

New Jersey Children's System of Care Stakeholder Convening

Made possible by Casey Family Programs

November 6, 2019

Department of Children and Families

50 East State Street, 2nd Floor Conference Room, Trenton, NJ 08608

Meeting Minutes

Participants

Stakeholders: Megann Anderson (NJ ACYF), Cheri Castellano (Rutgers UBHC, Mom 2 Mom), Michael Dallahan (Partners for Kids and Families), Anthony DiFabio (Acenda Integrated Health), Rachel Helt (Family Partners of Morris & Sussex Counties), Connie Greene (RWJBarnabas Health), Vera Sansone (CPC Behavioral Healthcare), Deborah Spitalnik (RWJMS/The Boggs Center on DD), Cecilia Zalkind (Advocates for Children of NJ), Peggy Kinsell (SPAN), Dawne Lomangino DiMauro (AVANZAR), Kathleen Noonan (Camden Coalition), Debra Wentz (New Jersey Association of Mental Health and Addiction Agencies, Inc.), Fred Simmens (Casey Family Programs)

DCF: Mollie Greene, Loletha Johnson

CHCS: Sarah Rabot, Pamela Tew

I. Welcome, Introductions, and Purpose

- Facilitators reiterated the convening structure, describe ground rules and roles of participants in the process.
 - Ground rules:
 - Listen to understand;
 - Respect diverse perspectives;
 - Stay on topic... or use the parking lot; and
 - Lean toward solutions
 - Assistant Commissioner Greene introduced new Deputy Director of CSOC, Loletha Johnson. Deputy Director Johnson introduced herself. Most recently, Ms. Johnson worked with family health services division within the NJ Department of Health (DOH).
 - Participants introduced themselves and shared any thoughts they had since the last meeting.

II. Level Setting

- Ms. Greene highlighted the focus of today's meeting which was enhancing CSOC capacity and ensuring equitable access. The two main areas of consideration are:
 - We need to address the way families with children with Intellectual and Developmental Disabilities navigate the complexity of multiple systems, paying particular attention to those of transition age.
 - Systematically across CSOC there are areas where there are disparities (e.g. racial, economic, gender). Who accesses what services at what time? To what extent does the intersectionality of race, class, and gender impact the way we think about our services. We need to understand the factors that influence the disparities that exist and to think about how we can address them.
- Ms. Greene also shared that CSOC recently hired a Family Liaison, Lisa von Pier.
 - The role of the liaison is to understand at the individual level what are the pain points and disconnects for families. The role will be rolling out in stages in the next few months.
- Facilitator reminded participants to be concrete in their thoughts and recommendations.

III. Identification of system strengths and challenges

- Participants were asked to identify both strengths and challenges in the children's system of care related to enhancing CSOC's capacity to ensure equitable access.
- Identified strengths include:
 - Mobile response.

- In some cases families have found that utilizing Mobile Response is an efficient way to get connected to services.
- Identified challenges include:
 - System navigation - even with two knowledgeable parents, it is hard. We need ways to engage families in a proactive, non-stigmatizing way;
 - There isn't always alignment with school requirements/services and community supports and services.
 - There is associated financial burden with obtaining assessments and reports;
 - The guardianship application process is complex;
 - Not always recognition of the trauma and mental health burden for parents and caregivers of having a child with disabilities and navigating the system (for some, not all);
 - Families reaching out to system partners often encounter voicemail boxes and not real people;
 - System can be crisis-driven instead of being prevention focused;
 - Racial disparities in incarceration related to substance misuse;
 - A lack of information for families and also workforce on the services and supports potentially needed as children with intellectual and developmental disabilities grow up;
 - Some services are not entitlement, so there are not enough of them;
 - Accessing SUD services is difficult;
 - Application process is too cumbersome.
 - There are different criteria established by different entities in terms of accessing services to treat Autism. There should be alignment through programs of what is standard in application process;
 - Resource families have reported that they feel it is harder for them to get CSOC services;
 - Unique challenges for different service categories; and
 - Dollars available through Family Support Act for supports changed when services were transitioned to CSOC. More clarity is needed
 - Supports are sometimes needed that aren't treatment in order to help normalize experiences and preserve family resilience.

