

New Jersey Department of Human Services Dual Diagnosis Task Force Report:



Collaborating to Provide Services and Supports for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders

October 10, 2008

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EXECUTIVE SUMMARY

The Dual Diagnosis Task Force, convened in January 2008 by the New Jersey Department of Human Services Commissioner Jennifer Velez, is committed to examining and resolving the serious lack of services, unmet service needs and other significant obstacles to receiving mental health and developmental disability services, encountered by individuals with developmental disabilities and co-occurring mental health and/or behavior disorders (i.e. people with dual diagnosis). The purpose of this report is to highlight the urgency of the need for reform; to share recommendations developed by the Dual Diagnosis Task Force (DTFF); and to provide a framework for change that would enable the service system to effectively serve the needs of children and adults with developmental disabilities and co-occurring mental health and/or behavior disorders.

Research shows the prevalence of mental health disorders in the developmentally disabled population ranges from 30 to 40 percent. Certain myths about mental health and intellectual disabilities persist in the service community and these myths inhibit service delivery. These myths include:

- Maladaptive behaviors are exclusively a function of the developmental disability
- The only treatment the mental health system can provide is medication
- Impairments in cognitive abilities and language skills make psychotherapy ineffective
- Either one system or the other must take full responsibility for the care and treatment

When individuals with developmental disabilities are hospitalized in state psychiatric hospitals, their average length of stay is three times as long as the length of stay of the non- developmentally disabled population. Of course, statistics like these do not begin to describe the human cost of an ineffective system of services and/or supports for those with a dual diagnosis (i.e. the family disruption; the opportunities lost; the emotional and in some cases physical trauma suffered).¹

DDTF presents in this report a framework, which the Department of Human Services can utilize, to assure that individuals with developmental disabilities and co-occurring mental health and/or behavior disorders can have the services and supports necessary to fully participate in community life. A participatory process was utilized in developing this report. The examination of existing services and systems, research of the service gaps and needs, and the recommendations developed to promote change are based upon cooperative effort and our shared vision, principles and values.

DDTF is comprised of individuals with developmental disabilities, family members, advocates, professionals and state officials with expertise in these areas. A number of subject matter experts located throughout New Jersey augmented the task force membership through their active participation on subcommittees. These individuals advised the task force and provided assistance in developing recommendations included in this draft report.

¹ Resource: National Association for the Dually Diagnosed (NADD)

DHS DUAL DIAGNOSIS TASK FORCE RECOMMENDATIONS

Priority System Recommendations

- Adhere to the values and principles articulated by the task force in **bringing recommendations into operational use**, which requires ongoing policy review and change to align practice and the system change goals;
- Establish a **county-based collaborative team process** to facilitate individualized service planning (crisis management and access to crisis prevention outpatient care), as well as to identify community needs, map local resources and further local system building;
- Create **workforce competency through cross-systems collaborative training**, multiple training opportunities and incentives for professional development (e.g. stipends, fellowships, student loan “forgiveness” programs); and
- Develop Case Management Capacity to serve DD/MI children and adults through a **change in Individual Service Planning Practice** (e.g. cross-system affiliation agreements crisis planning standards).

Priority Service Recommendations

□ Develop a continuum of crisis response services including:

- An array of supportive resources for youth and families to allow plan implementation based on identified needs at assessment and prior to need for crisis intervention
- Mobile response with a clinical outreach capacity
- Short-term emergency treatment
- Crisis respite beds
- Specialist screeners to work in conjunction with the DD/MI Crisis Response System
- Acute partial hospital programs

□ Develop Outpatient Service Centers

- ◆ Medical and dental care
- ◆ Standardized comprehensive assessment and evaluation
- ◆ Integrated mental health treatment and behavior management to address co-occurring disorders
- ◆ Capacity to provide and guide behavioral support in-home and within other community settings
- ◆ Capacity to outreach to local areas
- ◆ Capacity to provide training and on-the-job training opportunities

□ Develop or Expand Other Key Services

- ◆ Behavioral support capacity within service settings (e.g. residential services, supported employment, home, etc.) as well as for individuals who self-direct their services
- ◆ Dual Diagnosis Day Treatment
- ◆ Family/Caregiver education and support, including support through professionals (IFSS)* and through family and peer run organizations (FSO, YP)*; Family/Caregiver Education and Support should include teaching self-advocates and families (including foster resource families within the child welfare system) the effective behavioral management techniques.

Implementation Recommendation

In making these recommendations, the task force is cognizant of today’s difficult economic climate and its impact on implementation. The Task Force therefore, recommends an implementation strategy that would focus on identifying opportunities to maximize existing resources to make incremental changes.

The Commissioner of the New Jersey Department of Human Services will convene an Executive Oversight Board to manage the implementation of the recommendations and ensure that the vision for system change is achieved. The Executive Oversight Board will consist of the leadership of the Departments of Human Services (DHS) and Children and Families (DCF), including the Assistant Commissioners of the DHS Divisions of Developmental Disabilities and Mental Health Services, the DCF Commissioner and the DCF Director of the Division of Child Behavioral Health Services.

* See Acronym Listing on Page 46

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Donna J. Icovino, Co-Chairperson
Dual Diagnosis Task Force

October 10, 2008

Dear Commissioner Velez,

On behalf of the Dual Diagnosis Task Force, the Subcommittee membership, the valued participants at the Family/Caregiver Forums, and the children, adolescents and adults in New Jersey affected with developmental disabilities and co-occurring mental health and/or behavior disorders, it is with great honor and privilege that we present the final recommendation report of the Department of Human Services Dual Diagnosis Task Force.

By virtue of your leadership in establishing this Task Force, you have generated tremendous hope among countless individuals, and their families. Through your actions you have also demonstrated that as citizens of this great state we genuinely value the lives of people with disabilities; and that we have a shared responsibility for improving the quality of their care and supportive services to ensure that each and every person is given the opportunity to reach their potential regardless of their specific challenges.

This final report reflects the dedicated and collaborative spirit of the esteemed membership, which will serve as a beneficial working model moving forward. The proceedings fostered and produced an excellent diversity of viewpoints, as well as a commonality of opinion. In the end, there was great consensus in terms of the direction we needed to proceed to promote the ideals of wellness and recovery.

At the very heart of our deliberations was the compelling testimony given by self-advocates and family members who diligently served on the Task Force. Their experiences offered great insight into navigating a system of services filled with inherent bias that provides few viable options for individuals in times of crisis when they and their families are at their most vulnerable. In many ways, these real life accounts have served as a constant reminder of all that we need to accomplish as a Task Force. Moreover, these collective experiences have become the driving force behind this initiative that will undoubtedly result in needed and effective reform.

The final report contains priority recommendations, and furnishes a blueprint for developing a quality person-centered, accessible, cross-agency care system, which includes an Implementation Plan that incorporates essential sustainability measures. Your support of the creation of an Executive Oversight Board will unquestionably be the catalyst to meaningful systems and potential policy changes, and will help maintain the necessary momentum to accomplish our on-going and future goals as a Task Force.

The members of the Task Force look forward to the important work ahead of us as we begin to vigorously address the needs of individuals who are counting on us to lead the way. Together our combined efforts will be far reaching and achieve a lasting difference, and the benefits of our accomplishments will be truly priceless.

Sincerely,

Donna J. Icovino

Donna J. Icovino, Co-Chair

Acknowledgements

“No man is wise enough by himself.” - Titus Maccius Plautus

Dear Members of the DHS Dual Diagnosis Task Force and Advisory Subcommittees:

It is with the utmost respect and gratitude that we recognize your dedicated efforts on behalf of this vital task force initiative. From the onset, a great deal of thought went into the membership selection process. As a result, our membership is comprised of individuals with developmental disabilities, family members, advocates, service providers, professionals, state officials, and representatives.

Each of you joined the proceedings with varying perspectives based on your experiences relative to the issues faced by individuals with developmental disabilities, and co-occurring mental health and/or behavior disorders, especially in the area of crisis care. However, the common thread that connected the great diversity of opinions and ideas exchanged was the determined commitment by the membership to develop comprehensive recommendations that effectively address crisis care issues, including preventive and post crisis measures.

A substantial number of you serving on the task force have devoted most of your professional lives to improving the quality of care and supportive services for this special population of individuals. Whether professional or personal, during these proceedings all of you provided an informative look into your own challenges in terms of finding, advocating for, and in some cases creating ways to make the system work for those individuals in your care. The fact that you had this experience in common was no doubt a contributing factor to your success in drafting practical and feasible recommendations.

Many of you had participated on other task force and advisory committees that fell completely short of their goals, and therefore, you initially questioned why this initiative would prove any different from past ventures. What became increasingly clear and subsequently reinforced through your deliberations, was the intrinsic role of leadership at the highest level in any meaningful reform and systems building process. Fortunately, due to the leadership of Commissioner Jennifer Velez, Department of Human Services, and the establishment of the Executive Oversight Board, we possess the necessary ingredient to move the recommendations of this task force to the implementation phase; a plan will be developed that includes timetables as well as mechanisms for accountability and sustainability.

We wish to express our sincere appreciation to each of you who devoted your time, tireless energy, and invaluable expertise to these proceedings. We look forward to continuing our work together as we begin to build a system that better serves individuals with dual disorders. Your strong work ethic and commitment has already made a difference. Just imagine the possibilities as we move forward.

We wish to express our sincere gratitude to the New Jersey Hospital Association for hosting our multiple half and full day meetings at New Jersey hospital Association headquarters in Princeton, and for their gracious hospitality.

A very special note of thanks to The Bogg's Center for their generous offer to accommodate the entire membership for the report presentation to Commissioner Jennifer Velez, and for their helpful assistance organizing this event.

Last, but far from least, we would like to commend Nick D'Ambrosio and William Mars for their valuable participation. Sharing their compelling crisis experiences with us took great courage and showed incredible strength. We applaud all that William and Nick have accomplished, and wish them continued success in all they are yet to achieve. Nick and William serve as genuine inspirations to us all.

Sincerely,

T. Missy Balmir

T. Missy Balmir, Co-Chairperson

Donna J. Icovino

Donna J. Icovino, Co-Chairperson

New Jersey Department of Human Services Dual Diagnosis Task Force Report October 10, 2008

1.0 Introduction

1.1 Purpose of the Report

The Dual Diagnosis Task Force, convened in January 2008 by the New Jersey Department of Human Services (DHS) Commissioner Jennifer Velez, is committed to examining and resolving the serious lack of services, unmet service needs and other significant obstacles to receiving mental health and developmental disability services, encountered by individuals with developmental disabilities and co-occurring mental health and/or behavior disorders (i.e. people with dual diagnosis). The purpose of this report is to highlight the urgency of the need for reform; to share recommendations developed by the DHS Dual Diagnosis Task Force (DTFF); and to provide a framework for changes that would enable the service system to effectively serve the needs of children and adults with developmental disabilities and co-occurring mental health and/or behavior disorders.

2.0 Background

2.1 The Urgent Need for Reform

Individuals with developmental disabilities and co-occurring mental health and/or behavior disorders, along with their families and caregivers, encounter significant obstacles to receiving developmental disabilities and mental health services in New Jersey and across the country. Certain myths about mental health and intellectual disabilities persist in the service community and these myths inhibit service delivery. These myths include:

- ◆ Maladaptive behaviors are exclusively a function of the developmental disability
- ◆ The only treatment the mental health system can provide is medication
- ◆ Impairments in cognitive abilities and language skills make psychotherapy ineffective
- ◆ Either one system or the other must take full responsibility for the care and treatment

However, research shows the prevalence of mental health disorders in the developmentally disabled population ranges from 30 to 40 percent. When individuals with developmental disabilities are hospitalized in state psychiatric hospitals, their average length of stay is three times as long as the length of stay of the non- developmentally disabled population. Of course, statistics like these do not begin to describe the human cost of an ineffective system of services and supports for those with a dual diagnosis (i.e. the family disruption; the opportunities lost; the emotional and in some cases physical trauma suffered).²



² Resource: National Association for the Dually Diagnosed (NADD)

*Michael Icovino*³

“Mrs. Icovino, can you tell us what Michael is doing here? This is an absolutely inappropriate placement for him and we are concerned for his safety.”

Incredibly, this statement came as “good news” to Donna, mom to then-eighteen-year-old Michael, a young man diagnosed with Autism in early childhood and more recently with Bipolar Disorder who, until this point, had been residing successfully in a group home and attending school equipped to address his needs at the time. Made by a clinician at a state psychiatric hospital, the statement served as bittersweet validation of what Donna already knew to be true – that a State psychiatric hospital was not the appropriate setting for her son. Michael had been committed to the state hospital against Donna’s will by the a crisis screening center, after having been transported there by ambulance twice in two days because of behavioral episodes.

The first day, Donna was told by the on-duty clinician that they were “unable to treat an individual with developmental disabilities”, and Michael was released after two hours without having received any treatment whatsoever. Arriving back at the Crisis Center the following morning, Michael was mechanically restrained and medicated. Donna was again told that “there was nothing they could do for my son; because he was developmentally disabled they would have no other choice but to release him.” As Donna continued to push throughout the day (and across two work-shifts) for appropriate crisis stabilization/placement for Michael, she was “informed” by two separate clinicians at the Crisis Center that as Michael’s legal guardian she had “no rights in the decision process”; that once he was screened at the Crisis Center, “it was up to the psychiatrist to decide where Michael should be placed.”

Although the on-duty clinician begrudgingly admitted Michael to the hospital that evening, he was boarded onto an ambulance early the next morning—against his mother’s will—and taken to a state Psychiatric Hospital. Donna followed in her own car that chilly mid-winter morning, and vividly recalls it as, “without question, the saddest day of my life.”

Thankfully, Michael’s stay at the state facility was brief, and he was able to return to his school and his group home. Only later, through her own research, would Donna learn about the gross misinformation she had been given by Crisis Center staff during these traumatic days when her son was in crisis; and also about the appalling lack of services available for people dually diagnosed with developmental disabilities and mental health issues.

