

**DIVISION OF MENTAL HEALTH SERVICES
COMMUNITY MENTAL HEALTH SERVICES REGULATIONS
(N.J.A.C. 10:37)
Expires December 27, 2013**

Subchapter 1. Introduction and purpose.

10:37-1.1 Introduction and purpose

(a) Since the enactment of the Community Mental Health Services Act in 1957, there has been a broad expansion of public funding sources administered by the State and utilized to support community mental health services. In addition to grant-in-aid, there are funds from Title XX of the Federal Social Security Act, State Community Care and Screening purchase of service contracts, the State Capital Improvement Program and two State-funded demonstration community mental health centers. This amended chapter represents an integration of these multiple funding sources and the minimal requirements that are applicable to all of them. These requirements are conceptually based upon the Division's four operating principles: Normalization, Level of Functioning, Advocacy and Unified Services, which are described in a companion document titled "Principal Statement." Within the context of these principles, however, the Division encourages innovative implementation and a variety of comprehensive service models, developed in response to local needs and talents.

(b) Wherever the "Department" is cited, the term shall refer to the New Jersey Department of Human Services; wherever the "Division" is cited, it shall refer to the New Jersey Division of Mental Health and Hospitals. Subsequent to a period of public review and comment, this chapter shall become effective on November 3, 1980; it will be incorporated into guidelines for the Division's ongoing site visit, monitoring, program

development and evaluation activities for community mental health grants and contracts. Compliance with this chapter shall be required one year from its effective date, as of July 1, 1981. It is anticipated that total compliance will necessitate, in some instances, a reorganization of service components and priorities by participating agencies. It is for that reason that the Department is extending the implementation and compliance deadline for one year, in order to allow for local phase-ins and for technical assistance to be provided by the county mental health boards and the Division.

(c) Implementation of this chapter should serve to unify the community mental health system and to establish formal relationships between the community and the institutional mental health sectors. This chapter shall also become incorporated into the Division's inspection program for State and County psychiatric hospitals.

(d) Any questions concerning these requirements should be sent to the Division Director, New Jersey Division of Mental Health and Hospitals, 222 South Warren Street, Trenton, N.J. 08625.

10:37-1.2 Scope

The rules within this chapter apply to provider agency programs funded by the Division of Mental Health Services governed by the standards at N.J.A.C. 10:37-12 and N.J.A.C. 10:37A through 10:37I.

Subchapter 2. State Community Mental Health Citizens Advisory Board.

10:37-2.1 Membership

(a) The Community Mental Health Citizens Advisory Board shall consist of 15 members, to be appointed as described by Statute. Eight members shall be chosen from citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services; one from persons recommended by the State League of Municipalities; two from providers of mental health services and one from persons recommended by the chairpersons of the standing Assembly and Senate Institutions, Health and Welfare Communities.

(b) The term of each member shall be for three years, commencing on July 1 and terminating on June 30; provided, however, that of the new members appointed three shall be appointed for a term expiring two years, and four for a term expiring three years from July 1 following the date of appointment. Members of the present Community Mental Health Citizens Advisory Board serving on the effective date of the amendatory act shall continue to serve until the expiration of their current terms.

(c) In addition, the Board of Instructional Trustees will designate two members from persons currently serving on the Board of Managers of each of the four State psychiatric hospitals to be appointed in July of each year. The Director of the Division or his/her designee shall be a nonvoting ex-officio member of the Community Mental Health Citizens Advisory Board.

(d) At least two of the "consumers" cited in (a) above shall meet the definition of "consumer" cited in N.J.A.C. 10:37-4.1(b).

(e) The Board should have representation from all geographic areas of the State.

(f) The Board should reflect the sex, racial, and cultural composition of the State's population.

10:37-2.2 Functions

(a) The role of the Board shall be to serve as advocate and advisory to the Department for the development of mental health services in the community. To fulfill this role, the Board shall become and continue to be thoroughly acquainted with those programs of the Department dealing with mental health and related social services, and shall regularly review all such programs. It shall advise and recommend on the development of policies and procedures within the general directives of the Department covering community mental health programs.

(b) The Board shall promote and maintain constructive relationships with the county mental health boards, community mental health agency boards and other official bodies and organized agencies concerned with mental health services. It shall also serve, where possible, such advisory capacities to the Department in the area of community mental health as are required by Federal statutes.

(c) The Board shall choose one of its members to act as chairperson and shall meet as often as required to conduct the business of the Board and to assist and advise in the administration of the duties and responsibilities cited above, but not less than six times each year.

(d) The Board shall comply with the Open Public Meetings Act.

10:37-2.3 Power to establish committees

(a) The Board may establish within itself committees, as it deems necessary.

(b) The Board may establish any subsidiary unsalaried advisory or consultant committees or study groups as it may deem necessary and shall appoint the members thereof.

10:37-2.4 Scope of authority

The Board shall have the right to make recommendations, to the Division and the Department, concerning any aspect of mental health service delivery covered in this chapter.

Subchapter 3. County Mental Health Boards.

10:37-3.1 Establishment and composition

(a) In order to participate under this act, each county board of chosen freeholders or county executive, hereinafter the "appointing authority," shall appoint a County Mental Health Board, hereinafter the "Board," of not less than seven nor more than twelve residents of the county.

(b) The mental health board shall provide public leadership to the county in the development of mental health services.

(c) The board shall include as wide a spectrum of the County's population as possible. Members should be representative of the county's population, including such groups as:

1. Consumers of mental health services;
2. Local boards of health;
3. School boards;
4. Interested lay people;

5. Parent-teacher association;
6. County professional/medical associations;
7. County advocacy groups; and
8. Such other members as the appointing authority may deem necessary.

(d) Such persons noted in (c) above shall not, however, officially represent such groups, unless official authority to do so has been granted by the agency or organization.

(e) A minimum of two "consumers" of mental health services, as defined in N.J.A.C. 10:37-4.1(b), shall serve on the board at all times. Boards currently without vacancies or service recipient representation shall appoint consumer members, as cited in N.J.A.C. 10:37-3.1(a), first, as vacancies occur. (See N.J.A.C. 10:37-4.3.)

(f) The board should be representative of every Service Area in the County and should also reflect the sex, racial, and cultural composition of the county.

(g) The board shall not include persons employed by or having a fiduciary interest in any agency funded by the Division to provide mental health services.

10:37-3.2 Membership

(a) Members shall serve without compensation, for three years, with terms to begin July 1 and terminate June 30. Members may not be reappointed after serving two full three-year terms, until two years shall have elapsed since the expiration of such terms.

(b) Vacancies shall be filled within 60 days by the appointing authority. Vacancies shall be filled in the following manner:

1. If the unexpired term is greater than 50 percent of the entire term, the nominee may only serve one additional term.

2. If the unexpired term is less than 50 percent of the entire term, the nominee may serve two additional terms.

10:37-3.3 Attendance

Any member of a county mental health board who does not attend three consecutive board meetings without being excused, or does not attend more than 50 percent of the board's meetings in any single year should, upon notification by the County Mental Health Board Chairperson, be replaced by the appointing authority. Replacement should be accomplished within two months of that notification.

10:37-3.4 Conflicts of interest

(a) The following individuals shall not be eligible for County Mental Health Board membership:

1. A paid or unpaid employee/volunteer of an agency under the county mental health board's jurisdiction or funded by the Division;

2. A consultant of an agency under the county mental health board's jurisdiction or funded by the Division;

3. A member of the governing body of an agency under the county mental health board's jurisdiction or funded by the Division;

4. A member of a formal advisory body of an agency under the county mental health board's jurisdiction or funded by the Division.

5. Person engaged in issuing any policy or contract of individual or group business of any agency under the county mental health board's jurisdiction or those agencies' affiliate, subsidiary, or parent organization.

6. Persons who are members of the immediate household or a direct business associate of a person described above.

7. Persons employed by the county and/or its agencies; this exception shall not include the Board of Chosen Freeholders or a County Welfare Board that is not currently funded by the Division. A waiver must be sought from the Division for any other such appointees.

10:37-3.5 Roles, functions, and responsibilities

(a) Procedural responsibilities: The County Mental Health Board shall:

1. Elect annually a chairperson;
2. Meet at least eight times each year;
3. Comply with the Open Public Meetings Act;
4. Establish, and at least annually review, formal procedures concerning the composition of the Board and setting forth rules of order by which the Board shall operate;

5. Submit public notices and minutes of said meeting to the Division of Mental Health and Hospitals.

(b) Planning responsibilities: As set forth in the Division's Planning Guidelines:

1. Initiate and implement a planning process, encouraging participation from, at a minimum, other mental health planning authorities (for example, Health Systems Agency representatives), funded providers of services, clients, and interested citizens.

2. Develop a plan of mental health services for the county. At a minimum, that plan shall identify:

i. The county mental health authority(ies) and their respective roles and functions;

ii. The manner in which the plan was completed;

iii. A needs assessment section which reviews:

(1) The State and county identified target groups, and the reason they have been so identified;

(2) Services that are perceived by the community as being critical to meet the needs of identified State/county target groups;

(3) The availability or unavailability of those services identified in (b)2iii(2) above.

iv. A set of goals and objectives which will provide a framework for addressing the needs of State and locally identified target groups;

v. An action plan which designates the means and steps by which goals and objectives will be achieved.

3. Submit completed County Mental Health Plan to the Division within specified deadlines, for review and approval. If a county has a Charter form of government, the County Mental Health Board must submit the County Mental Health Plan to the County

Executive or his/her designate, for review and approval, prior to submission to the Division.

4. In the event that:

i. A county mental health plan is approved by the Division, the county plan shall provide the framework for mental health funding and program development in that particular county.

ii. An approved plan is not submitted by the county, the framework for mental health activity in that particular county shall be provided by the goals and objectives of the Division, contained within its Annual State Plan.

5. The initiation of the planning process, and subsequent completion of the plan, shall be conducted within the general policies and principles of the Division.

6. The county mental health authority(ies) should take an active planning role in coordinating the services of other county offices and departments relating to mental health services.

(c) Implementation responsibilities: Based on the County Mental Health Plan, the County Mental Health Board shall, at a minimum:

1. Receive, review, comment and, where necessary, solicit the following:

i. Initial and continuation funding applications for:

(1) State hospitals;

(2) County hospitals;

(3) Community Mental Health Projects regardless of revenue source.

ii. Certificate of Need applications for Mental Health Agencies;

iii. Affiliation agreements.

2. Receive, review and advise the Division of Mental Health and Hospitals on requested Service Area changes/redelineations.

3. Facilitate consumer advocacy and self-help groups.

4. Respond to client grievances as identified in N.J.A.C. 10:37-4.3.

5. Review and recommend funding allocations to agencies within the county, consistent with the approved County Mental Health Board Plan.

(d) Monitoring responsibilities: The County Mental Health Board shall monitor the service delivery and administration of all programs under the board's jurisdiction and make recommendations to the appropriate agency or department.

(e) Community education responsibilities: The County Mental Health Board shall encourage the development of and participate in community education programs.

(f) Assistance of Appointing Authority: The Appointing Authority should provide the Mental Health Board with suitable quarters and such assistance as may be required to carry out the functions identified above.

10:37-3.6 Professional Advisory Committee (PAC)

(a) The County Mental Health Board shall:

1. Appoint annually, members of its Professional Advisory Committee, minimally including a representative from each mental health agency receiving financial support from the Division. Two or more individuals connected with the same agency, either as employee and/or board member, may serve simultaneously as members; in such cases,

however, it shall be the responsibility of the County Mental Health Board to maintain a balance of representation, with no particular agency(ies) operationally dominating the PAC. Membership of the Professional Advisory Committee shall include the State and county psychiatric hospitals, the county welfare board and the Division of Youth and Family Services. The PAC should also include county criminal justice, Division of Mental Health Advocacy, Division of Vocational Rehabilitation, Substance Abuse Programs, a Municipal Welfare Board and the county mental health association.

i. Non-Division funded county welfare boards and mental health associations may be represented on the County Mental Health Board itself, rather than the PAC.

2. Approve rules and procedures for its PAC;

3. Consult with its PAC on all issues relating to professional aspects of mental health programs;

4. Actively involve the PAC in the development of the annual county mental health services plan.

(b) All meetings of the PAC shall be open to the public, except those portions dealing with matters of patient/client confidentiality.

