setting incident occurring in the past 2 year period. For youth with this history, 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. G. The child/youth/young adult has a history or pattern of assaultive behaviors as evidenced by a significant assaultive behavior which has occurred within the past 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. H. The child/youth/young adult manifests a pattern of sexually aggressive or reactive behaviors which may or may not have resulted in legal charges, with the most recent incident occurring within the past 2 year period. For those with this history, a psychosexual evaluation with documented risk level must be completed within 12 months of the referral for residential treatment, and the youth's risk to re-engage in sexually aggressive behaviors must be moderate or higher. Youth may be Tier I or II under Megan's Law; I. The child/youth/young adult exhibits a history or pattern of aggressive or cruel behaviors directed towards animals. For youth with this history, the most recent incident of animal cruelty behavior must be within 12 months of the referral for out-of-home treatment; J. The child/youth/young adult meets DSM IV/V criteria for PTSD 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 child/youth/young adult's presenting behaviors

	require intensive supervision and clinical interventions that cannot be provided at a higher or lower intensity of service (see Exclusionary Criteria/#5). . In addition, the child/youth/young adult may also have a history of the following: i. Multiple foster home/kinship home placements; ii. Multiple out-of-home treatment settings; iii. Juvenile Court/Juvenile Justice involvement; **If the child/youth/young adult is diagnosed with a developmental/ intellectual disability, he/she must also meet criteria K:** K. The child, youth, or young adult demonstrates symptoms consistent with a co-occurring DSM-IV-TR/ DSM V 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 child/youth/young adult'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.
Psychosocial, Occupational, Cultural, and Linguistic Factors	*These factors may change the risk assessment and should be considered when making level of care decisions.*
Exclusion Criteria	***Any** of the following is sufficient for exclusion from this level of care:* 1. The parent/custodian/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 placement. 2. The child/youth/young adult is at imminent risk of causing serious harm to self or others, and inpatient psychiatric hospitalization is indicated. 3. The child/youth/young adult's presenting problem compromises the safety of the current therapeutic environment.

4. The child/youth/young adult's level of cognitive functioning does not allow her/ him/ to benefit from the specialty therapeutic interventions.

5. The child/youth/young adult'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.

6. The child/youth/young adult is a Tier III under Megan's Law;

7. The child/youth/young adult has medical conditions or impairments that would prevent participation in services and that require daily care that is beyond the capability of this setting and the individualized wraparound process will not enable the child/youth/young adult to enter this intensity of service.

8. The child/youth/young adult has a sole and primary diagnosis of Substance Abuse and there are no identified co-occurring emotional or behavioral disturbances, which could be addressed by Specialty services.

9. The child/youth/young adult's intellectual/developmental disability includes one of the following:
   - The child/youth/young adult has a sole diagnosis of Autism and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM IV/ DSM V mental health diagnosis.
   - The child/youth/young adult has a sole diagnosis of and intellectual/developmental disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM IV/ DSM V mental health diagnosis.
   - The child/youth/young adult has a diagnosis of Autism and/or an intellectual/developmental disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM IV/ DSM V mental health diagnosis.
   - The child/youth/young adult's level of functioning falls below a FSIQ of 60 (special considerations will be made for FSIQ of 55-59);
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10. The child/youth/young adult 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.

Continued Stay Criteria	***All*** *of the following criteria are necessary for continuing treatment at this level of care*: 1. The severity of the psychiatric/behavioral/emotional disturbance continues to meet the criteria for this intensity of service. 2. The CSOC Assessment and other relevant information indicate that the child/youth/young adult continues to require the SPEC Intensity of Service. 3. The child/youth/young adult's treatment needs are consistent with Specialty Intensity of Service. 4. Specialty level services continue to be required to support reintegration of the child/youth/young adult into a less restrictive environment. 5. The JCR/treatment plan is appropriate to the child/youth/young adult's changing condition with realistic and specific goals and objectives that include target dates for accomplishment. 6. The child/youth/young adult's parent/custodian/legal guardian has been actively invested in treatment, as evidenced by regular attendance of treatment team meetings, participation in family therapy, and involvement with transition planning. 7. Individualized services and treatment are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice. 8. 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 ISP/treatment plan include strategies for achieving these unmet goals. 9. When clinically necessary, an appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored. 10. Collaboration between all Child Family Team (CFT) members, which may include, but not limited to, CMO, DCP&P, parent/legal guardian, child/youth/young adult, and SPEC provider, is clearly document in the treatment plan.

	11. There is documented evidence of active, individualized discharge planning.
Discharge Criteria	***Any*** *of the following criteria is sufficient for discharge from this Intensity of Service:* 1. The child/youth/young adult's documented JCR/treatment plan goals and objectives for this Intensity of Service have been substantially met. 2. The CSOC Assessment and other relevant information indicate that the child/youth/young adult requires a different clinical treatment focus or lower intensity of service. 3. Consent for treatment is withdrawn by the parent/custodian/guardian or young adult if age 18 and older, and there is no court order requiring such placement. 4. The child/youth/young adult is not making progress toward JCR/treatment goals and there is no reasonable expectation of progress at this intensity of service, despite treatment planning changes. The treating agency is responsible for continued care until a more appropriate clinical setting is secured. Before proceeding to transition a child/youth/young adult for this reason, the treating provider must first collaborate with the CSOC Specialized Residential Treatment Unit (SRTU) as per No Eject/No Reject protocol. In addition to the above criteria, the following shall be achieved: 5. Support systems (which allow the youth to be maintained in a less restrictive intensity of service) have been thoroughly explored and/or secured. 6. A discharge plan with follow-up appointments and an appropriate living arrangement is in place; and the first follow-up appointment will take place within 10 calendar days of discharge.