In naming her as co-chair for the first-ever Dual Diagnosis Task Force, Jennifer Velez, the Commissioner of the New Jersey Department of Human Services, referred to Donna as “a family member whose personal experiences propelled her to be the best type of advocate, one who is a positive catalyst for change.” She is compelled by her own story, and the disturbing stories of countless others—as we all must be—to seek lasting, systemic changes for dually diagnosed citizens of New Jersey.

³ In order to maintain confidentiality, all names and identifying information of individuals have been changed. Michael and Donna Icovino as well as David and William Wills have requested that their personal informations be included.

David Wills

When David was a young child living at home with his family he presented a constant danger to himself, requiring painstaking vigilance on the part of his parents. He would sometimes slip out the door and disappear before anyone knew he was gone; he would reach without warning into a hot frying pan to grab a tempting piece of meat; he would climb into the bathtub with all his clothes on and start the water running, or would even start hurling various objects into the bathtub, causing damage to the point that repairs had to be done on more than one occasion. Eventually, David's dad, William, had to install deadbolt locks on every door in the household, feeling it was the only way to keep David - and their home—safe. At the age of nine, David went to live outside his home, supported by a community-based educational/residential program.

William vividly recalls one particular incident, when David was fifteen years old and in crisis and had to be taken to the local hospital emergency room. It was clear almost as soon as they arrived that the hospital was not prepared to handle this kind of situation, and the response of the health care professionals on staff that day was to usher David into a “special room”, strap and lock him down to a gurney that was bolted to the floor and medicate him. “All they did was drug him and wait, for what felt to us like an eternity,” William says. Finally, a hospital social worker came in and ran through a battery of questions, after which David was released—much to the relief of his parents, though having not received any real treatment. One off-handed comment made that day by the social worker still sticks with William. “She said, ‘we cannot do much for these people’. It was just so depressing to hear this kind of statement from a hospital.”

2.2 What is Dual Diagnosis?

2.2.1 Definition

In this report, a “dual diagnosis” refers to a situation whereby an individual has both a developmental disability and a mental health disorder. People with developmental disabilities can exhibit the full range of psychiatric disorders. They may exhibit signs and symptoms of mental health problems such as depression, mood disorders, anxiety and thought disorders in the form of behavior such as verbal or physical aggression, self-injury, property destruction, impulsive behaviors, elopement, etc. Conversely, these unwanted, disturbing behaviors may indicate interpersonal, physical or environmental problems rather than a mental health disorder. There is nothing about an intellectual disability or a developmental disorder in and of itself, which explains aggression, property destruction, elopement or other unsafe behaviors. A comprehensive assessment should be performed to identify the multiple factors, including the possibility of a mental health disorder, contributing to these behaviors.

² The term “dual diagnosis” is also used to refer to individuals with co-occurring mental health and substance abuse disorders. The New Jersey Department of Human Services (DHS) Division of Mental Health Services and Division of Addiction Services collaborate to serve the needs of this population. The task force members acknowledged that individuals with a primary mental health diagnosis resulting in a cognitive impairment may also need the type of services that individuals eligible for DHS Division of Development Disabilities services receive. Members also acknowledged that ultimately it would be best if the system focused solely on service need rather than diagnosis or eligibility. Significant barriers would have to be overcome to achieve this outcome including the alignment of funding with eligibility requirements and the feasibility of expanding the population in light of limited resources. The issue should be examined to determine if there are opportunities to serve individuals that the system is presently missing.

2.2.2 The Experience of Individuals and their Families

Individuals and their families shared the following experiences:

- ◆ Long waits in the emergency room;
- ◆ Rejection from local inpatient units and/or inpatient stays in a unit far away from home;
- ◆ Multiple medication changes;
- ◆ Children and their families often experienced fragmentation of responsibility between the developmental disability, mental health and local education systems;
- ◆ Mental health and developmental disability providers with expertise in dual diagnosis are a scarce resource;
- ◆ Children often have to go to out-of-district school placements or get placed on homebound instruction;
- ◆ Families' work schedules often will not accommodate homebound instruction and often an out-of-home placement is sought;
- ◆ Encounters with the police or other emergency personnel during crisis episodes as group home staff may call 911;
- ◆ Eviction from group home placements;
- ◆ Family members report exhaustion from care-giving responsibilities; and,
- ◆ Treatment providers do not understand the complex medical and neurological issues faced by individuals with a dual diagnosis

Despite these many issues, people have experienced positive outcomes when treatment services are provided in a manner that simultaneously addresses a person's mental illness and his or her developmental disability treatment, from knowledgeable providers who work collaboratively across multiple service systems.

Jane

Jane, who has a dual diagnosis, is now in her twenties and resides with her sister and her sister's family, but her difficult journey began at birth. Born to a mentally ill woman who was committed to a psychiatric hospital at the time of Jane's birth, Jane was then adopted by a woman with significant borderline personality traits who had two daughters of her own. By age 21, having already been diagnosed with neurological issues and linked with DDD, Jane had begun to exhibit manic and dangerously provocative behaviors; she fell in with a bad crowd and was raped by a gang member. It was not until this traumatic event, when she was admitted to a local psychiatric unit, that Jane was finally diagnosed with Bipolar Disorder and was prescribed psychotropic medication.

During her time at a specialized clinic, the director and staff, with the skilled support and guidance of a clinician from a crisis response program, were systematically working to get Jane's needs met. The clinic's consulting psychiatrist took over Jane's medication management; recognizing her complex neurological needs, the director was able to get Jane to commit to attend weekly group therapy; and clinic staff worked at getting her into a work program. Although Jane now also suffers from Post-Traumatic Stress Disorder in addition to her other diagnoses and has been hospitalized a number of times, she has wonderful potential and has worked extremely hard over the years. Jane is someone who requires a tremendous amount of community support in order to safely avoid further hospitalization.

2.3 Overview of the Available Services and Supports

2.3.1 Services and Supports for Children

Like most other states, New Jersey's mental health and developmental disabilities service delivery systems have had great difficulty serving children with developmental disabilities who have co-occurring mental illness, emotional disorders or who demonstrate severe behaviors. On a national level, the US Health and Human Services (HHS) Office on Disability (OD), the Department of Education, the Center for Medicare and Medicaid Services and other federal partners are working to address the needs of these youth. The OD believes that children in this population are best served within a "System of Care" approach (i.e. services and supports that are individualized, community-based, child-centered, family-driven, culturally competent, comprehensive, integrated, and that foster the development of meaningful relationships between the child, the care provider, and the family). Their goal is to decrease existing barriers by addressing eligibility and financing problems, and by increasing access for families to non-clinical support systems such as in-home supports and respite care. The ultimate goal is to provide a seamless set of services that are accessible and available to all children and youth with co-occurring developmental disabilities and emotional/behavioral disorders.

Status in New Jersey

New Jersey is the first state in the country to establish a "System of Care" for children with emotional and behavioral disorders and their families in each of its local service areas. The children's behavioral health system has an array of services, including: Evaluation, Individual, Group or Family Counseling; Medication Management, Partial Care, Emergency Screening, Acute Inpatient, Intermediate Hospital Care, Intensive Residential Treatment Services, Intensive case management – CMO, Moderate CM – YCM, Intensive In-Community, Behavioral Assistance, Family Support and Mobile Response and Stabilization Services (See the Appendix for service descriptions).

Unfortunately, children with co-occurring developmental disabilities and emotional and behavioral disorders have somewhat limited access to this service array. Although there is some specialized capacity, there is a need to increase the system's ability to effectively meet these needs. The Division of Child Behavioral Health Services (DCBHS) and the Division of Developmental Disabilities (DDD) understands the complexity of need and are committed to appropriately serving dually diagnosed children, youth and young adults. DCBHS has allocated funds for the development of in-state community treatment home beds specifically for dually diagnosed youth, and for a training initiative that would build provider capacity to effectively serve children with a dual diagnosis.

DHS Division of Developmental Disabilities (DDD)

Children under 21 years of age represent the vast majority of those becoming eligible for DDD's services, and many present severe behavioral problems in addition to their developmental disability. Currently, the DDD provides information and assistance, family education, case management, family support services, some behavioral services, and limited residential services for children. DDD is able to offer to these children and their families the same array of Family Support services available to children without behavioral health problems. These services include: in-home and out-of-home respite, summer camp and after-school programs, help paying for medically-approved assistive technology devices and some home and vehicle modifications, and limited residential services. For those children who need it, DDD can also provide access to some behavioral services.

In 2008, the DDD began the Children's Placement Enhancement Pilot (C-PEP). C-PEP is a pilot program developed to enhance New Jersey's in-state community-based capacity, "to provide safe, stable and therapeutically supportive programs for children and/or young adults who have been placed out of state or are at risk of out-of-state placement because of their significantly challenging behaviors or medical needs." The pilot program is expected to last for two years, with the results to be used to guide program expansion.

Among the objectives of the C-PEP program is the development of in-state community residential programs for children and young adults, ages 6 through 21, who have significantly challenging behaviors and/or medical needs. The program is specifically designed to increase in-state alternatives for children and families and to reduce the isolation and family fragmentation that frequently results from out-of-state placement.

The Need for Comprehensive Clinical Evaluations

There is a long-recognized need for professionals with the clinical expertise to evaluate and treat children with co-occurring developmental disabilities and mental health disorders in a comprehensive and coordinated fashion. Families and professionals in the children's mental health and developmental disabilities systems experience this expertise as a scarce commodity and in fact, a DCBHS sponsored Developmental Disability/Mental Illness Stakeholder Workgroup recommended that Department of Children and Families include spending for expert assessment, diagnosis, consultation and planning for this special population.

Currently, the New Jersey Department of Health and Senior Services (DHSS) contracts with eleven hospitals to provide a statewide network of Child Evaluation Centers (CEC). Each center provides a comprehensive, multi-disciplinary evaluation of children with congenital or acquired neuro-developmental and behavioral disorders. In addition, six of the CEC's provide diagnostic services for children with or suspected of having Fetal Alcohol Syndrome. One of the centers, UMDNJ/NJ Medical School, also has an Autism Center.

These CEC's feature the clinical expertise in co-occurring disorders needed by the DCBHS and DDD service system. However, demand for in-state comprehensive evaluation is constant and the average wait time from first contact to evaluation (through the centers) is approximately 3-6 months. DCBHS and DDD with DHSS have explored options for expanding the capacity of these centers; however, these efforts have not yet been successful.

2.3.2 Services and Supports for Adults

Community services staff at the DDD were surveyed by the NJ Institute of Technology Developmental Disabilities Planning Institute to gain an understanding of the community resource needs faced by the division's clients. In general, there was a sense that demand for all services far exceeded the available resources and that DDD's traditional services were not up to the new challenges presented by younger clients, aging clients and individuals with increasingly complex and specialized needs - e.g. autism and dual diagnoses. (Lerman, P., Apgar, D., and Moore, C. (2007). *An Overview of Community Service Challenges in New Jersey*. Newark, NJ: New Jersey Institute of Technology).

The full range of mental health services offered by the DHS Division of Mental Health Services (DMHS) can be found in a matrix in this report's Appendices (page...); however, the DMHS has developed some specialized services to serve this population. Trinitas Hospital has a Dually Diagnosed Mentally Ill and Developmentally Disabled (MI/DD) Unit, which consists of a 10 bed closed acute unit for adults. Treatment is geared towards preventing long-term institutionalization and returning the patient back to the community with mental health and DDD services. Patients will be accepted on involuntary or voluntary status if they present with significant psychiatric and behavioral disorders that require inpatient treatment or demonstrate symptoms that potentially can escalate into crisis. A multidisciplinary team approach is provided utilizing crisis intervention, medication stabilization, therapeutic groups and family education.

DDD community services county supervisors consistently reported that "many current mental health providers do not have adequate training to treat persons with developmental disabilities"; and also felt the quality of specialized services (such as the ones provided by Trinitas Hospital) were good but that they were not adequate to meet a statewide need (e.g. Trinitas Hospital Specialized inpatient unit located in Elizabeth has 10 beds statewide).

DMHS funds some residential programs for adults with mental illness in community residences, owned or leased by the provider or through service agreements, providing support and encouragement, in the development of life skills required to sustain successful living within the community. Clients live in the most normalized, least restrictive environment possible to promote individual growth and safety. The programs focus on empowering the client's use of generic community supports to meet physical, psychological and social needs to promote an improved quality of life and emotional well being. Services could be provided in a family care home, group home, etc.:

- ◆ Family Services operates the Oasis residential program for individuals with DD/MI. Twenty beds are on the grounds at Ancora Psychiatric Hospital (APH) and 20 beds are located in the community. Entry is limited to consumers discharged from APH.
- ◆ SERV has a 12 bed residential program in Trenton, NJ for individuals with DD/MI referred from Trenton Psychiatric Hospital.

- ◆ SERV operates a two home residential program in Hudson County for individuals with DD/MI who are referred from Greystone Park Psychiatric Hospital.
- ◆ The Bergen ARC operates a group home for individuals with DD/MI in Bergen County. Pathways is a group home for individuals with DD/MI in Bergen County.

DMHS funds some comprehensive, structured, non-residential health services provided to adult clients with serious mental illness and developmental disabilities in a day program setting to maximize client's independence and community living skills. Partial Care (PC) programs provide or arrange services necessary to meet the comprehensive needs of the individual clients.



- ◆ Family Services operates the Visions PC program in Burlington County, a non-contract program licensed by DMHS.
- ◆ Family Services also operates a PC program in a separate building at Ancora Psychiatric Hospital (APH) for individuals with DD/MI who reside in the Oasis program.
- ◆ Vantage operates the LEAP program in Bergen County.
- ◆ Christian Health Care Center is a specialized DD/MI program in Bergen County.

DDD county supervisors identified a need for more residential services and day programs for individuals with behavioral challenges. When asked to identify priority family support service needs based on severity of need, the county supervisors identified the need to provide additional behavioral supports for children and in-home crisis services tailored to meet the needs of individuals with developmental disabilities.