10:37-3.7 County Mental Health Administrators

(a) By State law, all County Mental Health Boards may, with the approval of the Board of Freeholders, create the position of Mental Health Administrator. The Division strongly encourages the creation of this position in every County and suggests

additional staff for the mental health board, also including one non-clerical position for every 300,000 people living in a particular county.

(b) The Division shall approve the credentials of a candidate for the position of Mental Health Administrator, selected by the appointing authority, prior to his/her hiring.

(c) The county shall provide, as part of its submission of the candidate's approval request, a current description of how the Administrator will be responsible to the county and to the County Mental Health Board and a job description that reflects the Administrator's role in developing the County Mental Health Plan and other requirements under State law and these Regulations.

(d) Minimum qualification shall include:

1. Education: A Master's Degree from an accredited university in Psychology, Public Administration, Social Work, Public Health, Hospital Administration, Nursing or a related field. A Bachelor's Degree with significant work experience beyond the required three years, in one of the above areas, may be substituted for a Master's Degree with prior approval from the Division.

2. Experience: A minimum of three years experience in administration in mental health care or related fields.

3. Knowledge and abilities: Working knowledge of planning, budgeting and human services contract administration. Working knowledge of current developments in the field of mental health. Working knowledge of organizations and operations in the public sector including government, private, social service and health agencies and public institutions. Ability to devise model service systems and implement goals and objectives toward development of a unified services system. Ability to work

harmoniously with various leaders, representatives of the community, and consumer groups.

(e) Roles and functions: The County Mental Health Administrator shall:

1. Maintain accurate records and summaries of the county mental health board's and its professional advisory committee's deliberations and conduct regular clerical and business matters of the county mental health board and be responsible to that body;

2. Serve as the county mental health board's executive secretary;

3. Serve as liaison between the county mental health board and its advisory committee and county government, the Division, the Department and the Federal Department of Health and Human Services, and to local and regional planning bodies;

4. Provide leadership to county mental health policy groups and participants as an equal member in policy groups convened by the Division;

5. Participate in planning and implementation of all system and program development activities relating to the county, convened, initiated or required by the Division;

6. Act as a facilitator/convenor for meetings involving agencies under the county mental health board's jurisdiction, and county. State and/or Federal officials;

7. Submit an annual county mental health services plan to the Division, in accordance with the Division's planning guidelines;

8. Attend Statewide or Regional meetings of County Mental Health Administrators, and submit reports, as required by the Division;

9. Participate in formal monitoring of grant and contract services;

10. Participate as a full team member at all Federal, State, County site inspections of all services and agencies under the Board's jurisdiction;

11. Review, comment and make recommendations on proposals and applications for mental health services to the County Mental Health Board and to agencies of the State and Federal Government, as appropriate;

12. Participate in the review and negotiation of initial and renewal contracts;

13. In cooperation with the Division develop affiliation agreements for promoting and monitoring a county unified services system;

14. Insure proper communication of information concerning mental health services, funding, deadlines, etc. to funded agencies;

15. Play an active role in carrying out the county mental health board's advocacy functions including:

i. Receiving and following up on client questions and complaints regarding services, as outlined in N.J.A.C. 10:37-4.6.

ii. Increasing representation and participation of service recipients on county mental health board.

iii. Facilitating the development of self-help groups.

10:37-3.8 Reimbursement

(a) State reimbursement for the County Mental Health Administrator's salary shall be paid on a quarterly basis contingent upon:

1. The County's meeting the requirements of these regulations;

2. The Division's approval of the Administrator's credentials prior to hiring; and

3. Receipt and approval by the Division of quarterly certificates of satisfactory employment, signed by the chairperson of the County Mental Health Board.

(b) State annual reimbursement shall be at the rate of 75 percent of Administrator's salary, up to a maximum of \$12,000 annual reimbursement.

10:37-3.9 County administration of services

(a) As a means of reinforcing the concept of inter-governmental partnership in the delivery of public mental health services, the Division may enter into demonstration performance contracts, with a limited number of counties, for the county administration of all publicly funded mental health services.

(b) Guidelines for participation in a county performance contract shall minimally include:

1. Receipt of a county plan in compliance with Division guidelines and approved by the Division;

2. Identification of a single unit of county government, preferably a department, which shall act as the agent of the Board of Chosen Freeholders or the County Executive, in the negotiation of a performance contract, and be responsible to the Division for the implementation and monitoring of that contract. Such an administrative unit of county government shall be referred to as the "single county authority" for mental health;

3. Capacity of the county to fully administer mental health services, including community contracts and grants and the county psychiatric hospital, if that county has such a facility;

4. County-wide compliance with the rules and regulations promulgated by the Division;

5. Demonstration of policy and financial commitment of the county to the State's unified services policies, consistent with the New Jersey's Annual State Plan for Mental Health.

Subchapter 4. Consumer Requirements for all Community Mental Health

Program Elements.

10:37-4.1 Direct involvement

(a) Consumer involvement shall be facilitated and encouraged in areas such as service and program planning, service evaluation, and service delivery.

(b) "Consumer" in this section shall be defined as:

1. A person who has applied for, is receiving or has received mental health services from a State or other publicly funded mental health Program Element; or

2. A person who is the next-of-kin or guardian of a person described in (b)1 above.

10:37-4.2 Designed responsibility of agencies

(a) Each State-funded mental health program shall develop and submit to the County Mental Health Board and to the Division an acceptable Consumer Affirmative Action Plan as part of its Fiscal Year 1982 funding application or contract.

(b) The Consumer Affirmative Action Plan shall minimally include:

1. Membership on the governing body of the agency for two or more consumers except as indicated otherwise in N.J.A.C. 10:37-6, Article VI;

2. Opportunities for consumers and advocacy groups to review and have input into the development of the agency's annual service plan and funding requests;

3. Opportunities for agency consumers to meet with governing board to discuss Service Area needs, annual program plans, formal program evaluations and other issues of concern;

4. Adequate notice of the availability of the opportunities outlined in (b)1 through 3 above, with notices posted at the agency's program sites.

(c) In counties where there are consumer or advocacy organizations, these groups shall have an opportunity to review and to comment on the agencies' Consumer Affirmative Action Plans.

10:37-4.3 Designated responsibilities of County Mental Health Boards

(a) For consumer membership see N.J.A.C. 10:37-3.

(b) County Mental Health Boards shall hold at least one meeting annually for the purpose of directly gaining consumer input into the development of its annual mental Health Service Plan. Notice of this opportunity shall be posted in community mental health agencies and facilities in that county, in addition to complying with the Open Public Meetings Act.

(c) Consumers and advocacy organizations shall be given the opportunity to review the annual County Mental Health Services Plan prior to its submission to the Division.

10:37-4.4 Designated responsibilities of State Community Mental

Health Citizens' Advisory Board

- (a) For Consumer Membership see N.J.A.C. 10:37-2.
- (b) Consumers and advocacy organizations shall be given an opportunity for review and involvement in the development of the annual State Mental Health Plan.
- (c) The Division shall hold at least one meeting annually for the express purpose of gaining consumer input into the development of the annual State Plan. Adequate notice shall be given, as cited in N.J.A.C. 10:37-4.3(b).

10:37-4.5 Client rights

- (a) This section shall apply to all State-funded mental health Program Elements. Inpatient Units, including 24-hour Supervised Treatment Homes providing crisis intervention services for children, are also required to comply with laws governing the treatment of persons admitted to inpatient psychiatric facilities, including but not limited to N.J.S.A. 30:4-24, 30:4-24.1, 30:4-24.2 and 30:4-24.3.
- (b) Each client shall be made aware of the rights and privileges in receiving mental health services. Each agency shall establish a policy statement in this regard.
- (c) Notice of the client's rights set forth in this chapter and any rules governing the conduct of clients with respect to an agency shall be given to each client within five days of admission. Such notice shall be in writing, and shall be supplemented by an offer to discuss or explain the written description. Explanations shall be in a language which the client understands. If the client cannot read the provisions of the notice, it shall be read to him/her.

(d) In the case of an adjudicated incompetent client, such procedure in (c) above shall be followed for the client's guardian. Receipt of the written notice shall be documented in the client's file.

(e) If the client or guardian refuses to acknowledge receipt of the notice, the person delivering the notice shall document this in the client's file.

(f) Subject to any other provisions of law, no client shall be deprived of any civil right solely by reason of his/her receiving mental health services, nor shall such services modify or vary any legal or civil right of any client.

(g) No client may be presumed to be incompetent because she/he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.

(h) All funded mental health programs shall provide their clients with the following rights, a list of which shall be prominently posted in all facilities and brought to the attention of clients as described in (b) above, and by additional means as the Division may require.

1. The right to be free from unnecessary or excessive medication. (See N.J.A.C. 10:37-6.54.)

2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV.)

i. If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(2).

3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however, that a client in Inpatient Care may be restrained or isolated in an emergency pursuant to the provisions of N.J.S.A. 30:4-24.2d(3). (See N.J.A.C. 10:37-6, Article XV.)

4. The right to be free from corporal punishment.

5. The right to privacy and dignity.

6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

7. In inpatient or other residential care:

i. The right to normal opportunities for interaction with members of the opposite sex;

ii. The right of a client to wear his/her clothes; to keep and use his/her personal possessions including toilet articles; and to keep and be allowed to spend his/her own money for expenses and purchases;

iii. The right to have access to individual storage space for his/her private use;

iv. The right to see visitors each day;

v. The right to have reasonable access to and use of telephone, both to make and receive confidential calls;

vi. The right to have ready access to letter writing materials, including stamps, and the right to mail and receive unopened correspondence;

vii. The right to regular physical exercise several times a week;

viii. The right to be outdoors at regular and frequent intervals, in the absence of medical considerations;

ix. The right to practice the religion of his/her choice or abstain from religious practices. Provisions for such worship in Inpatient Care shall be made available to each person on a nondiscriminatory basis.

x. The right to receive prompt and adequate medical treatment for any physical ailment.

8. The rights in N.J.A.C. 10:37-4.5(h)1-4 may not be denied under any circumstances;

9. The rights in N.J.A.C. 10:37-4.5(h)5-7 may be denied to clients in Inpatient Care for good cause, in any instance in which the Director of the Program Element feels that it is imperative to deny any of these rights; provided, however, that under no circumstances shall a client's right to communicate with his/her attorney, physician or the courts be restricted.

i. Any such denial of a client's rights shall take effect only after a written notice of the denial, which includes an explanation of the reason for the denial has been filed in the client's record.

ii. Any such denial of a client's rights shall be effective for a period not to exceed 30 days and may be renewed for additional 30-day periods only by a

written statement entered by the Director of the Program Element in the client's treatment record which indicates the detailed reason for such denial or renewal.

10. Every client in Inpatient Care is entitled to a writ of habeas corpus upon proper petition by himself, by a relative, or a friend to any court of competent jurisdiction in the county in which she/he is detained and shall further be entitled to enforce any of the rights stated by civil action or other remedies otherwise available by common law or statute.

10:37-4.6 Client complaint/agency ombuds procedure

(a) This section shall apply to all State-funded mental health programs. Any questions related to service delivery, denial or termination of services shall be an appropriate subject for review. Any client, applicant, or person who has been a client within the last three months or his/her designee, parent or guardian, shall have the right to seek review. Such persons shall be identified below as "clients."

(b) Establishment of complaint procedure: Each agency shall establish internal client complaint procedures which will be subject to Division review and approval at the time of the agency's annual request for State funding.

1. Explanation to clients: Each client shall be made aware of the existence of a complaint procedure at second, non-emergency contact. Written notice, as well as a verbal explanation of agency complaint procedures, and external advocacy services which are directly available to clients at all times, shall be given to each client at the earliest appropriate opportunity. Under all circumstances, clients not accepted for

services shall be informed immediately of the State-wide advocacy services available to them. Information regarding external advocacy services shall minimally include the:

- i. Community Mental Health Law Project (if one exists in the client's county);
- ii. County Mental Health Administrator in the county;
- iii. Division of Mental Health and Hospitals' Ombudsperson;
- iv. Division of Mental Health Advocacy;
- v. Division of Youth and Family Services (for child abuse and/or neglect);
- vi. County Welfare Agency (for adult abuse).

2. Posting: The information contained in the written notice required above shall be posted in a prominent place in the agency's facilities.

(c) Designation of Agency Ombudsperson: The Agency Director shall designate a staff person to function as Agency Ombudsperson, on an as needed basis. Small agencies may choose to share staff for this function.