IV. Brainstorming Opportunities for Progress

- Next, participants broke into groups to begin generating ideas to move the system forward as it related to ensuring equitable access. Participants were asked to be bold, to be as concrete as possible and to focus on the "how" of each idea.
- Ideas were bucketed into 3 categories: 1) policy Ideas, 2) practice ideas, and 3) financing ideas.
- Participants came back together and shared the ideas generated, they included:
 - **Policy**
 - Engage in a process to map services and supports according to developmental stage/age - life cycle mapping;
 - Map out what services (family support, behavioral) are available for children under 5 (EI, Pre-K, home visiting) to assess case management, level of services, gaps, coordination;
 - Establish systemic coordination between schools, pediatricians and CSOC;
 - Create systems and service structures that support caregivers (MH/Trauma);
 - Build capacity to address prevention (less of a crisis-oriented system);
 - Expand supported decision making in promoting self-determination for emerging adults;
 - Coordinate reports between CSOC/education;
 - Align Autism SPA/PerformCare determination (look @ regulations);
 - Evaluate application process for services
 - Simplify intake process and provide real-life navigators (coaches/mentors) for application process;
 - Also, online modules for application support;
 - Change application to access I/DD services – look at number of reports needed, how recent they must be and how complex they are
 - Raise awareness of CSOC services (SUD especially);
 - Create a single point of contact for SUD services;

- Expand services to children under 5 and start by providing/or contracting for infant/mental health services on regional basis for CMO's and FSO's to access;
 - Leverage and partner with early childhood specialists
 - i. DHS: Infant toddler specialists (0-3), Grow NJ Kids
- Endorse best practices that currently exist so they can be replicated;
 - Maximizing and highlighting EBP/best practices;
- Develop a strategy to incorporate the voices of people who have been oppressed into the planning process;
- Use Health Information Exchanges to identify at-risk/complex kids; and
- Embed social workers in daycares in order to reach families.

○ Practice

- Address workforce development:
 - Train school staff & pediatricians;
 - Continue to develop capacity to be culturally competent – NJ is extremely diverse;
 - More training for co-occurring issues;
 - Modernize child development training for workforce;
 - Training for peers and clinicians-training should be integrated
 - Need to understand evidence based practice and be attached to outcomes
 - Workforce development needs to be continuous because of turnover and cover all systems including medical professionals that need to be aware of each other and collaborate;
 - Develop network of infant mental health specialists by providing scholarships to get IMH endorsement and build in to existing positions
 - Increase training on motivational interviewing for “front door” workforce;
- Provide regular application info sessions on regular basis;
- Establish strategies to be more visible to public;
- Develop resiliency services for mom, kids and families, infuse family resiliency as an approach in all supports and services;
- Support for prescribers of psychotropic medications, which are a big part of this – develop educational materials, decision trees and educate on best practices;
- Better utilize recovery specialist for engagement;
- Figure out how to connect with pregnant women pre-pregnancy;
 - Substance exposed infant prevention;
- Engage in a process to look at family supports as well as treatment services;
- Better establish a way to individualize SUD services for youth;
- Increase capacity for PerformCare to direct families to other supportive services and services outside of their network;
- Peers answering phone at PerformCare;
- Address right to refuse treatment for SUD;
- Rethink engagement strategies: earlier and better;
- PerformCare level of care determinations need to be re-evaluated; and
- Increase the number of live people answering calls.

○ Financing

- Possibly move prevention (normative services) services/family supports outside of CSOC;
- Do a deep dive into family support act related services;
- Establish a structure that allows for a family approach—each family is considered a person served to help with transition home;
- Rethink contracts that better ensure sustainability and availability of programs; and
- PerformCare contract could be re-evaluated to be more outcome driven.

V. Debrief

Convening Notes

- Ideas generated at this and sessions one and two will be brought back for further consideration and discussion at session four.
- CHCS will be developing a report following the full convening series outlining what was heard and providing a set of considerations for DCF.