The DHS divisions, DMHS and DDD, work together to jointly fund an outpatient services program, that offers periodic therapy, counseling and supportive services at a provider agency for relatively brief sessions (between 30 minutes and 2 hours). Operated by Catholic Charities – Metuchen, NJ, the program serves individuals with DD/MI at their Flemington office. Referrals are received from Hunterdon County DD providers.

The infrastructure development called for in DDD's Olmstead Plan (May 2007) presents a strategic opportunity to build the capacity to provide community mental health services to people with developmental disabilities. As a result, the DDD is collaborating with the DMHS to operate a crisis response system that is directly available to both division, screening centers and other DD and MH provider agencies and families through a 24/7 toll-free phone line. Statewide Clinical Consultation and Training (SCCAT) clinicians can conduct a face-to-face assessment of the individual within the crisis setting(s) and/or provide clinical consultation in order to develop a crisis management plan jointly with the DDD regional community services staff. The SCCAT team provides expertise to the agencies and families to treat and manage the psychiatric and behavioral problems of adults with developmental disabilities. These expanded operations began June 18, 2007. The 2008 contract calls for 835 face-to-face interventions at DMHS psychiatric in-patient screening centers, community mental health programs, community in-patient units, the DD/MI Unit at Trinitas, state psychiatric hospitals, DDD community programs and family homes.

The DMHS contract also includes six regional training sessions targeting mental health and developmental disabilities service providers, care coordinators and case managers as well as 80 training sessions for individual agencies. The faculty includes experts in the area of dual diagnosis and autism from throughout the DD provider community.

The DMHS also funds the UMDNJ Crisis Consultation & Community Outreach Program that serves Burlington, Cumberland, Gloucester, and Salem, NJ, which provides crisis intervention and preventive services to individuals with developmental disabilities experiencing mental health crises in four counties in the Southern Region. In addition, the program also educates and supports families, caregivers and community agencies. The primary mission is to maximize the psychiatric stability of “dually diagnosed” individuals who present in the crisis screening centers in the identified counties. The goal is achieved by utilizing a range of services including: multi-factor diagnostic assessment, individualized psychiatric treatment, brief counseling, client and family advocacy, caregiver education and training and additional service referrals as needed.

3.0 First Steps: Convening the Dual Diagnosis Task Force

3.1 The Dual Diagnosis Task Force

The Dual Diagnosis Task Force (DDTF), co-chaired by Donna Icovino, a parent who has advocated on behalf of her son with co-occurring disorders, reflects the Department of Human Services (DHS) commitment to including individuals with disabilities and family members in planning and policy-making. The task force's process relied heavily on broad based subcommittees, representing diverse perspectives across multiple service areas, who share the commitment to collaborate in order to enhance the lives of individuals with developmental disabilities and co-occurring mental health and/or behavior disorders and their families.

3.1.1 The DDTF Mission

Creating a System of Care

A system of care provides a broad array of services and supports that is organized into a coordinated network; integrates care planning and management across multiple levels; is culturally and linguistically competent; and builds meaningful partnerships with individuals and their families at service delivery and policy levels.

At its core, a system of care is a range of services and supports supported by an infrastructure and guided by a philosophy. (Beth Stroul)

The DDTF mission is to develop and recommend a framework for the DHS to assure that individuals with developmental disabilities and co-occurring mental health and/or behavior disorders have the services and supports necessary to fully participate in community life. The task force used a participatory process to achieve its mission, examining existing services and systems, service gaps and needs, and developing recommendations to promote changes based on our shared vision, principles and values.

As a result of its work, the state of New Jersey has a framework for developing a system of care that is responsive to need, supports wellness and provides ready access to effective treatment and supports in our communities.

3.1.2 DDTF Membership

The DDTF is comprised of individuals with developmental disabilities, family members, advocates, professionals and state officials with expertise in this area. A number of subject matter experts located throughout New Jersey augmented DDTF membership through participation on the task force subcommittees. These individuals advised the task force and assisted in the development of its recommendations which this draft report (See Appendices for the full list of members).

3.1.3 DDTT Process

Table 1 outlines the four subcommittees and their charges.

Table 1: Charge to the Subcommittees

Two Child and Two Adult Subcommittees:	Best Practice and Crisis Response	Collaborative Service Delivery
<p>Questions to Address</p>	<p>What services and supports do we have? Are they adequate? Do they work? What training is needed?</p>	<p>What would collaborative service delivery look like? What elements are necessary? How can we educate both systems about each other</p>
<p>Questions to Consider</p>	<p>Best Practice</p> <p>What are key services? What are key skills needed by MH providers? How should “more intensive support” be operationalized? What is the “appropriate level of supervision”? What are the appropriate clinical competencies for professionals? How should living environments be structured? How have traditional approaches been modified successfully? What are effective cross systems transitional services?</p>	<p>What are the strengths and what are the challenges of our service delivery system? How do individuals and their families enter the system and what is their experience with the process? How should an organized pathway to services be structured to support early identification, crisis prevention, greater accountability and quality improvement? How can we structure an individualized care planning approach and care coordination to reflect shared responsibility? What communication and information sharing channels are essential? How does our care management structure build on the strengths of individuals and their families and draw in natural supports?</p>
<p>Questions to Consider</p>	<p>Crisis Response</p> <p>What is the current crisis management structure at the service delivery level? How effective is our current crisis management structure? Does the crisis management structure reflect the New Jersey’s system principles for serving individuals with a dual diagnosis? Does the crisis response system link families and individuals to practical information, peer support as well as clinical services?</p>	<p>Can we provide services and supports across multiple systems in different contexts over a life span? What are our staff development strategies to ensure that we have an adequate number of staff with the right skills, knowledge and attitudes? How do we educate both systems about each other? How do we train families so they understand how to advocate for access to both Mental Health and DD services?</p>

3.1.4 Public Input

A family and agency caregivers forum was held September 18, 2008. A morning and evening session and a call-in option were provided in an effort to get as much public input as possible. The recommendations were also presented at a workshop during the October 6, 2008, New Jersey Association of Mental Health Agencies, Fall Behavioral Health meeting: “Seasons of Change” to gather additional input.

Comments Regarding Children

- ◆ Need to make key behavioral services accessible to the public system. Many behavioral providers won’t take insurance or Medicaid (e.g. Social skills training costs \$650/ 10-week session).
- ◆ A mother reported that neither the mental health nor developmental disability system could serve her son with Asperger’s syndrome.
- ◆ The eligibility criteria for DDD often exclude individuals with Aspergers.
- ◆ Short-term nature of some services is not adequate to meet ongoing behavioral support needs of children with dual diagnosis.
- ◆ Professionals as well as non-professional staff need training.
- ◆ Teachers act as gatekeepers for behavior modification and so sometimes children may not get what they need (only children with autism get behavior modification automatically).
- ◆ Income-based services, like SSI, reduce access for working single parents. Single parents also need help with medical transportation, accessible housing and extra family leave provisions.

Comments Regarding Adults

- ◆ There needs to be a comprehensive approach to services, for individuals with dual diagnosis and their caregivers. “Meds” cannot be seen as the only answer (or the fastest remedy). Behavioral management doesn’t get to the underlying issues. More counseling should be available. (e.g. individual with recent loss of parent, counselors reluctant to address the loss even though his/her behavior indicated he/she may be depressed because of it.)
- ◆ Developing additional short-term care beds should be a high priority as more than 10 specialized beds statewide is not enough. Also, short-term care facilities must accept persons with a dual diagnosis.

Comments Regarding Both Children and Adults

- ◆ Behavioral supports are urgently needed
- ◆ New Jersey needs access to a residential facility to provide a comprehensive, assessment program for children and adults with very challenging behaviors. The facility would be equipped with highly trained staff capable of assessing and creating plans that would effectively manage complex needs and behaviors (e.g. Kennedy-Kreiger in Baltimore, MD is one example. The services cost \$85,000/month and the usual length of stay is 6 months). The program would also be able to effect a smooth transition back to home with follow-up services.
- ◆ Cross-systems meetings between DDD and the children and adult mental health systems should be initiated to increase a sense of shared responsibility
- ◆ Need to distinguish between individuals with co-occurring disorders and those with developmental disabilities and severe behavior. The challenge is making an accurate assessment
- ◆ Need to identify specific types of mental health treatment (e.g. trauma therapies)

- ◆ Additional costs (e.g. more intensive staffing) needed to provide specialized supports for individuals with dual diagnosis should be factored into service rates
- ◆ Report should clearly identify DDD as “the buck stops here” entity in the system
- ◆ DDRT should be adapted to assess behavioral and mental health treatment needs
- ◆ There is an overall lack of healthcare professionals willing to serve the developmentally disabled; those who do often treat individuals insensitively (talking only to staff, no eye contact).
- ◆ Respite services and transportation services are needed; the southern part of the state particularly needs service development
- ◆ It should be standard practice to add services and staff support to facilitate transitions from the hospital to home or other living arrangement
- ◆ First responders should be trained
- ◆ Need outpatient specialist training
- ◆ Break down the funding silos
- ◆ Increase the number of Medicaid providers, including consideration of tele-health alternatives for in-home family support as well as other creative alternatives. (Tele-psychiatry and tele-health should be thoroughly explored and only used as appropriate to individual needs.)
- ◆ Approach individuals with dual diagnosis holistically with needs that span all life domains
- ◆ Examine the DMHS Access program for screening the hearing impaired for what might apply to improve screening for the developmentally disabled
- ◆ New Jersey should not create a “third silo” with only specialized services for individuals with a dual diagnosis; rather, current providers should be seen as a foundation on which to build an effective system of services and supports

4.0 System Recommendations

The Underlying System Philosophy and the System Infrastructure recommendations (except where noted) were made by the Adult Collaborative Service Delivery Subcommittee and endorsed by the Children’s Collaborative Service Delivery Subcommittee.

4.1 Underlying System Philosophy

First and foremost, the DDTF envisions children and adults and their families as the central focal point of the system. The DDTF recommendations embrace, acknowledge and empower the central role of the parent and/or guardian and the voice of the self-advocate.

The components of the underlying system philosophy are the articulated values and principles, leadership commitment, shared vision, partnership with children, adults and their families, integrated approach to mental health and developmental disability service design, and a strategic opportunistic approach to development. Figure 1 (on page 22) provides a visual display of the system of care framework underlying the reform recommendations of this report.

4.1.1 Vision, Values and Principles

◆ Vision

The Department of Human Services (DHS), through the Division of Developmental Disabilities (DDD) maintains the lifespan responsibility for individuals with developmental disabilities and co-occurring mental health and/or behavior disorders. The DHS will serve as a locus of collaboration and facilitate cross-agency partnerships to ensure that individuals with developmental disabilities and co-occurring mental health and/or behavior disorders receive the services and supports they need within their communities throughout their lives. These partnerships, based on a collaborative systems approach, will include the DHS operating divisions as well as the Department of Children and Families.

◆ Values and Principles

The work of the Dual Diagnosis Task Force (DDTF) is guided by the below outlined principles and values in envisioning a system of services and supports for individuals with developmental disabilities and co-occurring mental health and/or behavior disorders:

- ◆ Individuals with developmental disabilities and co-occurring mental health and/or behavior disorders will have access to services and supports that emphasize wellness and recovery.
- ◆ Children with developmental disabilities and co-occurring mental health and/or behavior disorders will have access to services and supports that emphasize well-being and resiliency and support a seamless transition to adult services as the child ages.
- ◆ Services will be person-centered, individually planned and coordinated, and will support the individual and his/her family as full partners in decision-making and self-direction.
- ◆ Services and supports will be holistic, personalized and comprehensive, addressing the individual's developmental, health and mental health needs.
- ◆ Responsibility for individual service planning and coordination will be clearly identified in the delivery system, and will be collaborative, creating linkages between service sectors and mechanisms for joint resource development.
- ◆ While providing a full array of necessary services for individuals with developmental disabilities and co-occurring mental health and/or behavior disorders including crisis intervention and inpatient services, the system of care will promote early intervention and crisis prevention in the most integrated community settings, including the individual's home.
- ◆ Service, supports and systems of care for individuals with developmental disabilities and co-occurring mental health and/or behavior disorders will be culturally competent and available to individuals in all areas of the state (i.e., neither location nor finances will pose a barrier to obtaining needed community-based treatment and services).
- ◆ Services, supports and systems of care for individuals with developmental disabilities and co-occurring mental health and/or behavior disorders will be provided in a manner that protects individual rights, assures due process and promotes self-advocacy.
- ◆ The planning, management and administration of services will promote transparency, maximize available resources and include mechanisms to support accessible, available, quality frontline clinical practice and services.
- ◆ Individuals with developmental disabilities and co-occurring mental health and/or behavior disorders should expect opportunities to increase their own understanding and skills base regarding treatment and decision making relevant to their mental health and/or behavioral problems.
- ◆ Individuals with developmental disabilities and co-occurring mental health and/or behavior disorders should expect to return to their homes and resume their lives, including returning to their jobs, schools and programs following treatment for mental health and/or behavioral problems.

4.1.2 Leadership Commitment

- ◆ State-level organizational leadership would demonstrate a commitment to problem-solving and expect the same commitment organization-wide and at the local level.

4.1.3 Shared Vision

- ◆ A palpable sense of shared responsibility between the developmental disability and mental health/behavioral health service systems for children and adults.

4.1.4 Integrated Mental Health and Developmental Disability Approach to Service Design

- ◆ When a child or adult has a dual diagnosis, neither disorder would be given priority over the other disorder. The service system would consider each person's dual diagnoses individually and address both based on best practice requirements.

4.1.5 Strategic Opportunistic Development Approach

- ◆ Maintain forward progress by identifying short-term, low-resource actions as well as medium and long-term actions that require new resources.