(d) Responsibilities of Agency Ombudsperson:

1. The responsibilities of the Agency Ombudsperson shall be:

- i. To receive client complaints;
- ii. To act as an advocate for clients who make complaints; and
- iii. To attempt to negotiate resolutions of issues raised by clients

(Complaints shall be investigated and negotiated within five working days.)

2. The Agency Ombudsperson shall submit a written report of findings, resolutions and/or recommendations to the Agency Director and to the client within

seven working days of the complaint. If the complaint has been resolved to the client's satisfaction, the grievance process shall end at this point.

(e) Optional establishment of Internal Agency Review Committee: The Agency may develop, by the Director's appointment or by staff/client election, an interdisciplinary review committee. It is suggested that such a Committee include an equal number of staff or Agency Board members and clients of the Agency. If established, such a Committee should:

1. Receive and review complaints within three working days of a request by a client or Agency Director;

2. Submit a written report of its findings and recommendations to the Agency Director within five working days of complaint.

3. Report to the Division of Youth and Family Services complaints or allegations of abuse and/or neglect, in accordance with N.J.S.A. 9:6-8.10.

(f) Internal Agency complaint resolution:

1. The Agency shall permit and encourage clients who object to a decision of a therapist, counselor, or service procurer, to consult with, and to obtain the opinion of, a second such person either within or without the Agency.

2. If a complaint has not been resolved by the Agency Ombudsperson to the client's satisfaction, the client may request review by the Agency Director. If an Internal Agency Review Committee has been established in the Agency, either the client or the Agency Director may request review by that Committee. The Director shall make the final Agency-level decision regarding the complaint, in a due process manner, as quickly as possible.

3. If the complaint has still not been resolved to the client's satisfaction, the client may request review by the County Mental Health Board.

(g) Responsibility of the County Mental Health Board:

1. The County Mental Health Board, through its Administrator, shall receive and review complaints referred from Agency Directors within five working days.

2. The County Mental Health Board shall make its findings and recommendations known to the Agency Director and to the client within seven working days of complaint. If the client is not satisfied with the recommendations of the Board, or the Agency's response to these recommendations, the client may request review by the Division.

(h) State-level review by the Division:

1. A client may request a review by the Division directly, and in confidence, at any time. Clients shall be encouraged by the Division, however, to seek an Agency-level review first and will be asked to justify the omission of an Agency or a County-level review. The Division will advise the Agency and the County Mental Health Board of all complaints received directly, unless the client, on notice, refuses to consent to such disclosure.

2. The Division may convene a Professional Review Committee, when needed, consisting of an interdisciplinary team appropriate to the subject of the complaint. The designees shall receive and review complaints referred by clients within five working days and shall submit a written report of its findings and recommendations to the Division Director within two more days.

3. The Division Director shall review this report and submit recommendations to the Agency Director and the client within seven working days. The Division shall

determine if any formal State remediation/funding compliance action is necessary based on the Agency's response to these recommendations.

(i) Procedures not to limit access to other remedies: These procedures are intended to be in addition to, rather than in replacement of, any other remedies available to clients for the negotiation or redress of complaints services delivery. It is not the intention of the Division that clients be required to exhaust these procedures before seeking negotiation or redress for complaints in any judicial or administrative forum.

(j) No suspension of Agency action during review: An Agency action which is the subject of a client complaint need not be suspended pending review under these procedures. A client, however, may request expedited, direct review by the Division at any time, and such review shall be completed within 72 hours of the request.

(k) Confidentiality: A client who requests assistance with or review of a complaint by an Agency Ombudsperson, Internal Agency Review Committee, Agency Director, County Mental Health Board or the Division, shall be required to consent to the disclosure of relevant records, in order to authorize persons providing assistance or review to discuss the subject of the complaint with relevant Agency staff if necessary.

Subchapter 5. Program Element Requirements.

10:37-5.1 Funding priorities

(a) It is the goal of the Division to implement every mental health program cited in N.J.A.C. 10:37-5, in every Service Area in the State. Minimally, as of July 1, 1981, there must be funded Emergency Services (ES) and Outpatient (OPD) programs

serving every Service Area of the State; they shall meet the requirements cited in Articles II and IV of this subchapter.

(b) In order to insure adequate hospital liaison activity, designated State- funded outpatient programs, as described in section 10:37-5.5, shall allocate a minimum of one full-time equivalent (F.T.E.) staff person for every 120 clients admitted to the State and county hospitals during the preceding fiscal year from the agency's designated Service Area.

(c) In-hospital pre-discharge planning and post-discharge service procurement responsibilities must be funded through State Grant-in-Aid and local matching funds, Federal CMHC funds, or Supplemental State funds, such as those provided to State-funded demonstration community mental health facilities. County Care and Title XX contract dollars shall not be used for this purpose without written, waiver approval by the Division prior to implementation.

(d) All direct service program elements (excluding Consultation and Education programs):

1. "Face-to-face" activity: All State-funded direct service staff shall spend a minimum of 65 percent of their time in "face-to-face" client activity. "Face-to-face" may include: telephone contact with clients, transportation time needed to perform home visits/outreach services, service procurement and advocacy contacts, made with other staff, program elements, or agencies on behalf of the client. "Face-to-face" shall not, however, include staff supervision, record-keeping, or report writing.

2. Service procurement:

i. Although "Service Procurement" is listed as a required service, to be provided in all of the State-funded program elements other than Consultation and Education, each mental health agency must identify a Primary Service Procurer Coordinator for each client served in a State-funded Program Element.

ii. In the case of Division of Youth and Family Services' (DYFS) clients, the role of Primary Service Coordinator may be shared with the client's DYFS worker.

iii. The Primary Service Coordinator shall be responsible for monitoring the client's Individual Service Plan (ISP) and for coordinating all service procurement and advocacy efforts made on behalf of individual clients, internal and external to that agency. Activities shall include, but not be limited to:

(1) Coordination of needs assessments;

(2) Service planning and linkage, monitoring; and

(3) Follow-up activities that facilitate each client's movement through the system.

iv. The Primary Service Coordinator may be a direct service provider in any Program Element. The Primary Service Coordinator should have thorough knowledge of the service system and should be able to consult with other mental health staff involved with the client, on a periodic basis and when specific difficulties arise.

10:37-5.2 Target populations

(a) The goal of the mental health system is to provide comprehensive services to everyone in need. However, target populations have been established to assure that those who are most in need, and/or have traditionally been underserved, receive a reasonable level of service. These priorities are not to be construed as totally exclusionary. Wherever the phrase "target populations" is cited in this chapter, the phrase refers to the populations and priority order below. State-funded Program Elements shall serve retarded and other handicapped individuals as they would any other person who falls within the following priority groups.

(b) State target populations:

1. Target Group I, indicating a person's history and/or serious risk of hospitalization, shall be given first priority in all mental health Program Elements governed by this chapter, except as indicated in Articles II and III of this subchapter, describing Emergency and Screening Program Elements.

2. Subcategories of Target Group I do appear in order of State importance; however, levels of service appropriate locally for each target subcategory shall be arrived at through individual Service Area needs assessments and each County's mental health planning process, with final Division approval.

3. Target Groups I and II are not mutually exclusive. Target Group II describes specific demographic categories of people; when these individuals meet any of the criteria listed in Target Group I, they shall be prioritized above other people meeting Group I criteria. When services are delivered to non-Target Group I clients, these demographic groups shall also be prioritized.

4. Target Group I:

i. Adults and children currently in a State/County/local psychiatric hospital who could live in the community with appropriate services;

(1) "Local" psychiatric hospital shall mean a local inpatient program which has been determined by the Division as meeting the requirements of Article VII of this subchapter, regarding Inpatient Care (IPU). Such an IPU must be affiliated with the State and County hospitals and must serve the other target populations cited in this N.J.A.C. 10:37-5.2.

ii. Adults and children in the community, with a history of State/County/local psychiatric hospitalization, who are in serious risk of rehospitalization;

(1) "Local" psychiatric hospital is defined in (b)4i(1) above.

iii. Adults and children in the community who are mentally and functionally impaired and in serious risk of psychiatric hospitalization.

(1) "Mentally impaired" in this context shall mean a person whose primary impairment is emotional, excluding those whose primary problem is a developmental disability, retardation, and/or organic brain syndrome. These exclusions shall not apply, however, to Emergency and Screening Service Program Elements, except where indicated in Article IV of this subchapter.

(2) "Functionally impaired" shall mean a person who is identified as having serious functional problems in personal, interpersonal, and/or social skill areas.

(3) "In serious risk" shall describe a person who is currently in crisis and/or is marginally functioning and, without intervention, will likely be hospitalized.

5. Target Group II:

i. Children (17 or younger) who are mentally, emotionally, and functionally impaired;

ii. Elderly (65 or older) who are mentally, emotionally, and functionally impaired;

iii. Minorities (black and/or hispanic or other minority groups identified in the County Plan) who are mentally, emotionally, and functionally impaired;

iv. Rural poor who are mentally, emotionally, and functionally impaired;

v. Urban poor who are mentally, emotionally, and functionally impaired;

(c) Additional target populations:

1. Additional target populations may be formally identified for certain localities through the County Mental Health Board's annual planning and needs assessment processes. The incidence and service needs of these additional target populations shall be documented by the County Mental Health Board and approved by the Division prior to their adoption as a local priority.

2. If a County Mental Health Board documents a significantly reduced need, or an already reasonable service level, for State target populations in a given Service Area, the State may approve an annual waiver regarding that particular State target population(s), and the County may address additional populations.

(d) Reporting:

1. Agencies providing mental health Program Elements governed by this chapter shall set up record-keeping procedures to identify all recipients of service who are members of each State target population group and any formally identified local target population described in (c) above.

2. Statistics shall be kept for each Program Element, showing the percentage of total clients served in each Element who belong to each designated target population. Reports citing this information shall be submitted to the Division as required under N.J.A.C. 10:37-6, Article XIV.

10:37-5.3 through 10:37-5.53 (Reserved)

10:37-5.54 Scope and purpose

(a) IPU programs shall provide 24-hour crisis-stabilization services, therapy, and supervision, outside of a client's home, in the least restrictive setting possible.

(b) IPU program requirements shall apply to 24-hour supervised treatment homes providing residential crisis intervention services to children.

(c) Crisis services provided overnight, in any location other than the client's home, should not occur unless the individual cannot be stabilized within his/her natural environment or the client needs to be removed from his/her usual environment to a protected IPU setting.

(d) As quickly as feasible, IPU programs shall restore an acutely distressed client to a level of functioning sufficient to allow the individual to return home and/or to receive mental health services in a less restrictive setting.

(e) These requirements shall apply to State and county psychiatric hospitals, as well as to community IPUs.

10:37-5.55 Designation of responsibility

(a) Systemic use of local inpatient facilities:

1. Each agency receiving State mental health funding for IPU programs, and other mental health agencies in that Service Area, shall use that State-funded local IPU whenever feasible, rather than refer Service Area residents to county and State psychiatric hospitals for admission.

2. Affiliation agreements must be executed by IPU programs, with the Service Area's public psychiatric facilities and with other State-funded mental health agencies in the Service Area. Agreements shall clearly outline admission criteria and procedures and those circumstances for which transfers among the local, county and State inpatient units shall be appropriate.

(b) Admissions:

1. There shall be a well-defined, written admissions policy, including admissions criteria and referral procedures for the IPU program; once developed, these criteria and procedures shall be widely distributed to all Service Area mental health and mainstream referral agencies. Such criteria shall be developed jointly with the Division, the County Mental Health Board, and the State and county psychiatric hospitals, as part of a formal affiliation process. Private psychiatric hospitals and V.A. hospitals may be included in the process of system unification when desirable and appropriate.

2. Inpatient Programs must be made available to Service Area residents meeting the admission criteria. Service Area residents shall receive services as a first priority; an emergency admission of an out-of-Service Area client, however, shall be possible.

3. Clients previously hospitalized in either a State or county psychiatric facility cannot be denied admission to a local IPU, nor automatically be referred to the State or county facility, solely because of his/her hospitalization history in a State or county facility.

4. Admission to Inpatient programs shall be in compliance with laws governing the voluntary and involuntary commitment of adults and children.

10:37-5.56 Funding requirements

(a) State-funded IPU programs must house the unit in a facility licensed by the Department of Health and/or approved by the Department of Human Services.

(b) IPU programs shall be eligible for public mental health funding as part of a formal continuum of services, demonstrated by affiliation agreements approved by the Division and the County Mental Health Board.

(c) Any agency receiving Capital Improvement Program (Bond Issue) funds for renovation and/or construction of an IPU Program shall serve involuntary, as well as voluntary, clients as stipulated in N.J.A.C. 10:37-5.18(c) and (d).

1. Programs receiving Capital Improvement Program funds for renovation or construction of an IPU or 24-hour supervised treatment home for children must serve both voluntary and involuntary clients as authorized by law.

(d) State-funded IPUs shall operate at an 85 percent utilization rate until such time that there are no voluntary commitments from a Service Area to a county or State psychiatric hospital. Through a formal affiliation agreement, between the public psychiatric hospital(s) and the State-funded local IPU, no voluntary admissions should be accepted to the public psychiatric hospital, if there are vacant, local IPU beds in a client's Service Area.

10:37-5.57 Population priorities

(a) See N.J.A.C. 10:37-5.2.

(b) IPU services should be made available to individuals who cannot cope successfully in the community at a time of crisis, are feeling severe emotional distress, and/or are dangerous to themselves or others.

10:37-5.58 Services to be provided

(a) Assessment and evaluation:

1. Every IPU client shall be assessed as to his/her Level of Functioning and Environment/Natural Support Systems. These assessments, in addition to the client's perceptions of his/her needs and emotional distress, should serve as bases for the development of a comprehensive Individual Service Plan (ISP). (See N.J.A.C. 10:37-6, Article VIII.)

2. IPU staff shall attempt to utilize and involve the client's natural supports whenever possible.

3. With the client's consent, staff should also identify living arrangements and employment circumstances, to try to effect a leave of absence without the unnecessary loss of a job or residence.

4. Other assessments and evaluations, as defined in the Division's Service Dictionary, may be made as appropriate.

(b) The following services are to be provided:

1. Health-related;

2. Therapy; and

3. Counseling.

4. Service procurement (Including discharge planning for appropriate community-based mental health, socialization, employment, housing and related social services) where possible.

5. Daily living education.

6. Recreation.

7. Information and referral.

8. Education (For Children's Inpatient and 24-Hour Supervised Treatment Homes).

10:37-5.59 Service approaches

(a) Inpatient Treatment/Service Approaches

1. IPU programs shall include a wide range of services and treatment modalities. These shall include medical psychiatric services, such as individual and group therapies, neuroleptics, etc. and various psychological interventions, such as behavioral

modification and structured group processes, as defined within the context of psychosocial therapeutic milieu.

2. Appropriate interdisciplinary staff shall be an ongoing part of treatment and service planning for each client. Selected staff members from other community mental health program elements (for example: Partial Care, Outpatient, etc.) should also become a part of the treatment team, as needed, for continuity of care purposes.

3. IPU Individual Service Plans (ISPs) shall be designed to relieve the client from present discomfort and to provide the client with the coping skills necessary to function in the community. The treatment/service plan shall be explicit in describing how/why the client could not cope in the community and what will be done, during the stay, to help the client to function more adequately upon discharge. (See N.J.A.C. 10:37-6, Article VIII.)

4. When appropriate, families and/or other support system members shall be encouraged to participate in goal setting, treatment planning, program services, and discharge planning.

5. When clients known to DYFS are admitted, the IPU shall notify and involve DYFS in program and discharge planning, as soon as possible.

6. Upon completion of needs assessments, if a client under the age of 18 is in need of DYFS services, referral to the appropriate District Office of DYFS should be completed.

7. The services of the various professional disciplines shall be integrated through regular staff conferences initiated for the purpose of needs assessment, services and discharge planning, and ongoing involvement of clients.

8. A daily schedule of group and individual program/service options shall be made available to each client and shall be developed with client participation whenever possible.

9. For clients who are discharged within 48 hours of admission, emphasis shall be on reinforcing the client's natural support system, where appropriate, and on treatment and discharge planning, described in (a)3 above.

(b) Records: IPU programs shall comply with the requirements for medical/service records as specified by the Joint Commission on the Accreditation of Hospitals and the Division. (See N.J.A.C. 10:37-6, Article XIII.)

(c) Client involvement:

1. Each client shall be involved in determining service goals, modalities of treatment and timetables, to the extent that his/her condition permits. Participation should be documented by having the client's signature on the plan. (See N.J.A.C. 10:37-6, Article VIII.) Client involvement shall include the development, modification, execution, and registration of an advance directive for mental health treatment if the consumer, after receiving complete information about such directives wishes to designate either a mental health representative or to execute an instruction directive.

2. Client participation in community-based activities (for example: Partial Care, vocational programs, or visits to a future residence), shall be encouraged and facilitated. Clients shall also be given opportunities to reorient themselves to their home community while still an inpatient.

3. See N.J.A.C. 10:37-4.

(d) Discharge planning:

1. Unified Services requirements applicable to State and County psychiatric hospitals shall also apply to community-based IPU programs. (See N.J.A.C. 10:37-6, Article XVIII.)

2. Discharge planning shall begin as soon after admission as feasible.

3. An Individual Service Plan (ISP) shall include linkages with appropriate community mental health and related social services. The ISP shall identify comprehensive service needs. (See N.J.A.C. 10:37-6, Article VIII.)

4. A review of the client's condition should be made after 24 hours in order to certify/justify the initial stay. A treatment plan shall be developed within 72 hours and be reviewed after one week. Each client's treatment plan should be updated as often as possible. A formal review of a client's treatment plan after the first week should minimally be made on the 14th and 28th day of enrollment. Subsequently the Individual Service Plan shall be reviewed and updated every two weeks up to three months, and every three months thereafter. In each review, justification for continued hospitalization, if necessary, should be recorded.

5. If a client is readmitted, the Unit should ascertain and document where a breakdown in the individual's community and natural support systems, his/her personal adaptive capabilities, and/or emotional or physical condition occurred, so as to avoid subsequent breakdowns.

10:37-5.60 Staff

(a) To adequately evaluate and meet the needs of clients, IPU programs shall have available a sufficient number of appropriate and qualified clinical, administrative, and support staff.

(b) A mental health professional from the disciplines of psychiatry, psychology, social work, or psychiatric nursing shall be designated as Director of the Program Element. If the Director is not a psychiatrist, he/she should have at least a Master's degree and several years of experience in direct service in mental health.

(c) A Board-certified or a Board-eligible psychiatrist shall work at least 10 hours per week in the Unit. Psychiatric time beyond 10 hours shall be related to the number of beds in the Unit and the number of minimum hours required per client per week. If the Director of the program is a psychiatrist, another psychiatrist shall be on-call in his/her absence for the direct medical and psychiatric supervision of all inpatients.

(d) In addition to the Director and medical/psychiatric coverage, other IPU staff shall include persons from a variety of disciplines, such as: psychology, social work, nursing, education (for children), rehabilitative counseling, and activities therapies. In addition, such other ancillary and paraprofessionals shall be utilized as appropriate.

(e) Persons with expertise in specialized areas such as addiction, battered women, rape and suicide prevention should be on staff or available as consultants.

(f) Qualified personnel shall be involved as staff, consultants, or affiliates, when indicated, in physical health services, speech, hearing, pharmacy, clinical testing, etc.

(g) The program shall have a written plan which delineates the number and qualifications of its clinical, administrative, and support personnel as determined by considering the following:

1. The size of the program;
2. The clinical characteristics of the client population;
3. The functional needs of the clients;
4. Other special characteristics of the program's clients, for example, age, substance abuse; and
5. All applicable Federal, State, and local laws and regulations.

(h) When appropriate clinical staff members are not available or not needed on a full-time basis, arrangements shall be made to obtain sufficient back-up and supplementary services on an attending, continuing consultative, or part-time basis.

(i) IPU programs shall have on duty, at all times, a licensed or registered nurse to plan, assign, supervise and evaluate nursing care, and to assure that patients receive the nursing care required.

(j) Licensing and credentialing shall be in accordance with JCAH psychiatric inpatient program management. The IPU shall verify licensure and qualifications of all staff.

10:37-5.61 Setting

(a) IPU Services shall be provided in a setting as close to a normal home environment as possible, without sacrificing client safety or care. The Unit shall be furnished and decorated to effect a home-like environment. Clients shall be encouraged to use personal belongings: clothes, toiletries, etc.

(b) The program shall provide adequate activities space.

(c) Private, individual counseling room(s) should be available.

10:37-5.62 Length of stay

(a) An acute inpatient admission should only last as long as it is clinically and medically justified.

(b) If a client needs an IPU stay in excess of 30 days, his/her record shall clearly indicate the clinical and functional problems necessitating longer treatment in this setting and time-limited service objectives and interventions to address these problems and to help the client towards discharge to the community.

(c) Any transfers among one State-funded IPU and any other IPU shall be clinically appropriate and shall follow the established conditions set forth in the affiliation agreements cited in N.J.A.C. 10:37-5.55(a)2 and (b)1. Any transfers to a State Psychiatric Hospital shall also adhere to the State Hospitals' Admissions Policy.

10:37-5.63 through 10:37-5.64

(Reserved)

10:37-5.65 Scope and purpose

(a) C & E shall include preventive activities such as:

1. Social action;
2. Community organization and class advocacy services, as well as;
3. Community education;
4. Information and referral;
5. Consultation; and

6. Evaluation of C & E programs. Emphasis shall be on improving community awareness and receptivity, in order to offer target populations greater self-determination and a better quality of life.

(b) The Program Element shall focus on the following goals:

1. To promote the mental health and reduce the incidence of mental illness in a Service Area, paying particular attention to the target population's needs.

2. To initiate social action to change conditions in the community that restrict opportunities or pose obstacles for target populations as noted in N.J.A.C. 10:37-5.2 and other vulnerable segments of the population.

3. To inform individuals, agencies, and organizations about the appropriate role of mental health services within the larger human services system. To educate the community about natural support systems which can be tapped to alleviate problems, without entering the specialized mental health system and thereby:

i. Reduce the number of inappropriate referrals to mental health agencies and psychiatric hospitals; and

ii. Encourage gatekeeper use of generic services and community-based alternatives to hospitalization (for example: educating boarding and/or nursing home operators about the Service Area's 24-hour emergency/crisis intervention service).

4. To increase community awareness of the mental health needs of the target populations and of the community-at-large through mental health education.

5. To actively involve broad community participation, at the local level, to organize and coordinate existing community resources and to develop new ones.

6. To maximize the community's capability to exercise control over the development of its own resources and the establishment of supportive environments, through advocacy, which are conducive to mental health

10:37-5.66 Designation of responsibility

(a) The C & E Director shall report directly to the mental health agency director, as a full member of the agency's mental health administration.

(b) C & E Staff, through its director or designee, shall provide liaison services, as needed, to the agency's governing and advisory boards.

(c) C & E shall be responsible for informing the public about the network of Service Area mental health services (including appropriate Federal CMHC affiliate services) available to the community. The C & E Staff shall be knowledgeable of other mental health components within their own agency and of affiliated providers and shall establish mechanisms (such as regular meetings, updated program descriptions, etc.) to communicate relevant information regarding intra-and inter-agency mental health and related social services.

(d) C & E Staff shall participate, as needed, in Service Area needs assessments. While working with community groups, any blatant service gaps in the Service Area shall be communicated to the agency director. To insure this representation, the C & E director must meet regularly with the agency director and with other department heads and affiliate agency directors.

10:37-5.67 Funding requirements

(a) "Consultation" shall refer only to programs aimed at agencies, organizations and groups of people, NOT those provided directly to individual clients.

1. "Case consultation" to assist staff in other community service agencies to prevent target group clients (noted in N.J.A.C. 10:37-5.2) from unnecessarily entering the formal mental health service system may be provided under C & E.

(b) Support for the C & E element will be restricted to agencies offering both components of service: consultation and community education.