4.2 System Infrastructure

The components of the system infrastructure that will promote collaboration and allow the system to maintain its central focus on the person and their family are: learning and workforce development; local planning teams; individual planning standards; policies aligned with the underlying system philosophy; financing & purchasing flexibility; systems management mechanisms including data and quality indicators and the use of information technology to facilitate communication.

4.2.1 Learning & Workforce Development

The DHS and DCF should examine what models of training are currently utilized at various levels, county, training contracts, state, etc., to create a comprehensive, cohesive training approach:

- ◆ DDD and DMHS/DCBHS should create a cross-system training curriculum.
- ◆ DDD required training should include mental health/dual diagnosis; DM-ID training.
- ◆ DHS should provide the financial support, contract accountability for training.
- ◆ Include cultural awareness/competence in all training efforts.
- ◆ Create additional opportunities to provide on-the-job training.
- ◆ Provide training incentives for provider organizations and academic institutions.
- ◆ The Children's Collaborative Service Delivery Subcommittee recommends the creation of Regional Centers of Expertise to promote evidence based practices that are effective for assessment, planning and guidance for dually diagnosed youth.
 - Each regional center will have training teams supported by various professional organizations including but not limited to: New Jersey Psychological Association, Professional Medical Groups, and National Association for the Dually Diagnosed.
 - These centers will provide technical assistance to families and providers, support families and work with providers to stabilize children in their home or community whenever possible.

- ◆ Address workforce competency, compensation and retention issues.
 - The Children’s Collaborative Service Delivery Subcommittee identified a model to build clinical expertise with community providers akin to the New Jersey Child Sexual Abuse Training Institute, Child Sexual Abuse Case Consultation Project.
 - Clinicians commit to carry a caseload (Pro-Bono if in private practice)
 - Intensive support is provided and certification is granted
 - The committee also recommended building knowledge with course requirements for college/graduate students
 - Developing standards for background, training and credentials for behavioral interventionists.
 - Direct care (e.g., BA/IIC, Mentor) training and specialized training

4.2.2 Local Planning Teams

Local collaboration should be mirrored at the highest level; therefore, a regional and state collaboration structure should be established as the top-down and bottom-up communication and problem-solving channels.

- ◆ Establish a county-based collaborative team process to facilitate crisis management and access to outpatient care for individuals

The Children’s Collaborative Service Delivery Subcommittee recommends that DCF and DDD strengthen the current DYFS-DDD regional case review process by including involved DCBHS partners, (Youth Case Management; Care Management Organization; Unified Case Management; and Mobile Response and Stabilization Services).

The DMHS’ County System Review Committee process with DDD participation could serve as the vehicle to address individual planning issues

- ◆ Establish a jointly-owned (DDD/DMHS) liaison, system coordinator, navigator, team leader
- ◆ Establish a county or multi-county based planning process to be responsible for local system building to identify needs, establish goals and develop strategies to achieve successful outcomes

The Children’s Collaborative Service Delivery Subcommittee recommends consideration of the County Interagency Coordinating Council (CIACC) as the forum for communication and locus of collaboration. The CIACC is the local county-based mental health planning council for children’s services that serves in advisory capacity to both county government and DCF. It participates in quality assurance processes, cross-system planning, and identifies service and resource gaps. It establishes priorities for resource development through the involvement of parents, youth, child-serving agencies, and community representatives. There are 21 CIACC’s under contract with DCF. The subcommittee further recommends:

- Improve communication and collaboration between CIACC and DDD that is needed
- CIACCs develop subcommittees to specifically focus on issues related to dually diagnosed youth
- If the above recommendation is not possible under the CIACC, then develop county-based multiple disciplinary teams charged with fulfilling the same mission and purpose

Note: For adults, the County Human Services Advisory Councils or County Mental Health Boards are possible entities that could serve as a forum for local system building.

4.2.3 Individual Planning Standards

- ◆ Use a uniform crisis assessment tool
- ◆ Integrate clinical treatment and behavior management

- ◆ Develop a joint DD/MH inter-disciplinary individual planning protocol focused on multiple life domains and proactive crisis planning
- ◆ Clearly identify pathways to care with specific community-based mental health and developmental disabilities resources that will accept and have the capacity to effectively serve individuals with co-occurring disorders
- ◆ Develop aging out protocols for a seamless transition to adult services
- ◆ Need to focus on the philosophy of practice vs. various silos
- ◆ Developing an integrated family plan for youth that integrates the goals and services of various providers into one comprehensive plan
- ◆ Shared consents for proper release of information, thereby creating a comfort level for sharing information within the scope of the law and limits of confidentiality

4.2.4 Realigned Policies

- ◆ Streamline administrative processes to ensure the system can respond in a timely fashion to emergency needs
- ◆ Review and realign all aspects of policy (legislation, regulation, procedures, and protocols) to eliminate service access barriers
- ◆ Update eligibility language to reflect current knowledge regarding “co-occurring disorders”

4.2.5 Financing & Purchasing Flexibility

- ◆ Joint funding to leverage federal funds
 - Prioritize funding allocation, blend resources
 - Need to be cognizant of fiscal constraints and to explore opportunities for blending resources to maximize federal participation without incurring additional state expense
 - Need for collaboration between DCBHS, DDD, DYFS, YSC, Education and others to provide wrap around services to children and youth, rather than setting up another silo system to replace what exist

4.2.6 Systems Management Data - Quality Indicators

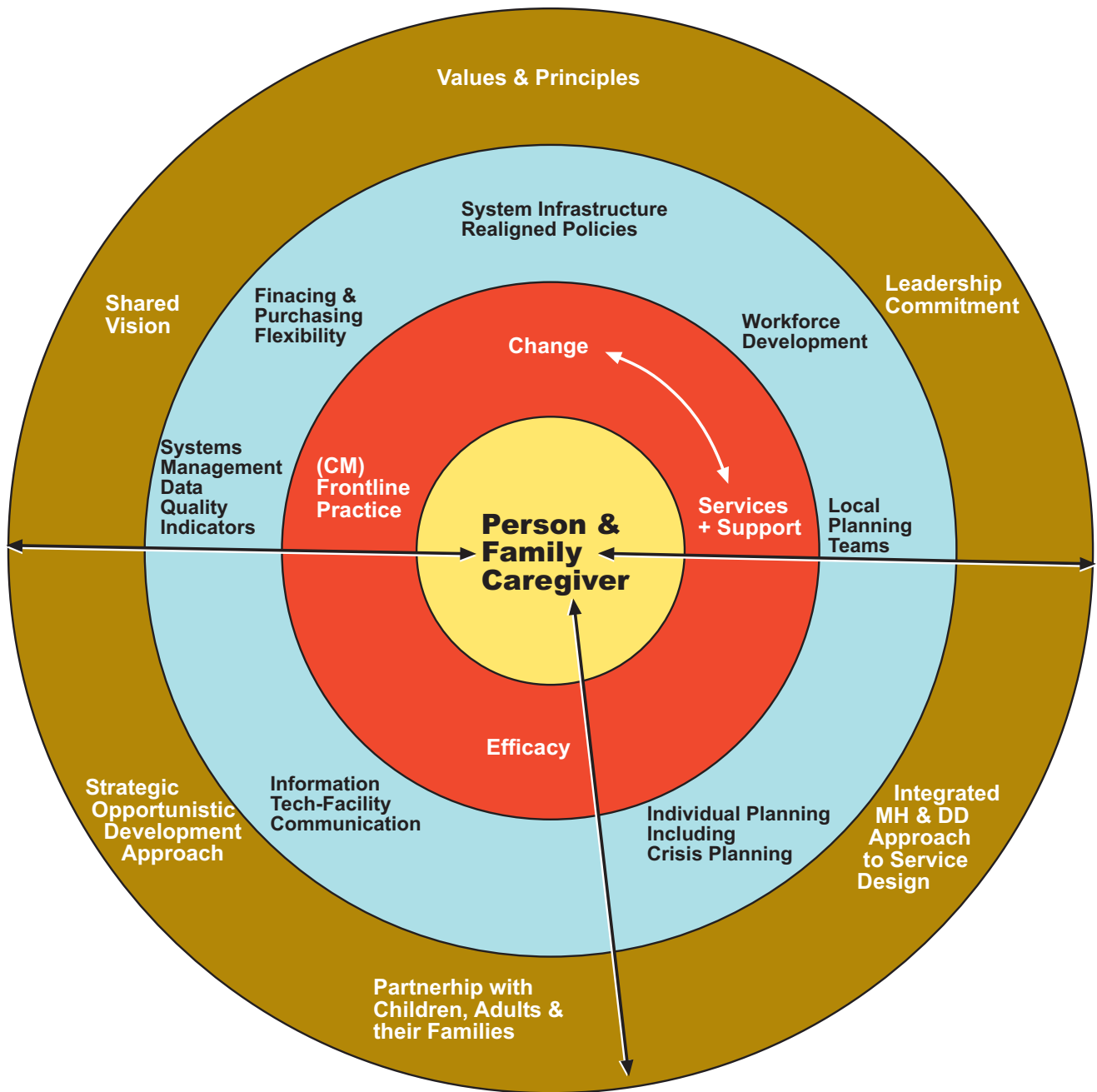
- ◆ Establish performance standards, indicators and data collection methods to understand service utilization and costs within the context of individual and overall population needs
- ◆ Data should be used to inform planning and resource development, driven by county needs assessment and service mapping of existing resources

4.2.7 Information Technology - Facilitating Communication

- ◆ Use information technology to facilitate communication (e.g. electronic medical records)

Figure 1 provides a visual display of the system of care framework underlying the reform recommendations of this report.

Figure 1 - System Reform Frame Work



'a range of services and supports supported by an infrastructure and guided by a philosophy'
 Building Systems of Care: A Primer S, Pires 2002

5.0 Recommended Service Continuum for Children and Adults

5.1 Recommended Service Continuum for Children

A summary of recommendations from the two children's workgroups is below:

Collaborative Service Delivery and Best Practice, Crisis Response

- ◆ Children, youth and young adults with disabilities should have access to the full spectrum of services available, regardless of the point of entry
 - Services should be based on identified needs and family choice
 - Services should be focused on support (family and youth), crisis prevention and meeting needs evident in early identification and comprehensive planning
- ◆ Increase the in-state capacity to serve the DDD eligible child; development of short term emergency treatment beds to prevent excessive stays in screening centers/emergency rooms and unnecessary hospitalization; a preventative measure against severe crisis events occurring
 - Increase availability of respite
- ◆ Develop regional specialization in case management within DCBHS (UCM, YCM, and CMO) and within DDD to include specialized staff to work with these families and provide technical assistance to other providers
 - Build case management expertise in Dual Diagnosis - Assessment, conceptual understanding, Essential Life Planning, ELP concepts
- ◆ Improve DDD case management services for disabled youth enrolled in DDD by reducing DDD case loads - fewer assigned youth and families - per worker (This model may be similar to the DYFS Adoption and Residential caseloads).
 - Construct children's case loads within DDD, specialized caseworkers who serve children only
- ◆ Develop a Family Access Line for information on DDD, who is collaborating with Division of Disability Services (DDS) to expand the DDS Call Center to support/answer DDD inquiries
 - Explore cataloguing all resources and housing such resources on the participating entities' websites and/or ensuring resource links are available from web page to web page of all systems
- ◆ Clear access through PESS to Children's Crisis (CCIS)
- ◆ Increase capacity of CCIS to meet needs of DD/MI population
- ◆ Availability of partial care, outpatient, medication management, family counseling and benefits and insurance counseling
- ◆ Strong linkage to advocacy organizations and support groups (e.g. SPAN, FSOs, ARC)
- ◆ Building non-traditional linkages (e.g. respite co-ops, local groups for home modifications, fraternal organizations)
- ◆ Early need for prevention and family support services, children need to be identified and registered with DDD earlier
- ◆ Increase availability of in-home Positive Behavioral Supports, Applied Behavioral Analysis or other approved, proven method - there is wide variability between a formal Applied Behavioral Analysis plan, positive behavioral supports or an informal behavioral structure within the home