10:37-5.68 Target agencies and populations

(a) The following are target agencies and populations:

1. Mental health system gatekeepers, including but not limited to:

- i. Boarding/nursing homes;
- ii. General hospital emergency room staff;
- iii. Human service and health agencies;
- iv. Schools;
- v. Court system (judges, police, parole officers, correctional facilities);
- vi. Police;
- vii. Clergy;

2. Community-at-large, including but not limited to:

- i. Natural support groups (relatives, neighbors, landlords, etc.);
- ii. Self-help groups;
- iii. Generic service, civic, and community associations;
- iv. Business/industry;

v. Realtors;

3. Agencies/groups impacting directly on underserved populations, serving children, elderly, minorities and the poor, including but not limited to:

i. Community action agencies;

ii. Day care centers;

iii. Senior citizen programs;

iv. Agencies serving children such as DYFS and the Departments of Education and Corrections.

10:37-5.69 Services

(a) Services to be provided: The C & E Program Element shall include, but not be limited to, these services:

1. Community organization (See Service Dictionary for specific definitions):

i. Locality development;

ii. System planning (in concert with the County Mental Health Board);

iii. Social action.

2. Systems/staff/case consultation;

3. Information and referral;

4. Community education and resource development.

(b) Priorities:

1. C & E departments shall develop annual C & E plans which include goals, objectives, current and projected programs, and identified target organizations and/or population groups. This plan shall be consistent with:

i. A community needs assessment, including data available regarding underserved geographical areas and/or populations in the agency's Service Area. This needs assessment shall be performed by the Research and Program Evaluation staff in the agency, whenever such staff is available;

ii. Inappropriate Service Area referral sources to State and county psychiatric hospitals; this data shall be gathered by the Emergency and Screening programs in the Service Area and should then be shared with C & E for coordination of Community Education efforts;

iii. County mental health plan;

iv. State and/or Federal Service Guidelines for C & E;

v. Overall center goals;

vi. Staff competencies;

vii. Cost effectiveness.

2. C & E objectives should be measurable, with clearly outlined, time-limited action steps for achievement.

3. Each C & E plan shall also include an outcome evaluation mechanism to:

i. Judge the impact of its C & E program on the audience, the service system, or the Service Area's target populations (as noted in N.J.A.C. 10:37-5.2); and

ii. Provide feedback from targeted agency/group/organization as to their perception of the C & E program's value.

4. In addition to (b)1 through 3 above, the C & E annual plan must address the following State C & E service priorities as well:

i. Incorporation of consultation/education aimed at boarding homes/single room occupancy residences in the Service Area. C & E staff shall develop programs for operators which:

(1) Make them aware of community-based emergency/crisis intervention services, as well as other services offered by the community agencies;

(2) Help them to utilize and recognize need for linkages with mental health and related social services as alternatives to hospitalization.

ii. Working with the Service Area Screening Service, if one exists, to identify gatekeepers referring people to State/county hospitals without first being screened by a community mental health agency. In conjunction with Screening Staff, C & E staff shall help to develop a coordinated inservice training program for its Service Area which:

(1) Sensitizes gatekeepers to the existence of community mental health services;

(2) Urges their utilization of community-based alternatives to hospitalization; and

(3) Increases their knowledge and skills in effectively serving individual clients appropriately.

iii. Locality development activities which will lead to expanded employment and housing opportunities for mental health target populations.

5. Staff shall identify local community resources, potential natural support systems and generic community services. Through community education, C & E shall

try to gain access for target populations to those services and to serve as a catalyst for the development of a coordinated network of service options for target groups and self-help groups.

6. The active participation and initiative of local communities shall be encouraged and considered vital to the success of the C & E Program.

7. A variety of methods shall be employed. These shall include, but not be limited to: systems/class advocacy, community meetings, workshops, training presentations and locality development. Systems planning, needs assessments and/or service utilization surveys may also be done but should be coordinated with the County Mental Health Board's planning process and existing Federal CMHC's Research and Evaluation Program in a particular Service Area.

8. C & E Staff shall give information regarding the service needs of the mental health target populations to the agency Director.

9. In implementing the above, the C & E Staff shall attempt to be change agents within their own agency, as well as in the larger community, by systematically working with community organizations, identifying community service needs and suggesting ways to modify service models to meet those needs.

10:37-5.70 Staff

In all State-funded C & E Programs, there must be an identifiable C & E Unit with a designated Director. He/she must be involved in the actual delivery of C & E services as well as in their coordination, planning, development, and evaluation. The Director shall have demonstrated experience in both community education and organization.

10:37-5.71 Setting

Workshops, lectures, discussion groups and programs may be held on-site or off-site. Outreach attempts must be made to reach gatekeepers, human service agencies and natural support systems.

10:37-5.72 through 10:37-5.73

(Reserved)

10:37-5.74 Scope and purpose

(a) Systems Advocacy Services shall be available to the State target populations, as well as any underserved groups or geographical areas defined in an approved county plan.

(b) SA Services shall provide clients with a cluster of services that shall be available to the client, independent of and in addition to the mental health and other services that the client may require, desire, and/or currently be receiving. For example, SA Services may provide individual support, lay advocacy, legal representation, companionship, and, where necessary, service procurement, to clients in institutional, community agency, and/or natural settings.

(c) The systems advocate may promote client interest through participation in the development, implementation, and/or monitoring of Individual Service Plans for specific target population clients.

(d) The systems advocate shall work with the client and providers of service toward achieving the highest degree of independence for that client through promoting and participating in the progressive utilization of less restrictive, more normative settings and services.

(e) The systems advocate shall encourage, and, where necessary, ensure continuity and comprehensiveness of care and opportunities for community involvement.

10:37-5.75 Designation of responsibility

(a) The goal is to have a SP Program Element in each county, in order to offer SA Services to target population clients entering the mental health system. The specific role of the SA program in a particular county shall be outlined in an approved County Plan and/or in the State Mental Health Plan.

(b) Each SA program shall be sponsored by an organization, or a component thereof, independent of a direct mental health or other human service provider. Such an entity might be, but is not limited to, a County Mental Health Association, advocacy group, etc. The Division may waive this requirement if an agency presents an organizational structure which demonstrates clear administrative autonomy between the advocacy activities and the provision of direct services.

1. For the purpose of this section, "Direct Services" shall mean the provision of any one of the other Program Elements contained in this chapter or related social, vocational, and housing services.

(c) Counties designated by the Division in the State Plan and determined by the Division to have complied with the funding priorities noted in N.J.A.C. 10:37-5.1(a), (b) and (c),

shall work with the Division to develop a SA Program in the Fiscal Year following that designation.

(d) Each SA program shall be formally affiliated with all mental health provider agencies (including State and county hospitals), the County Mental Health Board, and related human service providers (especially housing and county welfare).

1. Affiliation agreements with mental health providers must clearly define the local role of the SA program and assure client access.

2. Affiliation agreements with human service providers must assure that their services be accessible and available to mental health target population clients within the county.

3. Each SA program shall be formally affiliated with all external advocacy groups, particularly those that seek to redress client grievances, and/or abridgement of clients' rights. At a minimum, this must include the Division of Mental Health Advocacy and the County Mental Health Board.

(e) Community education/consultation activities aimed at non-mental health/human service gatekeeper agencies, as appropriate, shall define the role of the SA program if/when a SA client comes into contact with that gatekeeper agency.

(f) The SA program shall participate in client complaint procedures as determined by the Division and consistent with the regulations in N.J.A.C. 10:37-4.6.

(g) The SA program may work with C & E programs of mental health agencies, volunteer groups, etc. to facilitate the integration of mental health clients into local communities through companionship, community education, and other volunteer programs.

(h) The SA program may periodically site visit mental health agencies and State and county hospitals that serve its area and prepare reports to the County Mental Health Board and the Division, if such a role is identified as appropriate by the county and/or the Division.

(i) SA workers shall provide outreach to boarding homes to assure availability of services to residents, as needed.

(j) The SA Program Element shall not engage in the provision of clinical mental health services.

10:37-5.76 Funding requirements

(a) SA Program Element may be funded by, but is not limited to:

1. Grant-in-aid;
2. Community care and/or Federal CMHC;
3. Title XX; and
4. Other State or Federal funding sources.

10:37-5.77 Population priorities

(a) SA programs shall serve target populations as indicated in N.J.A.C. 10:37-5.2.

(b) When appropriate, every attempt shall be made to work with the families and other natural supports of all populations served.

10:37-5.78 Services

(a) Services to be provided may include, but shall not be limited to:

1. Service planning: Including, at a minimum, participation in preparation of Individual Service Plans, for specified clients.

2. Personal advocacy:

i. Monitoring of Individual Service Plan (see N.J.A.C. 10:37-5.78(b) 5).

ii. Assisting when necessary, or requested by client, in service procurement (see N.J.A.C. 10:37-5.78(b)2).

iii. Assisting, when requested by client, in the initiation of both internal (see N.J.A.C. 10:37-4.6) and external grievance procedures.

iv. Ensuring, and where necessary or requested by client, assisting in the utilization of the least restrictive, most normative setting/support system.

3. Legal services and procurement of public entitlements.

4. Companionship (see N.J.A.C. 10:37-5.78(b)4).

5. Service coordination and monitoring (see N.J.A.C. 10:37-5.78(b)2 and 3).

6. Outreach services: At a minimum, this shall include efforts to contact boarding homes and other residential facilities, in order to familiarize potential clients with the above services.

7. Information and referral services.

(b) Service approaches:

1. The SA worker shall act as a companion, advocate, supporter, and/or representative for clients. The client's expressed interest is paramount in deciding what role the SA worker will pursue. These roles may include that of:

i. Broker/service procurer;

ii. Mediator/negotiator for client with agency: to reach consensus as to the desirability of specific services.

iii. Advocate: to request that client receives services to which he/she is entitled.

2. When a mental health agency or program is, for some reason, unable to assist in service procurement, or if the client so request, the SA program shall fulfill service procurement functions, for non-mental health services, as required by the client (for example: housing, welfare, medical assistance, employment, etc.). This function shall be performed in close conjunction with the involved mental health agency(ies) and their internal Primary Service Procures who have been identified for each client as required by N.J.A.C. 10:37-5.1.

3. The SA worker shall help assess the client's interest in and ability to live independently. An important function of the SA worker in assisting the client to achieving independent living is through the coordination of systems (Institutional, organized community resources, and natural supports) that might not normally or regularly interact with one another. Companion advocates shall encourage clients to take advantage of available services.

4. Current involvement by client with a funded mental health agency or program is not a necessary condition for SA services. A SA worker may maintain a relationship, upon request, with a former mental health client after formal mental health services have been terminated. In cases when an individual requests help, but refuses formal mental health services, the SA worker may provide companionship, service procurement, legal representation, etc.

5. A function of a SA worker may be to monitor the implementation of completed Individual Service Plans for a specific group of targeted clients, as determined necessary by the Division.

10:37-5.79 Staff

(a) SA staff shall minimally include:

1. Program Director with two years of experience in administration, advocacy, service procurement and community organization.

2. SA workers, who may be paraprofessionals, with a minimum of two years of experience in advocacy, counseling, community organization, service procurement or a related area.

3. The recruitment of qualified former mental health clients and volunteers shall be encouraged.

10:37-5.80 Setting

(a) SA programs shall take place at locations convenient to the client. SA shall establish working hours or an on-call capability to provide services to clients at State and county hospitals, boarding homes, gatekeepers, courts and mental health agencies as needed in the appropriate Service Area(s).

(b) The primary location of SA activities should be in the local community with the client.

Subchapter 6. General Administrative Requirements for All State-funded Community Mental Health Program Elements.

10:37-6.1 through 10:37-6.12

(Reserved)

10:37-6.13 Compliance requirements

The Division shall reserve the right to establish conditions and/or consequences for non-compliance with this chapter, which may include but not be limited to: notice of outstanding areas of non-compliance, mandatory phase-in schedules, reduction in funding and/or termination of funding, to become effective subsequent to June 30, 1981.

10:37-6.14 Waiver

For special demonstration projects or for cases in which there are documented, extenuating circumstances, the Division reserves the right to waive any part of this chapter. Requests for such waivers shall be submitted to the Division, and to the County Executive and/or the County Mental Health Board, in writing, and must receive written approval from the Division prior to implementation.

10:37-6.15 Appeals

Agencies funded to provide any of the Mental Health Program Elements described herein and facing reduction or termination in funding, due to non-compliance with this chapter, shall have the right to appeal that decision to the appropriate County Mental Health Board, to the Division Director or designee, to the State Community Mental Health Advisory Board, and then to the Department, in that order.

10:37-6.16 through 10:37-6.18

(Reserved)

10:37-6.19 Scope and purpose

When a client's Individual Service Plan identifies the need, that client should be enrolled in a Consumer Health Education program(s). Consumer Health Education (CHE) is a type of Daily Living Education Program which includes structured learning experiences to increase competencies. Competency areas include: participation in normative roles of living, as a social being, worker, home manager, consumer and citizen. Community mental health program staff should provide or arrange linkage to appropriate CHE programs as part of ongoing Assessment/Evaluation and Service Procurement processes for clients. As often as possible, a client should be encouraged to enroll in Adult Education and other mainstream educational programs.

10:37-6.20 Specific requirements

(a) CHE should be conceptualized within an educational design and should include courses in the following categories:

1. Personal and physical health care: To assist individuals with their own physical appearance and health; to encourage them to participate in their health care process. Includes, but is not limited to: personal hygiene, rest, nutrition, safety, visits to physicians, dentists, etc. Sample courses are: Dental Hygiene, Self-Medication, Learning about Your Epilepsy, Hypertension, Diabetic Self-Care, Coiffure and Cosmetology, Basic Hygiene, Physical Fitness and First-Aid.

2. Human behavior: To teach individuals aspects of human interaction and to help them incorporate positive learned behaviors into their daily lives. Sample courses are: Loneliness, Anger, Self-Appraisal, Human Communication, Human Sexuality, Women's/Men's groups, Death and Dying.

3. Home management and vocational planning: To instruct individuals in the skills necessary for living and working in the community. Such programs include: Use of the Telephone, Housekeeping, Nutrition, Shopping, Cooking, Banking and Money Management, Filling out Job Applications, Interviewing Techniques and Transportation.

4. Community adjustment, services and leisure activities: To inform individuals of the resources and services available within the community and to advocate for their use. Courses include: Library Orientation, Community Awareness, Voting, Senior Citizens Groups and Community Resources.

(b) Specific courses should be developed within the context of stated goals and behavioral objectives.

(c) The actual learning experience may occur within a classroom setting, a simulated setting or in the community (bank, library, grocery store, etc.), provided or arranged by a mental health program.

10:37-6.21 Necessary community involvement

(a) Staff shall make every effort to involve community services/resources available to the general public in providing CHE skills development programs, preferably within the community. Community resources such as Neighborhood Health Centers, Planned

Parenthood, Adult Education courses, Voter Education/Registration programs, etc., shall be explored and clients made aware of their available offerings.

(b) Staff should instruct additional providers of services such as affiliating students, community volunteers, etc., in the concepts of CHE and urge them to provide skills development courses as part of their agency's programs.

10:37-6.22 through 10:37-6.41

(Reserved)

10:37-6.42 Scope and purpose

(a) Scope:

1. Service/Treatment planning should begin at the time of a client's entry into any mental Program Element, except Emergency Services.

i. In the case of ES, crisis stabilization shall be the first service priority. After stabilization, if the client needs ongoing mental health services, a comprehensive service plan shall be developed by the Screening Program Element, if available in that Service Area, or the OPD Program Element. ES shall make that linkage.

2. Service/Treatment planning shall continue through discharge from one Program Element and/or referral to another Program Element. Reassessment of client needs and the appropriateness of the ISP shall be made at regular intervals, as specified by JCAH standards for community mental health services.

3. Emphasis should be on a client's strengths and interests, so that abilities can be built into the ISP and utilized to alleviate problems and to enhance the client's feeling of self-worth.

4. A provider agency shall adopt such policies and practices as are necessary to provide appropriate informational materials concerning advance directives for mental health care to all interested consumers and their families and mental health care representatives, and to assist consumers interested in discussing and executing an advance directive for mental health care.

5. Before formulating any ISP, staff shall consult with the client and with the DMHS Registry to establish whether the client has executed an advance directive for mental health care. Any directive of which the provider agency becomes aware shall be considered in formulating the ISP. At the time the ISP is developed, and at any time the ISP is reviewed or modified, the client shall be counseled about the opportunity to execute or modify any such directive, based on the current need for care and treatment preferences of the client. Disputes about the implementation of an advance directive shall be subject to the process provided in accordance with the requirements of N.J.A.C. 10:37-4.6

6. Comprehensive ISPs shall consider key areas of life support need: living arrangements, education, vocational services, financial assistance, legal services, companionship, and medical care, as well as clinical treatment.

(b) Purpose:

1. Once completed, the ISP shall serve as a monitoring device, to insure that needed and appropriate services are being delivered in a timely manner.

2. The documentation provided by the ISP shall provide a logical record against which client progress can be reviewed.

3. The ISP shall become the basis for Service Procurement and advocacy services for each client, as defined in the Division's Service Dictionary.

4. The ISP should identify Program Element responsibilities for service provision, linkages which must be made with other agencies, the time periods in which service should be rendered, and desired results.

5. The ISP shall become the vehicle for clarifying the relationship between the client's problems and the specific services planned to help those problems.

6. The updated ISP should be used to evaluate service's impact on a client's life satisfaction and daily function during treatment.

10:37-6.43 Designation of responsibility

(a) There must be a comprehensive ISP guiding service provision to each client in every Program Element except Emergency Services.

(b) Each client shall be given the opportunity and shall be encouraged to participate in the initial development of his/her ISP and in subsequent reviews and revisions of that ISP. Clients should sign their treatment plans, to indicate involvement and agreement.

(c) To the maximum extent possible, each Program Element shall involve the client's family and friends, in the needs assessment processes and in the development of the ISP, except when contradicted or when the client does not wish these other people involved. Efforts to involve clients and their natural support systems, as well as reasons for their noninvolvement, shall be documented in the client's record.

(d) When possible, an interdisciplinary team should assess client needs and develop an appropriate ISP. The team should consist of staff persons and community agencies, who are working with the client. Team participation should be a continuing process which operates concurrently with the delivery of services.

(e) When a team is utilized, there shall be a designated coordinator or "primary service procurer" who has overall responsibility for implementing the plan and insuring that linkages have been established among the appropriate Program Elements and other agencies. (See N.J.A.C. 10:37-5.1.)

10:37-6.44 Required content

(a) Each ISP shall minimally include:

1. Client needs assessment and evaluation (as defined in the Division's Service Dictionary):

i. An Individual Level of Functioning and an Environmental/Natural Support System Assessment shall be completed for every client, except those in Emergency Services for whom this is not feasible.

(1) Agencies which want to propose the use of a Specific Level of Functioning (SLOF) scale other than the instrument developed by the Division, must submit their rationale and instrument to the Division for approval, prior to implementation.

ii. The client's own perception of his/her abilities, problems, distress areas, and aspirations, should be taken into account.

2. Service/treatment goals and objectives:

i. Based on the needs assessment, goals should be recorded and specify desired impacts on the functioning of the client, the client's environment, and/or emotional distress.

ii. Each goal shall be specified by specific time-frames and action steps.

iii. Criteria for service/Program Element termination and a projected discharge date should also be included. Discharge planning should be a part of the initial ISP, whenever possible.

3. Accountability:

i. There should be a clear relationship between the needs assessment's identification of problems and the individual services to be delivered to each client.

ii. Each ISP shall identify the persons responsible for direct provision of services and those staff responsible for linking clients to services not directly provided.

10:37-6.45 Required review and modification

(a) The client's progress towards meeting the goals outlined in the ISP shall be reviewed and updated on a regular basis.

(b) Inpatient clients shall have an ISP developed within 72 hours. It shall be reviewed after one week and every two weeks thereafter up to three months. ISPs shall be reviewed and updated every three months thereafter.

(c) For non-inpatient programs, each ISP shall be reviewed no later than 90 days after service initiation and every six months thereafter, to justify service continuation. (See

N.J.A.C. 10:37-6, Article XII.) When objectives have shorter time limits, more frequent reviews should occur.

(d) ISP shall be modified, as often as necessary, to reflect changing client needs.

(e) Progress notes included in the client's record at regular intervals should be directly related to the ISP. Progress notes shall also document regular team meetings convened for the purpose of evaluating the client's progress and the ongoing appropriateness of the Service Plan.

(f) A discharge note must be completed within 15 days after discharge.

10:37-6.46 through 10:37-6.48

(Reserved.)

10:37-6.49 Least restrictive setting

(a) Services shall be organized to meet the comprehensive needs of individual clients and shall be offered in the least restrictive environment possible, dependent on the client's functional level and emotional and psychiatric needs. Agencies shall:

1. Develop an intake procedure which, prior to the development of an Individual Service Plan (ISP), and after crisis stabilization, identifies a particular client's strengths and weaknesses, using a Level of Functioning and Companion Environmental/Natural Supports Assessment tool (see Division Service Dictionary for definitions);

2. Consider the range of services available within that Service Area and identify:

i. The service needs of that client; and

ii. The least restrictive setting available to meet those needs.

3. Consider alternatives in the following sequence:

i. Natural support systems: The client's living arrangement and the people who usually provide support to him/her in crisis. If no such people are readily identified, the staff may help the client to develop a natural support network with someone with whom there seems to be good potential for supportive contact.

(1) If the natural support system is unable to meet the client's needs in a timely manner, formal community services should be explored and used.

ii. Community services: These services should be explored and arranged as follows:

(1) Generic services/community supports: Income maintenance, housing, health, transportation, etc., shall be arranged when necessary, with the mental health Program Element acting as advocate and service procurer. In the cases of DYFS clients who are children, the primary advocate and service procurer/coordinator should be the DYFS worker.

(2) Mental health services: If the client's needs cannot be met by his/her natural environment or by the generic services available in the Service Area and client need dictates, the client shall be provided with local community mental health services, either by the intake agency, or through alternative arrangements with other mental health Program Element providers in the Service Area. The least restrictive alternative, i.e., ambulatory Outpatient Program Elements, should be emphasized over more restrictive, i.e., inpatient alternatives, as appropriate.

iii. Division of Youth and Family Services (DYFS) residential network: Residential services provided directly and through contract by DYFS are appropriate for placement of children whose natural support setting is no longer sufficient to maintain a child in his/her home. Mental Health support services shall be provided, as needed, by mental health providers.

iv. Institutional: Local, inpatient units in general hospitals should be emphasized over less local settings, such as a county hospital. County psychiatric hospitals shall be the preferred setting, rather than a Regionalized State hospital, in Service Areas where General Hospital inpatient units are not available. The community mental health agency in that Service Area shall then work with the Hospital to maximize the therapeutic benefit of the IPU stay while also beginning discharge planning as quickly as possible.

10:37-6.50 through 10:37-6.52

(Reserved)

10:37-6.53 Medication education and counseling

(a) All State funded Mental Health Program Elements using medication as a therapeutic modality shall regularly provide counseling services aimed at informing clients about medication(s) and the potential interactions if combined with alcohol or non-prescribed drugs. Medication counseling shall be included within the service plan of each client for whom psychotropic medication has been prescribed. Counseling efforts shall be documented in the client's record.

(b) As part of their medication counseling, such clients shall receive an individual written medication information fact sheet for each prescribed medication. The Division shall, if requested by an agency, supply a sample format for these fact sheets. Such fact sheets shall delineate the medication's purpose and potential side effects, as well as responses to potential side effects and any special precautions, for example, heat related precautions, of which clients should be aware. Clients shall also have the opportunity to participate in a planned program of self-medication which shall teach clients to administer their own prescribed medication dosage and to report side effects promptly. Explanations shall also include:

1. Types of medication prescribed;
2. Name of medication(s), dosage(s), and time to take medication(s);
3. Effects of medication(s), including expected benefits, risks, side effects and special precautions, for example, hypothermia;
4. Prescriptions;
5. Whom to go to with questions (for example, physician, nurse, pharmacist);
6. Reimbursement options for medication purchases;
7. Reasons for regular medical check-ups at recommended intervals; and
8. The dangers of combining prescribed medications with alcohol or non-prescribed drugs.

(c) Medication counseling should occur whenever a different medication is prescribed, whenever a significant change in dosage is made or whenever there is a history or suspicion of alcohol or chemical abuse. Counseling may be provided by a physician, nurse, certified nurse practitioner/clinical nurse specialist or by a community or

consulting pharmacist; however, counseling should be coordinated with the physician or the certified nurse practitioner/clinical nurse specialist prescribing the client's medications.