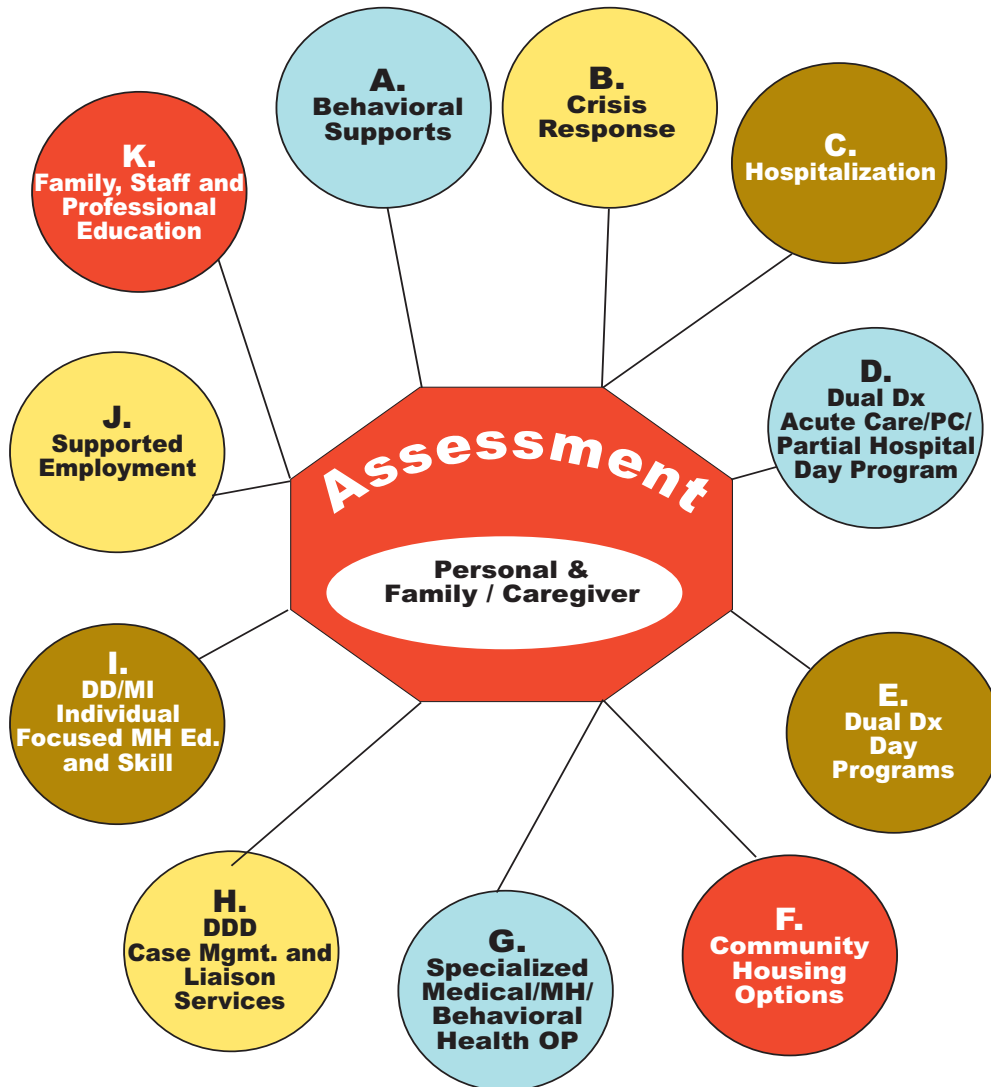
- ◆ Increase collaboration and coordination between DDD and the schools regarding the behavioral plans utilized by each, recommending shared consents for release of information and training each on the types of plans utilized
 - The Children’s Collaborative Service Delivery Subcommittee identified a model to enhance cross-systems collaboration and training/education for **school personnel** throughout the state: the Ocean County Behavioral Health, Child Protective Services and Education Systems Partnership three day training.
 - The Ocean County three day training for school personnel provides a detailed overview of the DCF System of Care and all supports and services available to youth. This grassroots project began with meetings with the County Superintendent and moved through the township superintendents, principals, child study teams, student assistance counselors and a designated representative from each school to function as a liaison. Representatives from DYFS, psychiatric emergency screening, CIACC, Emergency Response Committee, Traumatic Loss Coalition, FSO, YCM, CMO, MRSS, partial care, out patient services, and substance abuse were participants.
 - DDD participation is deemed essential; and it is recommended that DDD develop a curricula module to be included.
 - Family Crisis Intervention Units, FCIU and the county Youth Services Commission, YSC should also be included in the training.
 - The training has proven to be so successful that Monmouth County is also in the beginning stages of developing a curriculum; and several other counties have reached out to Ocean County personnel for guidance.
- ◆ Conduct cross training of all system partners (DCBHS case management, MRSS, JJC - Judiciary staffs, FCIU, DYFS, DOE, DVR, DDD), parents, providers and child serving entities on service entry, resources, interventions and supports. Need to examine what models are currently used at various levels: county, training contracts, SCCAT, Rutgers, etc.



5.2 Recommended Service Continuum for Adults

The following is a summary of recommendations from the Adult Best Practice and Crisis Response Subcommittee. Figure 2 represents the recommended service continuum.

Figure 2 - Recommended Services Continuum



Assessment is key; hence, it is wrapped around the individual with DD/MI and their family or caregiver. Much discussion, in the Adult Crisis Response/Best Practice Subcommittee, was on the importance of assessment. Therefore, the Subcommittee did not make it a separate service, but made it central. Once the assessment is complete, **services** radiate around the person and family/caregiver. The person and family member/caregiver can access services in any order, as needed, once the assessment is complete.

The services recommended are suggested by the various subcommittee members, are not prioritized and provide a full picture of the subcommittee's ideas regarding the continuum of services that would be desirable. Detailed descriptions of the recommendations for a comprehensive service continuum are outlined in the next eleven sections.

5.2.1 Behavioral Supports

- ◆ Ensure community-based services
- ◆ Provide behavior plan development/implementation in both residential/day program settings
- ◆ Services could be provided by “Integrated Mental Health Service Delivery Teams” consisting of mental health practitioner, behaviorist, and health care manager with 24/7 responsiveness working with DDD and DMHS providers
- ◆ Intensive in-home Applied Behavioral Analysis (ABA)/Positive Behavior Supports(PBS) Services focused on ABA/PBS trained therapist intervening in the community (home and/or program) to support caregivers in reducing challenging behavior
- ◆ In-home behavioral telehealth services for families supporting individuals with dual diagnosis; Psychiatric, behavioral and other professional services can be delivered via direct intervention in the home through telehealth software that brings the family and professional together
- ◆ Behaviorist’s needs:
 - Available in staff positions in residential settings
 - Available in network arrangements for groups of small providers/skill home providers
 - Need to be included on integrated teams
 - Need to link with DDD Case Managers, Health Care Managers (Medicaid) and Care Managers (DMHS)
 - Provide training in positive behavior supports to staff and families
 - Train staff and families in data collection, analysis and development, implementation and monitoring of behavior plans

5.2.2 Crisis Response

- ◆ Clinical Outreach Team/ Mobile Crisis Response Team
 - Provide rapid response 24/7/365
 - Assess situation and identify critical behaviors, environmental factors and mental health issues contributing to situation.
 - Formulate and implement a crisis stabilization plan including face to face intervention with consumer, family, staff, and link-up with mental and behavioral health services
 - Collect data to trend crisis calls, inform policy development, and service provision
- ◆ Telepsychiatry Program in Crisis Screening Centers
 - 24/7/365
 - Psychiatrists can “see” the consumer through teleconferencing equipment, prescribe medication, and determine treatment with team including caregivers
 - For large residential facilities, can place equipment there and service can augment mobile response team
- ◆ Hospital-based Dual Diagnosis Specialist Crisis Screener
 - Dual Diagnosis Specialist could be assigned to cover several Screening Centers within a region, and deployed at the site when and where a consumer presents
 - More efficient (than training) revolving sets of staff
 - Dual Diagnosis Specialist would conduct periodic trainings at his/her sites to keep the crisis team aware of basic signs that suggest the need for further evaluation (by the Dual Diagnosis Specialist)
 - Increase the likelihood of greater expertise being developed and available
 - Crisis Respite Services
 - 24/7/365 have services available at all time
 - Crisis screening centers can arrange emergency respite at DHS provider agencies through DDD Case Managers made available 24/7 through some mechanisms
- ◆ Step-Down Facilities (SF)
 - For individuals who have been stabilized at the emergency room, but require more long-term stabilization before returning to the community
 - SF would allow for more consistent staffing, and implementation of interventions to ensure the correct plans are in place
- ◆ “Crisis Intervention Team” (CIT)
 - Emergency response personnel and police trained in recognizing and handling individuals with dual diagnosis in crisis

- Camden County “Crisis Intervention Team” partners with county resources, local law enforcement, and mental health professionals. Cherry Hill and Collingswood police have received CIT training.
 - Notification of outpatient treating physician, when individual with dual diagnosis is admitted to crisis center or psychiatric hospital; Inpatient psychiatrist must consult with outpatient psychiatrist.

5.2.3 Hospitalization

- ◆ Treatment at community hospitals, in different regions of the state, with DD/MI units for consumers in need of hospitalization in the hope of preventing longer term county or state hospitalization

5.2.4 Dual Diagnosis Acute Care/Partial Care/ Partial Hospital Day Program

- ◆ Place for individuals in a state of dysregulation or crisis
- ◆ May need to be regional to be able to draw from a few counties to maximize census in program and pool scarce resources
- ◆ Would reduce/prevent hospitalizations and out of home placement
- ◆ Individual stabilized using therapy, ABA/PBS interventions and medication management
- ◆ Caregivers to be intimately involved, trained in concepts and behavioral interventions
- ◆ Step-Down Facilities
 - For individuals who have been stabilized at the emergency room or on an inpatient hospital unit, but require more long term stabilization before returning to the community, or do not have a community residence to which they can return
 - Step-down facilities would allow for more consistent staffing and implementation of interventions to ensure the correct plans are in place

5.2.5 Dual Diagnosis Day Programs

- ◆ Appropriate placement once an immediate crisis has been resolved; serve to reduce the number of future crisis situations
- ◆ Treatment would include counseling, medication, education for consumer, residential staff, family regarding mental health issue, therapy groups, skills groups, and activities to increase independence and sustain community placements
- ◆ Multiple tools would be available on-site to assist consumers with reaching their personal, vocational and educational goals
- ◆ Provide evaluation and treatment when individuals are destabilized

5.2.6 Community Housing Options

- ◆ Supervised and semi-supervised housing, including, but not limited to, group homes and supported apartments
- ◆ Adequately educated staff to support people with Dual Diagnosis
- ◆ Respite housing for individuals living in any setting (ie., family, supervised, or any other, would be part of the residential care system)

5.2.7 Specialized Medical/Mental Health/Behavior Support Out-Patient Assessment and Treatment Facilities

- ◆ Local, specialized, medical/mental health facility with capacity for providing psychological and psychiatric evaluations, psychotherapy, psychiatric and non-psychiatric medications, and medical exams
- ◆ Facilities to which adults with dual diagnoses, or suspected dual diagnoses, can go for a comprehensive biopsychosocial work-up in order to identify factors contributing to behavioral and mental health challenges
- ◆ Agency must have multi-disciplinary team, consisting of medical, psychiatric, nursing psychiatric, psychological, case management, behaviorist, etc., who can provide comprehensive assessment
- ◆ Increase number of outpatient psychotherapists in the community
 - Stipend for therapists with this specialty in mental health centers
 - Stipends for internships in agencies already providing services

5.2.8 DDD Case Management/Liaison Services

- ◆ Case Managers would have appropriate background in human services, and experience in a clinical discipline (ie. social work, counseling, nursing, psychology, etc.)
- ◆ Case Managers would be qualified to assess consumer's needs, provide linkages within the DDD system, "outside" social services, mental health services, vocational services, etc.
- ◆ Case Managers would also serve as a liaison to agencies outside the DDD system
- ◆ Service would be available statewide to all DDD consumers 24/7/365
- ◆ Centralized, accessible computerized data would be available to DDD workers scheduled 24/7
- ◆ Crisis screening centers, residential programs, families and hospitals would access this service by calling an emergency telephone number
- ◆ Mechanism needs to be in place for case manager to be notified when individual is admitted to crisis screening center or psychiatric hospital
- ◆ Provide clinical supervision to these case managers through the DDD psychologists, or on a contractual basis through clinical supervisors who already work with community-based clinical case management teams

5.2.9 Supported Employment

- ◆ Supported Employment Services (SEP) help clients to prepare to enter or re-enter the workforce successfully. Services include job placement and interviewing assistance, supervised work assignments, and follow-up support; The DMHS Wellness and Recovery Plan targets SEP for expansion (subject to state appropriations) and for augmentation with Supported Education options.

5.2.10 DD/MI Individual Focused Mental Health Education and Skills Building

- ◆ Utilize various educational venues throughout the state for adult consumers to continue their education and training specific to dual diagnosis issues
- ◆ Receive instruction about their medication and psychiatric illness, stress management, anger management, social skills, and coping techniques geared to the developmental level and learning styles of moderately through mildly intellectually disabled adults
- ◆ Stress wellness and recovery model

5.2.11 Family, Staff, Professional and Paraprofessional Education and Support

- ◆ Training of mental health personnel in diagnosis and treatment of psychiatric disorders in persons with intellectual disabilities
- ◆ Crisis Screeners, community mental health center clinicians, state hospital physicians to be trained in the use of the Diagnostic Manual-Intellectual Disabilities (DM-ID)
- ◆ Community mental health center clinicians and State hospital physicians to be trained in the treatment of persons with ID
- ◆ Cultural competency training for medical and mental health professionals; Cultural competency offered at non-ID professional organization; Involvement of New Jersey based professional organizations and agencies that will offer CEUs and CMEs for training in core competencies related to different disciplines.