(d) Agencies shall have policies to provide written and verbal information on medications, side effects and special precautions such as those that are heat related, to immediate family members, defined as parents, spouse, adult siblings and adult children and, where appropriate, to others designated by the client as involved in a care giving role. A client's consent shall be obtained in order to release the aforementioned information. Written information shall be in a language understandable to the recipient. Provision of such information to the recipient shall be documented in the client's record.

(e) The agency shall provide for direct care staff to receive education regarding types of medication, their adverse reactions or potential side effects, special precautions, and procedures to respond to adverse reactions. Such education shall be documented.

(f) Prior to May 1 of each year, agencies shall make clients, staff, and appropriate family members aware of heat related problems in relation to psychotropic medications.

10:37-6.54 Psychotropic medication

(a) "Psychotropic medication" shall include medications which have a direct effect upon the central nervous system and are capable of modifying behavior and/or mood. Drugs included, within the context of this chapter, are:

1. Anti-psychotics;
2. Anti-depressants;
3. Agents for control of mania and depression, such as lithium;

4. Anti-anxiety agents;
5. Anti-convulsants; and
6. Psychomotor stimulants.

(b) Before initiating treatment with psychotropic medication(s), a comprehensive drug history shall be obtained and documented with special emphasis on which drugs have, in the past, produced a positive response, and which drugs have caused allergic or toxic reactions. Unfavorable reactions shall be emphasized in the record and listed as individual risk factors. In cases where the client may have taken a combination of drugs prior to coming to the agency, inquiries shall be made, especially with regard to alcohol, street and over-the-counter drugs.

(c) Agencies shall establish protocols for early detection, intervention and documentation of response to troublesome side effects and allergic or toxic reactions to medication.

(d) To avoid serious drug interactions, communication shall occur between the physician or the certified nurse practitioner/clinical nurse specialist treating the mental illness and other physicians who may be treating other diseases in the same client. The patient's medical record shall contain documentation by the treating physician or the certified nurse practitioner/clinical nurse specialist of the communication.

(e) Progress notes or a checklist for citing medication reaction shall be in each client's chart. This documentation shall be completed by a physician, a nurse or a certified nurse practitioner/clinical nurse specialist on admission, updated on the appearance of abnormal signs, and notes made each time the medication is reviewed.

(f) Target symptoms to be treated shall be recorded in the client's record, as a baseline against which the client's clinical condition is evaluated. Effects of medication on the target symptoms and behavior shall be reviewed and recorded.

(g) Medications shall be reviewed, at a minimum, each time the treatment plan is reviewed, based upon requirements stated within Division of Mental Health Services program rules. Results of these reviews and new treatment recommendations shall be recorded in the client's record by medical staff.

(h) The use of psychotropic drugs in children should be carefully scrutinized. In those situations where the manufacturer or the Food and Drug Administration does not recommend certain dosage levels, or where a specific medication is not approved for children, in spite of its apparent clinical effectiveness, the physician or the certified nurse practitioner/clinical nurse specialist should seek a second opinion in writing from a qualified child psychiatrist, pediatrician, or clinical pharmacologist. Written informed consent shall be secured from the parents or guardians, specific to the use of any psychotropic medication(s).

(i) Clients shall have the right to refuse medication and to be free from unnecessary or excessive medication. Consumers' medication experiences should be considered by physicians in their medication practices and their preferences granted whenever it is clinically and pharmacologically sound to do so.

10:37-6.55 through 10:37-6.72

(Reserved)

10:37-6.73 Scope and purpose

(a) A written record shall be maintained for each client served. The record shall:

1. Describe the client's status at service initiation, a comprehensive needs assessment, services provided and progress made, and the client's functional ability and status at the time of discharge from a Program Element, with followup/transfer or additional linkages noted as part of Individual Service Plan (ISP). (See Article VIII of this subchapter.)

2. Substantiate that the assessment process served as the basis for the service plan.

3. Serve as a basis for service coordination, implementation, evaluation, quality assurance, and training.

4. Be current and accurate.

5. Facilitate the determination of the client's problems and the service which is being provided at any specified time.

6. Provide documentation of the staff's having followed regulations concerning client rights. (See N.J.A.C. 10:37-4.5.)

7. Provide documentation of the involvement of the client, parents, siblings, school personnel, employer, friends, community agencies and other significant figures involved in the client's service/treatment plan.

10:37-6.74 Required contents for all records

(a) The client record shall contain the following information:

1. The identifying and other data indicated on the Division's Unified Services Transaction Form for enrolled and terminated clients.

2. Comprehensive assessment and evaluation of client needs, including level of functioning and a natural support resource inventory for all clients.

3. A social, psychological, and/or a psychiatric mental status evaluation, as needed.

4. Individual service plan with updated revisions.

5. A copy of any advance directive for mental health care executed by the patient, and a note that indicates the whereabouts of any copies of the directive, including whether the advance directive has been registered with the DMHS, if known, or if no advance directive has been executed, a note documenting the actions taken by the staff of the agency to provide the client with the opportunity to execute an advance directive.

6. Clinical diagnosis based on the clinical evaluation of the client.

7. Client and/or mental health care representative consent for a service initiation, evaluation, or research, as permitted or required by law, and appropriate authorizations for record sharing.

8. Utilization Review Committee meeting notes which include the attendees, recommendations made, and actions taken.

9. Medications.

10. Laboratory or other diagnostic procedures.

11. Unusual incidents, occurrences such as:

i. Treatment complications;

- ii. Accidents or injuries;
- iii. Morbidity;
- iv. Death of a client; and
- v. Procedures placing the client at risk or causing pain/harm.

12. Correspondence related to the client and signed, dated notations of relevant contacts regarding the client's service/treatment.

13. Discharge or transfer summary in addition to the discharge plan which shall also be developed with the client and completed within 30 days of last service.

14. The record shall contain documentation of procedures that place clients at risk or in pain including, but not limited to restraint, seclusion; and/or behavior modification using painful stimuli. Such records shall document the justification for the use of the procedure, attempts of staff to provide alternatives, the specific procedures employed, the required authorization, and the measures taken to protect the client's safety and rights.

15. All entries in the record shall be legibly signed and dated.

10:37-6.75 Inpatients records: supplementary content requirements

(a) Inpatient records in State, county, and State funded general hospital psychiatric units shall include all information cited above. Additional information necessary to meet State licensure and Federal accreditation shall also include:

1. Results of evaluations and services: Psychological testing, educational and socio-vocational evaluations, pathology and clinical laboratory examinations, radiology

examinations, psychiatric and other medical treatment, and any other diagnostic or therapeutic procedure performed.

2. Psychiatric evaluation: Mental status, psychodynamics, sociodynamics, precipitating stress, premorbid personality, tentative diagnosis, a treatment plan, prognosis based on that plan, and subsequent modifications of the plan.

3. Physical examination if performed, shall include pertinent findings.

4. Admission notes: All additions to the history and subsequent changes in the physical findings.

5. Progress notes: Written by medical staff members or other individuals who have been granted clinical privileges, nursing staff, the interdisciplinary treatment team members, consultants, community liaison staff, and/or ancillary service staff.

6. Progress notes: By staff cited in (a)5 above, documenting the treatment plan, a pertinent chronological report of the client's functional abilities and clinical condition, changes in each condition and the results of service/treatment. Progress notes should include only pertinent, meaningful observations and information.

7. Medical orders: Written only by members of the medical staff and medical residents.

8. Telephone orders: Given by a physician only; shall be accepted and written by a licensed nurse only; such action shall be limited to urgent circumstances. Telephone orders shall be authenticated by the responsible physician within 24 hours, specifying date of initial contact or admission to the program.

9. History: Incorporating the client's chief complaint, details of present illness, past service history, and social, vocational and family history. The history shall be a record of information provided by the client or by his agent.

10. A Summation, in the event of a patient's death, in the form of a discharge summary, shall include the circumstances leading to death and shall be signed by a physician.

11. An autopsy shall be performed whenever indicated and results recorded in the record within 72 hours; the complete protocol shall be made a part of the record within three months.

10:37-6.76 Policies and procedures regarding recordkeeping

(a) All agencies shall have written policies and procedures governing the compilation, storage, dissemination, and access to client records. (See N.J.A.C. 10:37-6.79.)

(b) Policies and procedures shall be designed to ensure that:

1. The program fulfills its responsibility to safeguard and protect the record against loss and unauthorized alteration or disclosure of information;
2. The content and format of client records are uniform; and
3. Entries in the client record are dated and signed.

(c) The agency shall provide adequate physical facilities for the storage, processing, and handling of records. The facilities shall include suitably secure rooms and files.

(d) When a program stores client data on magnetic tape, computer files, or other types of automated information systems, adequate security measures shall prevent inadvertent or unauthorized access to such data.

(e) The program shall maintain an indexing or referencing system that permits the location of a record that has been removed from a central file area.

10:37-6.77 Retention of records

(a) Records of adults must be retained five years after the last date of service. Records of children must be retained for five years after they reach their 18th birthday.

(b) Records may be destroyed by burning or shredding. The destruction must be complete; no readable material or client identification may remain.

(c) A list of the destroyed records must be kept on file for an additional five years. This list should include the client's name, case number and date of destruction. It should be signed by the staff person who supervised the records' destruction.

10:37-6.78 Record departments

(a) All Federally funded community mental health centers and all psychiatric hospitals shall have Records Department, adequately directed and staffed to facilitate the accurate processing, checking, indexing and filing of all records.

(b) Appropriate records for active clients shall be kept on the unit where the client's services are primarily provided and shall be directly accessible to the service staff.

(c) Records for terminated clients shall be maintained in a central location under the supervision of the Records Department.

(d) All records services shall maintain a system of identification and filing to facilitate the prompt location of client records. It is desirable that the model for the unit record system be used.

(e) Records departments shall maintain, control and supervise the records and their quality.

(f) In Federally funded community mental health centers and psychiatric hospitals, a qualified records librarian or an accredited records technician shall be hired and shall advise, administer, supervise, or perform work involved in the development, analysis maintenance, and use of records and reports.

(g) Records personnel shall be involved in staff development programs, including orientation, on-the-job training, and regular inservice education programs.

10:37-6.79 Confidentiality of records

(a) All certificates, applications, information and records directly or indirectly identifying persons who are receiving or have received mental health services from a provider licensed by the Department, or for whom such services were sought, shall be kept confidential and shall not be disclosed by any person, except under the following circumstances:

1. Upon authorization of the consumer:

i. For adult consumers: Upon the written authorization of the consumer, or his or her legal guardian or authorized representative, if any.

ii. For consumers who are minors:

(1) A minor, 14 years or older, who has requested admission and has been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service

pursuant to R. 4:74-7A(c), may authorize the disclosure of his or her records in the same manner as an adult;

(2) The minor's parent or legal guardian may authorize the disclosure of the minor's records, provided that the minor shall be given prior notice and an opportunity to object to the disclosure. Objection by a minor, 14 years or older, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service pursuant to R. 4:74-7A(c), shall render the authorization of the parent or guardian void; or

(3) Disclosure of the clinical records of a minor, 14 years of older, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service, pursuant to R. 4:74-7A(c), is permitted only upon written authorization of the minor; however, a parent or guardian, upon proper inquiry, shall be told the minor patient's current medical condition if the minor does not object to such disclosure;

2. Pursuant to court order directing disclosure, upon its determination that disclosure is necessary for the conduct of its proceedings before it and that failure to make such disclosure would be contrary to the public interest; or

3. To carry out the provisions of Title 30 or Article 9 of Chapter 82 of Title 2A of the New Jersey Statutes (N.J.S.A. 2A:82-41), or as required by other Federal or State law.

(b) Consumer records may also be disclosed to the following persons, upon presentation of appropriate credentials, under these circumstances:

1. Employees of the agency who are involved in the care of the consumer provided, however, that when a consumer enters treatment(s) he or she will be informed that agency staff will have access to his or her records.

i. Employees of the agency may disclose information that is relevant to a consumer's current treatment to the staff of another such agency, so long as such disclosure is in compliance with the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164;

2. Clinical records and audit teams, monitoring and site review staff designated by the Department, the Office of Legislative Services, the New Jersey Department of Health and Senior Services, and the Center for Medicaid and Medicare Services;

3. A person participating in a Professional Standards Review Organization; and

4. Officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies, pursuant to N.J.S.A. 52:17b-78 et seq.

(c) The records of a minor shall be released upon request to the Department of Children and Families in connection with investigations of whether the minor has been abused or neglected.