Staff and Family Education

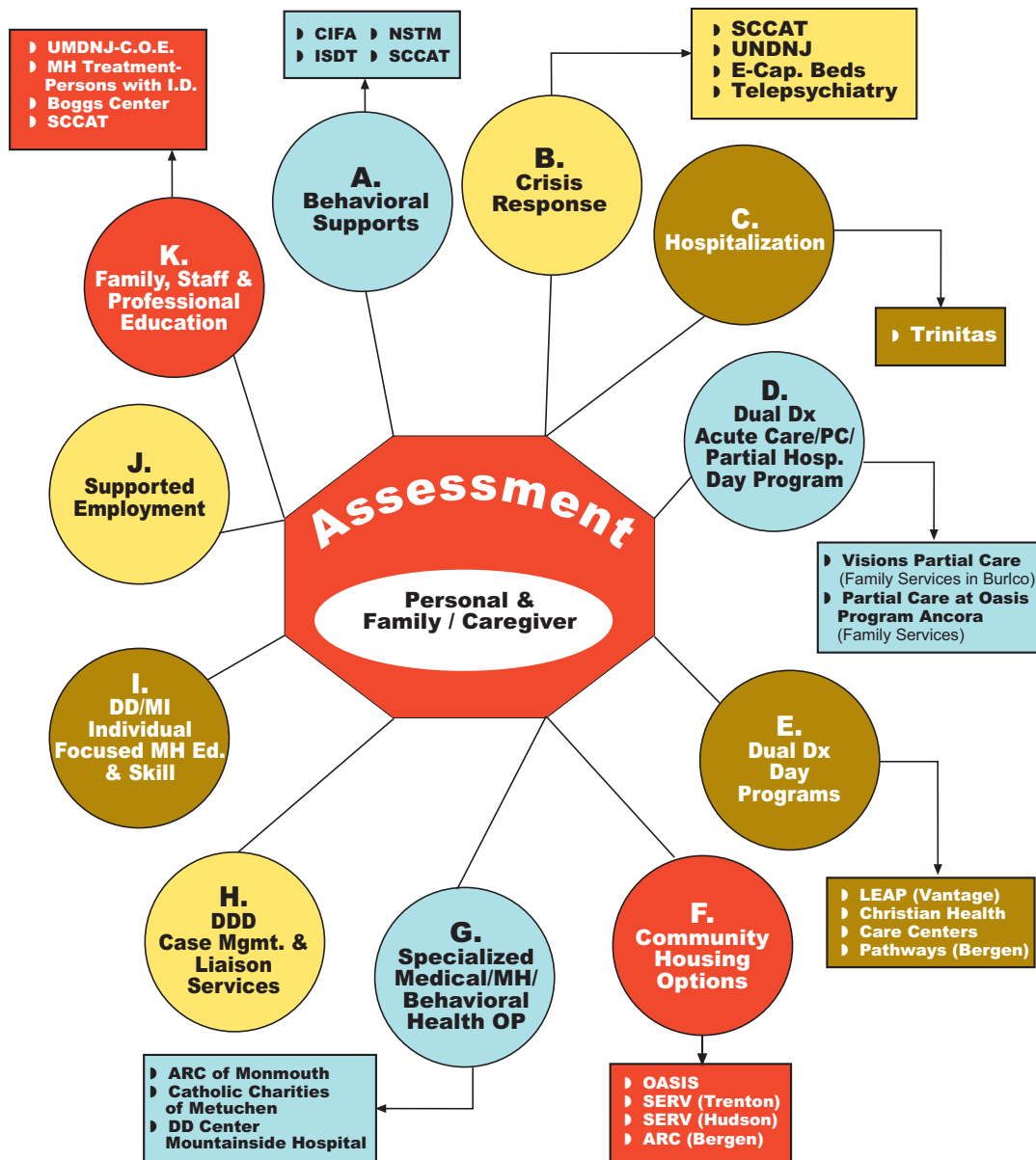
- Once core competencies are identified for staff, families and those supporting consumers with dual diagnoses, opportunities need to be created for individuals to master these core competencies
- Curriculum needs to be available to learn about dual diagnosis, and relevant skills at every level of support
- Certificate of Completion can be offered upon the individual's mastery of the material
- Courses offered can be geared to different disciplines (medical, including psychiatry, psychology, social work, professional counseling, direct care, etc.)
- There should be supervision to ensure that the staff/family member is successfully applying the principles of the material to their specific situation with the consumers whom they support
- More proactive training needs to be available to staff members about dual diagnosis, and effective interventions; this training should be more individually oriented rather than generic
- Staff members need more specific consultation and training as programs are initiated

- ◆ Create Educational Opportunities for Professionals and Paraprofessionals
 - DDD could play a critical role in informing academic institutions about sites that serve individuals with Dual Diagnosis, and creating externship positions at these sites, which would begin to train future professionals in this area of specialization
 - DDD might look into the prospect of expanding educational opportunities for medical professionals (MD's, RN's, PA's)
- ◆ Incentives for Direct Care Staff Supporting Individuals with Dual Diagnoses
 - Need to create career paths so that staff at all levels has some incentive to remain in the field and grow their competency
 - Need to tie staff salaries to building core competencies
 - Agencies can establish co-operative arrangements with colleges and universities to provide training for staff that could lead to advancement

Examples of Existing Services for Adults

Figure 3 represents a sample of the existing service continuum.

Figure 3 - Examples of Some Existing Services for Individuals with Dual Diagnosis



6.0 Priority Recommendations

Table 2 outlines the priority service and system recommendations, which are the key items the DHS and the DDTF will focus upon for implementation of recommendations.

Table 2
Dual Diagnosis Task Force (DDTF) Top Priority Service and System Recommendations

6.1 Top Priority System Recommendations

Recommendations	Implementation Comments: Strategic Opportunities
<ul style="list-style-type: none"> Adhere to the values and principles articulated by the DDTF in the operational implementation of the recommendations. This will require ongoing policy review and change to align practice and the system change goals. 	<p>The Commissioner of Human Services will establish an Executive Oversight Board to oversee the implementation of the Dual Diagnosis Systems Change Implementation Plan.</p> <p>DMHS will continue to work with our agencies to improve access for individual with dual diagnosis.</p>
<ul style="list-style-type: none"> Establish a county-based collaborative team process to facilitate individualized service planning (crisis management and access to crisis prevention outpatient care), community needs, resource mapping and local system building. 	<p>Members discussed the current vehicles of communication for the various divisions and service providers, and the need to improve communication between parties. Existing planning bodies were identified as possible forums.</p> <p>Children: After much discussion and careful thought, the group felt that the CIACC appears best suited to serve as the local system building body for cross-system planning, quality assurance processes, identifying service and resource gaps, and identifying priorities for resource development.</p> <p>Adults: Development possibilities include the County Mental Health Boards, County Mental Health System Review Committees or Human Services Advisory Councils</p>
<ul style="list-style-type: none"> Create workforce competency through cross-systems collaborative training, multiple training opportunities and incentives for professional development (e.g. Stipends, fellowships, student loan “forgiveness” programs) 	<p>Inventory all training resources and identify cross training and joint training opportunities for all system partners, self-advocates, parents, providers and child and adult serving entities. Need to examine what models are currently used at various levels: county, training contracts, DCBHS, SCCAT, Rutgers, Boggs Center etc.</p> <p>Children: DCBHS Cross-System Training Grant has been awarded and training will begin in the fall</p> <p>Adults: DMHS regional trainings on dual diagnosis will continue to be offered; The College of Direct Supports; collaboration with NADD on certification</p>
<ul style="list-style-type: none"> Develop Case Management Capacity to serve DD/MI children and adults through a change in Individual Service Planning Practice 	<p>Incorporate collaboration into Individual Service Planning Practice through cross-system affiliation agreements</p>

6.2 Top Priority Service Recommendations

Recommendations	Implementation Comments: Strategic Opportunities
<p>Develop a continuum of crisis response services including:</p> <ul style="list-style-type: none"> ■ An array of supportive resources for youth and families to allow plans to be implemented based on identified needs at assessment and prior to the need for crisis intervention. ■ Mobile response with a clinical outreach capacity ■ Short-term emergency treatment ■ Crisis respite beds ■ Specialist screeners to work in conjunction with the DD/MI Crisis Response System ■ Acute partial hospital programs 	<p>Children: Create access to response services for dually diagnosed youth or adults experiencing escalating behaviors/emotions at the site of their need.</p> <p>Four programs exist in the state that provide some level of service to youth or adults involved with various divisions; MRSS, CIFA, DDHA and SCCAT. All have similar components/elements, which are integral to crisis response service delivery as follows:</p> <ul style="list-style-type: none"> □ Family involvement, preventive focus, needs assessment, timely on site response, focus on engagement with family and youth, strengths based planning, etc. □ Access to some of these services is limited to those youth enrolled in the system which contracts for the service, or to adults. Access to these services needs to be available to dually diagnosed youth based on need criteria and not contract stipulation □ The services mentioned above would need appropriate training, supervision in working with this population, as well as access to specialty provider consultation (e.g. developmental pediatrician, child psychiatrist, neurologist, behavioral analysts, behavioral support staff, licensed mental health providers trained to work with dually diagnosed youth, etc.) during the hours of crisis response program operations. Also, alternative treatment and support options to inpatient hospitalization, such as partial hospital or day programs, therapeutic treatment and/or respite options (at home and out of home), informal supportive resources, need to be available for crisis response to function in a system of care philosophical framework with those same goals, values and principles. □ All available services should conform to the Federal Medicaid and State Plan criteria around maximizing federal revenue for the state. <p>Adults: Expand the number of Emergency Capacity beds through the Olmstead Initiative (beds available beyond those transitioning from developmental centers).</p> <p>DMHS has involved the DDD in the Acute Care Task Force.</p> <p>DMHS will continue to provide training in dual diagnosis for certification for screeners to improve service delivery to individuals with DD/MI.</p> <p>DMHS will continue to encourage appropriate providers to attend Systems Review Committee meetings.</p>
<p>Develop Outpatient Service Centers</p> <ul style="list-style-type: none"> ■ Medical and dental care ■ Standardized Comprehensive Assessment and Evaluation ■ Integrated mental health treatment and behavior management to address co-occurring disorders ■ Capacity to provide and guide behavioral support in in-home and other community settings. ■ Capacity to outreach to local areas ■ Capacity to provide training and on-the-job training opportunities 	<p>Children: Identify and appropriate DDD and DCBHS resources to be shared in the development and support of federally-reimbursable “one stop shop” evaluation centers.</p> <p>Develop cadre of DCBHS-approved providers of biopsychosocial assessments with specialized training and set-aside capacity for serving DD/MI youth and families.</p> <p>Explore and encourage partnerships with pediatricians in New Jersey around coordination of care including referral for evaluation and assisting with plan development/implementation.</p> <p>Adults and Children: The DDTF would prefer that there be a (minimum) standard set of services within each region and that these services be locally available on a county by county basis. The members also recognized that realistically, capacity building will be incremental, and so the first step will be to assure these services are available regionally. Additionally, the Task Force would like to emphasize that these services must be provided in an integrated, collaborative and coordinated fashion.</p>

(continued next page)

6.2 Top Priority Service Recommendations (continued)

Recommendations	Implementation Comments: Strategic Opportunities
<p>Develop or Expand Other Key Services</p> <ul style="list-style-type: none"> ■ Behavioral support capacity within service settings (e.g. residential services, supported employment, home, etc.) as well as for individuals who self-direct their services ■ Dual diagnosis Day Treatment ■ Family/Caregiver Education and Support including support through professionals (IFSS) and through Family and Peer operated organizations (FSO, YP). Family/Caregiver Education and Support should include teaching self-advocates and families (including foster resource families within the child welfare system) effective behavioral management techniques 	<p>Intensive in home Applied Behavioral Analysis (ABA)/Positive Behavior Supports (PBS) Services focused on ABA/PBS trained therapist intervening in the community (home and/or program) to support caregivers in reducing challenging behavior.</p> <p>DDD Family Information Sessions.</p> <p>IFSS is the DMHS Intensive Family Support Services Program. The FSO or Family Support Organization is a family-run organization under contract with DCBHS to provide family-to-family support. The Youth Partnership is a youth peer support organization within the FSO.</p>

7.0 Implementation and Sustainability

7.1 Executive Oversight Board

The Commissioner of the New Jersey Department of Human Services will convene an Executive Oversight Board to manage the implementation of the recommendations and ensure that the vision for system change is achieved. The Executive Oversight Board will consist of the leadership of the Departments of Human Services and Children and Families, including the Assistant Commissioners of the DHS Divisions of Developmental Disabilities and Mental Health Services and the Commissioner of the Department of Children and Families and the Division Director of the Division of Child Behavioral Health Services.

7.1.1 Implementation Plan and Timeline

- ◆ Action Steps
- ◆ Timeline
- ◆ Accountability
 - Plan-Do-Check-Act Approach
 - Data Collection and Reporting
 - Stakeholder Communication

7.2 Finance Committee

The Finance Committee is charged with identifying financing strategies for leveraging the resources needed to implement the priority recommendations. The Finance Committee will also make recommendations regarding the development of new HMO contract requirements, including whether or not certain Medicaid behavioral health services should be managed by the HMOs or carved out and provided through Fee for Services.

7.3 Realigning Policies and Practice

The Implementation Plan will include action steps to review the system partners' policies and procedures that will enable the implementation of the priority recommendations. The review process will include pending Federal and state legislative and regulatory changes, which may impact the implementation of the DDTF recommendations and require an update of eligibility language to reflect current knowledge regarding "co-occurring disorders."

7.4 Strategic Opportunities with Current or Anticipated Funding

The Olmstead Initiative begun in July 2007 and the “Waiting List Plan” to be initiated in State FY 2009 is the Division of Developmental Disabilities (DDD) continuation of an action plan for systems change. The systems change implemented thus far has provided opportunities for residents of State Developmental Centers (DCs) who want to live in the community and will now focus on persons already living in the community, specifically those who are on the Division’s Community Services Waiting List (CSWL). The Division has re-allocated \$12.5 million for this purpose in Fiscal Year 2009 (FY09).

The C-PEP Pilot

In 2008, the Division of Developmental Disabilities began the Children’s Placement Enhancement Pilot (C-PEP). C-PEP is a pilot program to enhance New Jersey’s in-state community-based capacity “to provide safe, stable and therapeutically supportive programs for children and/or young adults who have been placed out of state or are at risk of out-of-state placement because of their significantly challenging behaviors or medical needs.” The pilot program is expected to last for two years, with the results to be used to guide program expansion.

Among the objectives of the C-PEP program is the development of in-state community residential programs for children and young adults, ages 6 through 21, who have significantly challenging behaviors and/or medical needs. The program is specifically designed to increase in-state alternatives for children and families and to reduce the isolation and family fragmentation that frequently results from out-of-state placement.

DCBHS released a “Treatment Home Services” RFP for the development of twenty four treatment home beds specifically for the dually diagnosed youth returning from out of state care or likely to be referred for out of state care or a similarly restrictive setting, thereby increasing the capacity for out-of-home treatment. Eight beds were awarded and DCBHS will re-release a RFP for the remaining beds late fall or early winter.

DCBHS awarded a “Dually Diagnosed (Developmental Disabilities/Mental Illness) Training Program” RFP to provide a comprehensive organized DD/MI training and technical assistance program that will assist DCBHS, system partners, DDD, community providers, and other stakeholders to work effectively with the dually diagnosed population. Training sessions are anticipated to begin in October 08.

8.0 DDTF Future Agenda

8.1 Comprehensively Examine the Transition Process for Young Adults with Co-Occurring Disorders

The DCF and the DHS-DMHS are piloting a new effort to help ensure a coordinated system of planning and care for youth who are aging out of DCF’s care and transitioning into the adult mental health system of care; Christine Mozes, Director of the DCF Division of Youth and Family Services, Kevin Martone, Assistant Commissioner of the DHS Division of Mental Health Services, and Nadia Robinson, Director of the DCF Division of Child Behavioral Health Services have announced a collaborative piloting of aging-out services for New Jersey youth. Their shared goal is to concretize the policy of the DCF and the DMHS, which calls for the provision of a coordinated system of planning and care for those youth aging-out of DCF care and in need of transitioning into the adult mental health system of care provided under the auspices of the DMHS. *(The recent reports of the Association for Children of New Jersey and the Government Accountability Office poignantly document the challenges and disappointments facing youth with behavioral health needs as they approach and move into adulthood.)*

This collaborative effort will be piloted in four counties: Burlington, Middlesex, Monmouth and Ocean, New Jersey. Many other counties are underway with similar work and planning conferences. The pilot will capitalize on the existing strengths and strategies of community leaders, which chief among them are the CIACC (Children’s Inter-Agency Coordinating Council) conveners and members. The CIACCs will play an important role in this effort; each will receive a quarterly update/progress report from the pilot team, as the team will look for guidance, feedback, course corrections, and support from the CIACC.

DDD's Life After 21

“Life After 21” is a two-part information and education session that focuses on providing graduates and their families information and education to enhance their understanding of adult services and maximize individual potential. Outreach is made to all individuals on the DDD caseloads who will be graduating from their school entitlements in 2009, 2010, and 2011.

Life After 21 - Part 1 occurs in the Fall:

- ◆ providing information and gathering tools to assist families in planning for supports and services based on individual needs
- ◆ Overviews provided by NJWINS, DDD Day services both traditional and non-traditional, and DVRS
- ◆ Resource information disseminated regarding DDD day service options and DVRS contacts
- ◆ Presents a “Provider Marketplace,” which is an opportunity for families to become acquainted with Adult Agencies/Service Organizations providing supports and services in their neighborhoods

Life After 21 - Part II occurs in the Spring:

- ◆ Providing families with specific planning tools for individuals preparing to graduate
- ◆ Specific resource information regarding DDD day service options and DVRS day service options made available to individuals and families
- ◆ Assisting families with planning for the services and supports they wish to receive after graduation

These sessions assist families in planning so that their graduates will have as seamless a transition as possible from school to adult life.

The DDTF recommends coordination with and active participation of DDD in transition planning for all dually diagnosed, DD/MI youth.

8.2 Best Practice Development in Partnership with NADD

The National Association for the Dually Diagnosed (NADD) is embarking on a major multi-year initiative that will improve the quality of services provided to individuals with a dual diagnosis (MI/ID): the NADD Competency-Based Dual Diagnosis Certification Program for service programs and personnel. The three separate, 15 - 20 person, subcommittees are working hard to develop competency-based certification programs for:

1. Programs/Facilities
2. Clinicians/Professionals
3. Direct Support Staff

A license or degree no longer predicts competency. It is important that certification be competency-based because this will provide a reliable, valid assessment of the ability of the individual or organization to perform appropriate functions. A competency-based system recognizes the importance of knowledge, skills, attitudes, abilities, personality traits, and other characteristics in performing the required functions.

Certification in Dual Diagnosis is important to:

1. Provide a care provider system with a demonstrated level of expertise in co-occurring MI/ID;
2. Provide a workforce with a demonstrated level of expertise in co-occurring MI/ID;
3. Assure that public and private healthcare dollars are purchasing effective services; and
4. Assist families/advocates make informed choices about services.

The NADD Competency-Based Dual Diagnosis Certification Program will be a gold standard that can be used in all states and will assist states and localities in decision making about services, contracting, funding, and infrastructure (**Information from the National Association for the Dually Diagnosed (NADD) website**).

8.3 Comprehensively examine the Service Needs for Individuals with Co-occurring Disorders whose developmental disability was caused by an Acquired Brain Injury.

The DDTF will explore the status of this issue with NJ Advisory Council on Traumatic Brain Injury, which serves as an advisory body to the DHS on matters related to brain injury services.

9.0 Appendices

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9.2 Additional Background Information

9.2.1 Current Children's System of Care in New Jersey

The DCBHS within the DCF, is the single state agency that provides contracted services to children, youth and young adults with emotional and behavioral health care challenges and their families across multiple child-serving systems. The DCBHS was created to coordinate and expand existing services and to develop new community services to help youth and their families recognize their strengths and plan services to meet their needs. DCBHS developed the following state and local system partners for its System of Care:

A statewide **Contract System Administrator (CSA)** to support utilization management, care coordination, quality management, and information management for the statewide System of Care. The CSA provides the DCBHS, the care management entities and other system partners with the information needed to manage the Individual Service Planning process toward child and family satisfaction, quality outcomes and cost effectiveness. The CSA provides data to the DCBHS. The CSA creates a virtual single point of processing that registers all enrollees; authorizes services, is a single electronic record; and tracks and coordinates care for all New Jersey children who are screened into the system at any level. The CSA acts as an agent of state government contracted by and accountable to the DCBHS to manage services.

Unified Care Management (UCM) serves youth and their families/caregivers with high and moderate level of care coordination needs that were formally served by the local Care Management Organization (CMO) and Youth Case Management (YCM). UCMs are a single entity that exercises significant responsibility for brokering services in a local area. In April 2008, Essex County became the first UCM in New Jersey. DCBHS is now soliciting proposals for UCMs in two additional counties (Mercer and Monmouth, NJ).

Care Management Organizations (CMOs) organize and coordinate community-based services and informal resources through face-to-face care management at the local level, of individual children and families with multi-service needs and multi-system involvement. These non-profit organizations provide a full range of treatment and support services to children with the most complex needs, working with child-family teams to develop individual service plans. The CMOs' goals are to keep children in their homes, their schools and their communities. The CMOs are fully operational in 14 vicinages covering 20 of the 21 counties in New Jersey.

Youth Case Management (YCM) is a care management service for children/youth and their families who require a moderate level of face-to-face case management. YCMs are fully operational in 20 of the 21 counties in New Jersey.

Family Support Organizations (FSOs) provide direct peer support and assistance to children and families, by family members of children with current or past system involvement. FSOs paralleled the development of each CMOs. FSOs are a parent run organization that provides assistance to families in CMO and UCM counties through peer mentorship, education and advocacy, information, referral and the hosting of parent and peer support groups. FSOs act as a guide for professionals and provide direct peer support to families whose children are enrolled in DCBHS services. The FSOs are fully operational in all 21 counties in New Jersey.

Mobile Response and Stabilization Services (MRSS) provides face-to-face intervention to children who are experiencing escalating emotional and/or behavioral issues. The goal is to prevent the disruption of children's living situation and to help maintain children in their current living environment. Staff responds within one hour of the initial call and provides de-escalation, assessment and crisis planning and may initiate stabilization services for up to eight weeks. This service is available 24 hours per day, seven days per week. MRSS are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

The System of Care also includes but is not limited to the following service components including the traditional children's mental health services:

Intensive In-Community and Behavioral Assistance Services (BA/IIC), developed as a needed component of the new system of care, is a flexible, multi-purpose, in home community rehabilitative services for parents/ caregivers/ guardians and children/youth with behavioral and emotional needs. Intervention is geared toward strengthening the family and preserving the family constellation within the community setting. Services include, but are not limited to, group, individual or family therapy, clinical consultation/evaluation, instruction in anger management, parenting skills and problem solving behavioral management and psycho-social education. **Intensive In-Community** are services to strengthen the family,

provide family stability and to preserve the family constellation in the community setting. Services are flexible as to where and when they are provided based on the family's needs. Interventions may be provided as a component of Mobile Response and Stabilization Services or as a longer-term treatment intervention. This family-driven treatment is based on targeted needs as identified in the Individual Service Plan (ISP), which also includes specific interventions with target dates for accomplishments of goals that focus on the restorative functioning of the child/youth and family. Also developed as part of an ISP, Behavioral Assistance provides specific, outcome-oriented interventions that are components of a detailed plan of care prepared by a licensed clinical behavioral healthcare practitioner. **Behavioral Assistance** is a dynamic process of intervention and ongoing evaluation resulting in effective modification of specific identified behaviors. Behavioral Assistance services involve applying positive behavioral principles within the community using culturally based norms to foster behaviors that are rehabilitative and restorative in nature. The model is flexible allowing for some interventions to be provided in small group setting. These services are available statewide.

Screening/Emergency Services are for children and youth experiencing a psychiatric crisis and need to access inpatient hospitalization. These services are available 24-hours a day, seven days a week and are typically within community hospitals' emergency service departments.

Children's Crisis Intervention Services, located in community hospitals, are acute inpatient units that provide assessment, crisis stabilization, evaluation, and short-term intensive treatment. The New Jersey Department of Health and Senior Services, following designation by the DCF Division of Child Behavioral Health Services, licenses these units.

Intensive Residential Treatment Services (IRTS) are a non-hospital based secured intensive treatment setting that provides services to youth who require 24/7 care in a safe, secure environment with constant line-of-sight supervision, medication management and a concentrated individualized treatment protocol. Services are provided to youth with a wide range of serious emotional and behavioral needs.

Psychiatric Community Residence (PCR) are psychiatric community residence for youth licensed by the Department to provide mental health rehabilitation services in an out-of-home treatment setting.

Residential Treatment Centers (RTC) provide intensive treatment services for 13 or more children on a 24-hour a day basis, which includes facilities providing educational services on or off grounds as well as programs that provide adventure-based treatment. This also includes facilities certified to provide voluntary inpatient psychiatric care. RTC, are located both in the State of New Jersey and outside of the state.

Specialty Services are new in-state beds for children needing specialized services such as fire setters, sex offending behavior, serious assault behavior, and children experiencing significant trauma due substantiated abuse and neglect. Prior to the development of Specialty Services beds, children needing these services were placed out-of-state.

Group Home Care are homes licensed to provide board, lodging, care and treatment on a 24-hour basis for generally 12 or fewer children in a community based setting. The intensity of the mental health treatment and the average length of stay may vary depending on the program design.

Treatment Homes are New Jersey's approach to Therapeutic Foster Care. This level of care is for children who require more intensive treatment and supervision than is found in a traditional or kinship foster care placement. Children are placed in the safe environment of a private home setting, licensed as a treatment home and the treating parents have received specialized training in the care of children with emotional and behavioral problems.

Treatment Homes are designed for children with behavioral and functional disturbances who have the capability to engage in community-based activities in a family setting. Community resources are used in a planned, purposeful and therapeutic manner that encourages residents' autonomy appropriate to their level of functioning and safety and as indicated in their Individual Service Plan. Services provided in this setting may include mentoring, counseling, behavioral management and crisis intervention. A treatment home parent participates as part of the Child Family Team and assures that the youngster receives needed psychiatric and psychological services, medical care and education. Treatment home parents receive supervision and are supported by the staff and programs of the treatment home agency. This level of care is transitional, typically considered for children who have been recently discharged or are being diverted from a more intensive level of care. It is intended to maintain the child in the community while preparing for permanency - return to family of origin, adoption, permanent foster care, kinship care or independent living.

Partial Care Programs are intensive, non-residential day treatment services generally provided in after-school or half day programs which can include counseling, psychiatric assessment, medication, behavior management, rehabilitation and recreation components.

Outpatient Services are available in a variety of community agencies and settings. Services include individual, group and family therapy, medication management, and therapeutic recreation.

Flexible Wraparound Funds for Non-Traditional Supports are available to children and families served by Mobile Response and Stabilization Services and by all levels of Care Management.

Each county in New Jersey has a **County Inter-Agency Coordinating Council (CIACC)**. CIACCs were created by law to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACC provides a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.

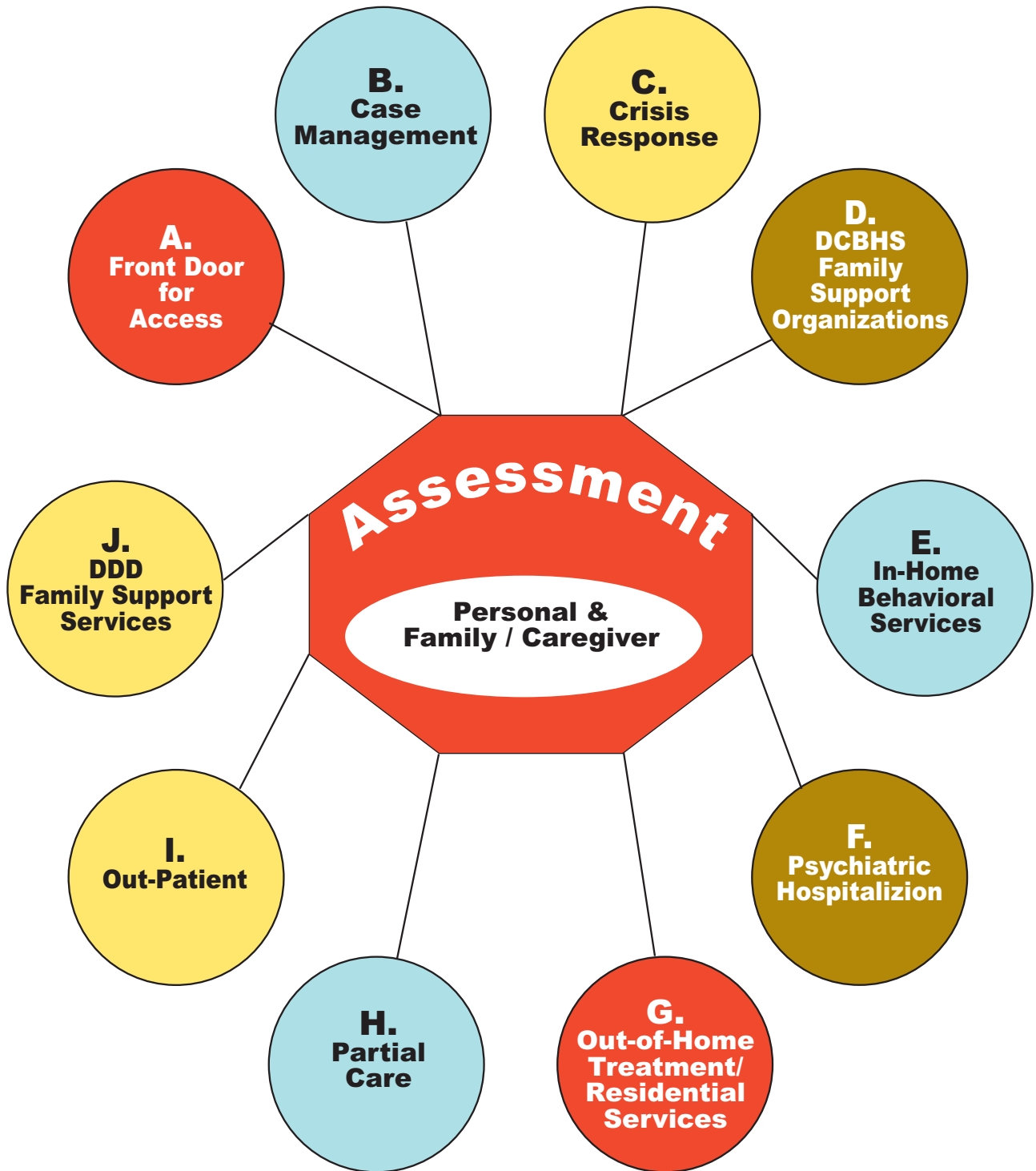
Traumatic Loss Coalitions (TLC) were developed in every county to identify and train a network of professionals to systemically address issues related to mental health emergencies for youth subsequent to trauma and to provide mental health professionals with training that reflects the current knowledge base about the mental health needs of the community subsequent to traumatic incidents involving youth.

Current DDD Services and Supports for Children

Table 3: Key to DDD and DCBHS Existing Services presented in Figure 4

Service	DCBHS	DDD
Front Door for Access	Single Point for Access – Contracted Systems Administrator (CSA)	Proposed Call Center; Family Information Sessions DDD Intake
Case Management	For moderate-to-high needs; YCM, UCM, CMO	Multiple levels distinguished by varying caseload ratios
Crisis Response	Mobile Response and Stabilization Services, pilot currently in Burlington County	Regionally specific behavioral health services through state staff or agency contracts.
DCBHS Family Support Organization	Direct peer support and assistance	-----
In-Home Behavioral Services	Intensive in-community (IIC) Behavioral Assistance (BA)	Clinical support teams and/or behavioral support contracts (same as above in Crisis Response)
Psychiatric Hospitalization	Private hospitals (3); Children’s Crisis Intervention Services (CCIS) (9); Intermediate Units (2)	No contracts directly through DDD; the Trinitas Specialized CCIS is available to DDD children in need.
Out-of-home Treatment/ Residential Services	Intensive Residential Treatment Services (IRTS); Psychiatric Community Residences (PCR); Specialty Beds; Residential Treatment Centers (RTC); Group Homes; Treatment Homes	Community-based Respite Services; Children’s Placement Enhancement Pilot
Partial Care	Free standing or hospital based programs	Children’s day activities are provided by the education system
Out-Patient	Mental health clinics, outpatient hospitals, private offices	Individually accessed through one’s insurance company
DDD Family Support Services	-----	In-home/out-of-home Respite; Assistive Devices; Home & Vehicle Modifications; After-School Programs

Figure 4 - Existing Services through DDD and DCBHS



**Mental Health Services offered through the
Division of Mental Health Services (DMHS)**

Mental Health Services	Description	Specialized Services for Individuals with DD/MI
Outpatient Services (Adult/Child)	Services provided to adult and child clients who possess a psychiatric diagnosis, including clients who are seriously and persistently mentally ill but excluding substance abuse and developmental disability unless accompanied by treatable symptoms of mental illness. Periodic therapy, counseling and supportive services are generally provided at the provider agency for relatively brief sessions (between 30 minutes and 2 hours).	Catholic Charities - Metuchen operates a Outpatient Mental Health program that serves individuals with DD/MI at their Flemington office. Referrals come from Hunterdon County DD providers. Jointly funded by DMHS & DDD.
IFSS (Intensive Family Support Services)	Comprise a range of supportive activities designed to improve the overall functioning and quality of life of family members with a relative who has a mental illness. Services could include: psychoeducation groups, individual family consultations, respite, family support groups, system advocacy, linkage and referral, and medication monitoring. Services may be delivered in the family's home, at the agency, or at other sites in the community convenient to the family.	
Partial Care and Partial Hospitalization	Comprehensive, structured, non-residential health services provided to adult clients with serious mental illness in a day program setting to maximize client's independence and community living skills. Partial Care programs provide or arrange services necessary to meet the comprehensive needs of the individual clients.	<p>Family Services operates the Visions PC program in Burlington County, a non-contract program licensed by DMHS.</p> <p>Family Service also operates a PC program in a separate building at Ancora Psychiatric Hospital (APH) for individuals with DD/MI who reside in the Oasis program.</p> <p>Vantage operates the LEAP program in Bergen County.</p> <p>Christian Health Care Center is a specialized DD/MI program in Bergen County</p>
Supported Employment	Competitive work in integrated work settings for individuals with mental illness for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of a severe disability and who, because of the nature and severity of their disability, need intensive supported employment services and extended support services.	
Self-Help Centers	Consumer operated community-based centers providing DMHS subsidized activities designed to encourage consumers to interact with their peers to promote mutual support in dealing with common problems, and social interaction in a non-clinical setting.	
ICMS (Integrated Case Management Services)	Consumer-centered services provided predominantly off-site in the consumer's natural environment. Personalized, collaborative and flexible outreach services are designed to engage, support and integrate consumers, 18 years of age or older who are severely and persistently mentally ill, into the community of their choice and facilitate access to needed mental health, medical, social, educational, vocational, housing and other services and resources.	
PACT (Program of Assertive Community Treatment)	Comprehensive, integrated rehabilitation, treatment and support services to those individuals most challenged by the need to cope with serious and persistent mental illness, as evidenced by repeated hospitalizations and to those individuals identified as at serious risk for psychiatric hospitalization. PACT, provided in vivo by a multi-disciplinary service delivery team, is the most intensive program element in the ambulatory continuum of community mental health care. Services to an individual may vary in type and intensity, but treatment has no predetermined end.	

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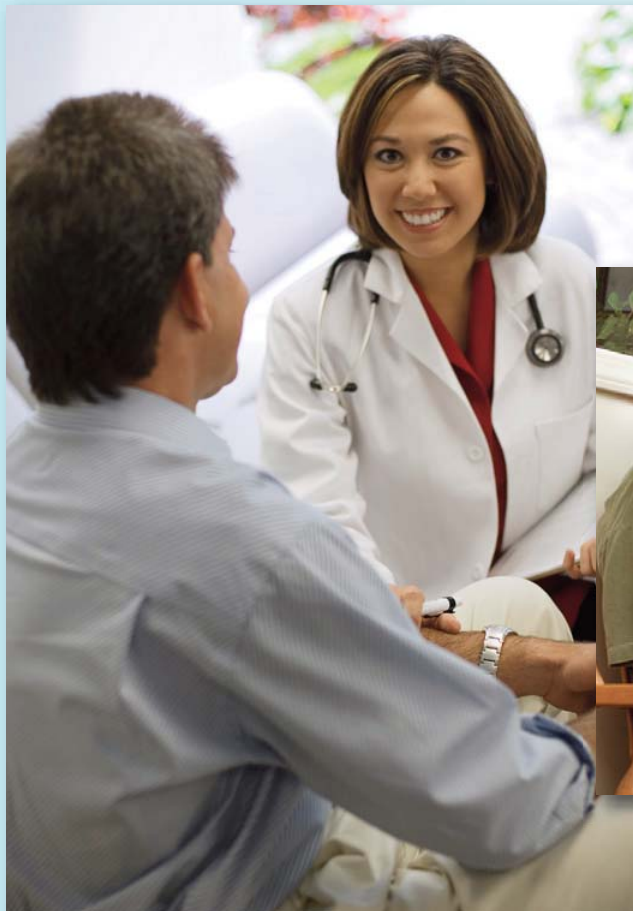
**Mental Health Services offered through the
Division of Mental Health Services (DMHS)**

Mental Health Services	Description	Specialized Services for Individuals with DD/MI
Supportive Housing	Supportive housing is designed to ensure consumers of mental health services, a choice of permanent, safe, affordable housing. Supportive housing offers individuals opportunities for involvement in community life. Emphasis is placed on the development and strengthening of natural supports in the community.	
Residential Services	A program for adults with mental illness in community residences owned or leased by the provider or through service agreements providing support and encouragement in the development of life skills required to sustain successful living within the community. Clients live in the most normalized, least restrictive environment possible to promote individual growth and safety. Programming focuses on empowering the client's use of generic community supports to meet physical, psychological and social needs to promote an improved quality of life and emotional well being. Services could be provided in a family care home, group home, etc.	<p>Family Service operates the Oasis residential program for individuals with DD/MI. 20 beds are on the grounds at Ancora Psychiatric Hospital (APH) and 20 beds are located in the community. Entry is limited to consumers discharged from APH.</p> <p>SERV is developing a 12 bed residential program in Trenton for individuals with DD/MI referred from Trenton Psychiatric Hospital (TPH).</p> <p>SERV operates a 2 home residential program in Hudson County for individuals with DD/MI referred from Greystone Park Psychiatric Hospital (GPPH).</p> <p>The Bergen ARC operates a group home for individuals with DD/MI in Bergen County</p> <p>Pathways also operates a group home for individuals with DD/MI in Bergen County.</p>
Designated Screening Centers (Adult / Child)	Provide mental health services including assessment, emergency and referral services to persons with mental illness in a specified geographical area. A screening service determines if an individual being considered for commitment meets the standards for both mental illness and dangerousness as defined by law and that all stabilization options have been explored or exhausted. There are designated screening centers throughout the state.	
Inpatient care STCF (Short Term Care Facility)	An STCF is an acute care adult psychiatric unit in a general hospital for the short term admission of individuals who meet the legal standards for commitment and require intensive treatment. All admissions to STCF's must be referred through a designated screening center. STCF's are designated by DMHS to serve a specific geographic area, usually a county.	
State & County Psychiatric Hospitals	The psychiatric residential mental health facilities operated by the state and counties are authorized to accept persons in need of involuntary commitment under the law. Admissions are only accepted from screening centers and short term care facilities.	
SCCAT Program (Statewide Clinical Consultation & Training) Funded by DMHS and DDD	Statewide Clinical Consultation & Training (SCCAT) is a clinical outreach team that provides crisis response, consultation and training to provider agencies of the Division of Developmental Disabilities (DDD) and the Division of Mental Health Services (DMHS) and to families. The SCCAT team provides expertise to the agencies and families to treat and manage the psychiatric and behavioral problems of adults with developmental disabilities. The SCCAT team will provide a crisis assessment or consultation to agencies and caregivers seeking assistance with the mental health and behavioral crises of the adults with developmental disabilities whom they support.	These services have been specifically developed to serve individuals with DD/MI.

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**Mental Health Services offered through the
Division of Mental Health Services (DMHS)**

Mental Health Services	Description	Specialized Services for Individuals with DD/MI
Trinitas Hospital – MI / DD Unit	The Dually Diagnosed Mentally Ill and Developmentally Disabled (MI / DD) Unit is a 10 bed closed acute unit for adults. Treatment is geared towards preventing long-term institutionalization and returning the patient back to the community with mental health and DDD services. Patients will be accepted on involuntary or voluntary status if they present with significant psychiatric and behavioral disorders that require inpatient treatment or demonstrate symptoms that potentially can escalate into crisis. A multidisciplinary team approach is provided utilizing crisis intervention, medication stabilization, therapeutic groups and family education.	These services have been specifically developed to serve individuals with DD/MI.
UMDNJ – Crisis Consultation & Community Outreach Program	The UMDNJ Crisis Program provides crisis intervention and preventive services to individuals with developmental disabilities experiencing mental health crises. In addition, the program also educates and supports families, caregivers and community agencies. The primary mission is to maximize the psychiatric stability of “dually diagnosed” individuals who present in the crisis screening centers in the identified counties. The goal is achieved by utilizing a range of services including: multi-factor diagnostic assessment, individualized psychiatric treatment, brief counseling, client and family advocacy, caregiver education and training and additional service referrals as needed.	These services have been specifically developed to serve individuals with DD/MI.



Acronym Listing

Administrative Office of the Courts	AOC
Applied Behavioral Analysis	ABA
ARC of Bergen and Passaic County	ARC (Bergen)
Children's Crisis Intervention Services	CCIS
Children's Placement Enhancement Pilot	C-PEP
County Interagency Coordinating Council	CIACC
Care Management Organization	CMO
Contract Systems Administrator	CSA
Developmental Disability/Mental Illness	DD/MI
Department of Children and Families	DCF
Department of Education	DOE
Department of Human Services	DHS
Division of Child Behavioral Health Services	DCBHS
Division of Developmental Disabilities	DDD
Division of Mental Health Services	DMHS
Division of Vocational Rehabilitation	DVR
Division of Youth and Family Services	DYFS
Dual Diagnosis Task Force	DDTF
Executive Oversight Board	EOB
Essential Lifestyle Planning	ELP
Family Crisis Intervention Unit	FCIU
Family Support Organization	FSO
Human Services Advisory Council	HSAC
Intellectual Disability	ID
Juvenile Detention Alternative Initiative	JDAI
Juvenile Justice Commission	JJC
Mobile Response and Stabilization Services	MRSS
National Association for the Dually Diagnosed	NADD
Positive Behavioral Supports	PBS
Psychiatric Emergency Screening Service	PESS
Request for Proposal	RFP
Statewide Clinical Consultation and Training Program	SCCAT
Statewide Parents Advocacy Network	SPAN
Supported Employment Program	SEP
Unified Case Management	UCM
Youth Case Management	YCM
Youth Services Commission	YSC