(d) Whenever possible, names of consumers shall be deleted from the records being reviewed under (b) above and consumers shall be identified only by use of their initials.

(e) Nothing in this section shall preclude disclosure, upon proper inquiry and after the consumer has had the opportunity to object and does not express an objection, of information as to a consumer's current medical condition to any relative or friend.

(f) Information may be disclosed to any licensed mental health provider or medical health care provider who has a contract with the Division of Mental Health Services or the Department of Human Services, or to the consumer's personal physician if it appears that the information is to be used for the benefit of the consumer.

(g) The records of a deceased individual who has received services or for whom services were sought may be released to the estate's administrator or executor. If there is no administrator or executor, records may be released to the next of kin indicated in the consumer record. A valid written authorization for the release of information must be obtained from next of kin:

1. Natural or adoptive parents;
2. Siblings;
3. Grandparents;
4. Family caregiver of record;
5. Spouse; or
6. Child/children.

(h) Where disclosure to third parties is authorized pursuant to (b) above, the following conditions shall be observed:

1. The custodian of the records shall, by written notice, advise the person receiving the records that disclosure without the authorization of the person who is the subject of the records, or as otherwise provided by law, is prohibited.
2. Information and records disclosed for any purposes shall be limited to that information which is relevant and necessary for the purpose of the disclosure, except as authorized by the consumer or his or her representative or required by law. Where the disclosure is between agencies for the purpose of treatment and is not limited by the

consumer's authorization, the agency releasing the information shall rely upon the recipient's assertion of need for the information.

3. A request for information regarding a consumer and the action taken upon the request shall be recorded in the consumer's clinical records and accounted for if requested by the consumer for up to six years from the date of the disclosure.
4. Consumers or other persons consenting to the disclosure of records shall be informed of their right subject to (j) below to inspect the material to be disclosed.
5. Information disclosed shall be limited to information generated at the provider agency. However, the agency shall list the sources of nondisclosed information contained in the consumer's records.

(i) Consent to disclosure of records shall be evidenced by a signed authorization from the consumer or his or her legally authorized representative.

1. The authorization shall contain the following:

- i. The name of the agency disclosing the information;
- ii. The name or title of the person organization to which disclosure is made;
- iii. The name of the consumer;
- iv. The purpose of the disclosure and predictable outcome;
- v. The information to be disclosed;
- vi. The date on which the authorization is signed; and

also be documented in the consumer's records, as to the clinical data, findings, etc., that led to the denial of access.

3. A consumer is entitled to inspect or receive a copy of his or her financial records.
4. A consumer who formerly received services from an agency is entitled to inspect and/or receive a copy of his or her own records. However, if a particular consumer has been inactive for brief periods of time in the past and repeatedly requests and obtains service re-admission, the same criteria for access to records outlined in (j)2 above shall apply.

(k) Modification of records:

1. A consumer may submit in writing to the Director of the agency a statement for the purpose of clarifying or correcting his or her clinical records.
2. A consumer may request in writing to the Director of the agency an amendment or clarification of a clinical record and, not later than 30 days after the date of the receipt of such request, the agency shall acknowledge in writing such request and, within 10 days thereafter:
 - i. Make each correction, in accordance with the consumer's request, of any or all portions of a record which the consumer believes is not accurate or complete; or
 - ii. Inform the consumer of its refusal to amend the record or portions thereof, in accordance with such consumer's

request; the reason for the refusal should be explained to the consumer and documented in the consumer's record.

(l) At the time that a formal consumer record is going to be initiated for ongoing service purposes, each consumer shall receive notice:

1. Of the specific conditions under which information may be disclosed without his or her authorization;
2. That he or she may request access to his or her records;
3. That he or she may supplement or request a modification of his or her clinical records; and
4. Of the name of the agency's privacy officer and the avenues for redress of any complaints the consumer may have that his or her privacy was violated.

(m) Agency records directly or indirectly identifying a consumer shall be retained for six years.

10:37-6.80 through 10:37-6.82

(Reserved)

10:37-6.83 Scope and purpose

This article established the minimum reporting required for all agencies receiving financial assistance through the Division. Information submitted shall serve as the basis for monitoring agency compliance, as well as for planning and program development.

10:37-6.84 Designation of responsibility

(a) All agencies receiving funds through the Division are required to submit periodic client service and fiscal reports. The following regulations specify the type and frequency of reports required for each state-funded Program Element.

1. State grant-in-aid: client data:

i. Unified Service Transaction Forms (Revised MC-1-2):

(1) All agencies participating in the grant-in-aid program must maintain accurate client records for the purpose of complying with the Division's statistical reporting requirements. The Unified Services Transaction Form (USTF) represents the minimum data set which must be recorded as part of each client record. Copies of the USTF shall be available from the Division.

(2) Copies of the USTF-1 and USTF-2 must be kept in each client's clinical record at all times and made available for site reviews and program audits.

(3) All data elements found on the USTF-1 (Acceptance) and USTF-2 (Termination), are required to be reported to the Division. The USTF-1 and USTF-2 must be completed and forwarded to the State as specified in the Division's Reporting Manual. Except in extraordinary

situations, the forms should be mailed within 48 hours after acceptance or termination has occurred.

ii. Quarterly client characteristic reports: In addition to the USTF, all agencies receiving grant-in-aid funds must submit a quarterly client characteristic report to the Division. (See N.J.A.C. 10:37-5.2 for additional record-keeping requirements.) This quarterly report is an unduplicated count of target populations served by each Program Element. As specified in the Dictionary of Mental Health Terms, Program Elements include:

- (1) Consultation and education;
- (2) Emergency;
- (3) Inpatient;
- (4) Outpatient;
- (5) Partial care;
- (6) Residential;
- (7) Screening.

iii. Quarterly caseload summary: The Division will provide each agency and the County Mental Health Board with a quarterly caseload summary report. The quarterly caseload summary is a count of all case openings and closings. It is a summary of duplicated enrollments and terminations rather than a reflection of individual clients. The quarterly caseload summary report will contain the following information:

- (1) Caseload at beginning of quarter;
- (2) New admissions during quarter;

(3) Re-admissions during quarter;

(A) From the current year;

(B) From a prior year;

(4) Terminations;

(5) Caseload at end of quarter; and

(6) Sub reports on all target populations as specified in N.J.A.C.

10:37-5.2 and program histories from data forwarded on the USTF-1 and USTF- 2.

iv. Waivers: Agencies with access to computer processing capability may submit a written proposal to provide the Division with the requisite USTF data through alternate procedures. These proposals must be approved by the Bureau of Information Systems, Office of Program Evaluation, before any modification of the above procedures may be instituted by the agency.

v. Fiscal reports: All agencies receiving grant-in-aid funds are also required to submit the "Quarterly Financial Statement." This report is due one month after the close of each quarter. In addition, all the agencies will submit the "Actual Agency Budget and Income Statement," which is due by the end of the first quarter of each fiscal year.

vi. Staffing reports: All agencies receiving funds through the grant-in-aid programs or the Community Care Title XX programs will be required to submit a Uniform Staffing Report to the Division on an annual basis.

2. Contract service reports: All agencies receiving funds through the Division's Community Care or Title XX contracts shall be required to record the data on the

Unified Services Transaction Form by December, 1980. Copies of the USTF-1 and USTF-2 must be kept as part of each client record and made available for site reviews and program audits. In addition, "Monthly Contract Information Summaries" and the "Monthly Contract Expenditure Reports" must be submitted directly to the Division.

3. Submissions to County Mental Health Board: Copies of all reports submitted to the Division, other than individual USTFs, shall also be forwarded to the appropriate County Mental Health Board.

(b) All agencies licensed by the Department to provide mental health services are required to submit annual reports to the Division regarding their compliance with P.L. 2005, c. 233, the Advance Directives for Mental Health Act. The annual report shall not include patient identifiers, but shall include:

1. The number of consumers admitted to treatment during the preceding year who had executed an advance directive before admission;

2. The number of consumers who executed or modified an advance directive for mental health care while a client of the provider;

3. The number of advance directives that were invoked by the treating professionals at the facility to treat a consumer;

4. The number of persons who revoked an advance directive during the past year while a client of the agency;

5. The number of consumers who were transferred to another provider for treatment because the provisions of an advance directive permitted or authorized treatment that was not available at the reporting provider agency; and

6. A narrative that describes any systemic problems encountered during the year in the implementation of the Act, problems in accessing the Registry, complaints from patients or families, or other issues.

(c) In situations in which a transfer of care is necessary, including a transfer for the purpose of effectuating a patient's declarations in an advance directive for mental health care, a provider agency shall, in consultation with the responsible mental health care professional, take all reasonable steps to effect the appropriate, respectful and timely transfer of the client to the care of the appropriate alternative mental health care professional, psychiatric facility, or provider agency, as necessary, and shall assure that the client is not abandoned or treated disrespectfully. In those circumstances, a provider agency shall assure the timely transfer of the client's medical records, including a copy of the client's advance directive for mental health care.

10:37-6.85 through 10:37-6.87

(Reserved)

10:37-6.88 Services requiring prior approval

(a) As of July 1, 1981, no State-funded mental health program element shall be permitted to use psychosurgery, insulin therapy, electroconvulsive therapy, seclusion, and/or physical restraints, until such time as the Director of the Agency submits a

written description of the proposed policies and procedures concerning the use of such modalities, and the Division of Mental Health and Hospitals approves them in writing. General, procedural approval must be sought and received prior to implementation. Any subsequent modification in procedures requiring prior approval must be re-submitted to the Division for approval.

(b) The Division shall review proposed policies and procedures within three days of their receipt by the Division.

10:37-6.89 through 10:37-6.98

(Reserved)

10:37-6.99 Training and staff development

(a) The Division shall convene staff development sessions for State-funded agencies concerning the implementation of Division principles and administrative requirements. These sessions shall include, but not be limited to, areas such as normalization, functional and team approaches, advocacy, unified services planning, reporting requirements, etc.

(b) Agencies shall participate in these sessions as requested, and shall also reinforce the Division's sessions at the local level. Each agency shall develop a written plan or orientation for each new staff person which will include, but not be limited to, the following topics:

1. Division principles;
2. Agency goals and objectives;

3. Table of organization of agency;
4. Job description;
5. Fire evacuation procedure; and
6. Emergency procedures (for example, unusual incidence procedures).

7. Staff rights and responsibilities under the Advance Directives for Mental Health Care Act (P.L. 2005, c. 233).

(c) The Division shall also facilitate and provide training opportunities related to additional needs identified by local agencies and County Mental Health Boards.

10:37-6.100 through 10:37-6.102

(Reserved)

10:37-6.103 Scope and purpose

To implement a Unified Service System, there must be clear guidelines for continuity of care and for the interaction between the public psychiatric inpatient facilities and the community-based Program Elements responsible for residents of a given Service Area. The following regulations include requirements for each stage of hospitalization in which community and hospital interaction is essential.

10:37-6.104 Designation of responsibility

(a) County and State psychiatric hospitals shall have a recently negotiated affiliation agreement detailing community/hospital interaction procedures for every county that it serves. Each Chief Executive Officer shall designate one hospital staff person to

coordinate all hospital/community interfacing and to be responsible for monitoring the implementation of Unified Services efforts with community agencies.

(b) The Affiliation Agreements shall minimally include the procedures cited below.

1. Admissions: Criteria for hospital admissions:

i. Hospital admission staff shall be made aware of the Division's State Hospital Admission Policy and criteria. Staff should be trained to implement the appropriate screening and referral processes. If the county hospital does not choose to adopt that policy, it should formalize and implement its own criteria.

ii. Hospital admission staff shall gather and analyze Inappropriate Admissions Information on an ongoing basis. Minimally, information shall include (categories may be further delineated by Division):

(1) Number and percentage of appropriate and inappropriate referrals to hospital;

(2) Number and percentage of inappropriate referrals not admitted;
and

(3) Key referral sources to hospital of inappropriate admissions.

iii. If an inappropriate admission is made, efforts to exhaust less restrictive community-based alternatives shall be outlined. Discharge shall then be expedited. The hospital, working with BTS, DYFS, and/or the local mental health OPD agency, shall locate a more appropriate community-based living arrangement as quickly as feasible.

2. Community-based screening prior to hospital admission (see N.J.A.C. 10:37-5, Article III):

i. The hospital shall analyze the information cited in N.J.A.C. 10:37-6.104b1ii above, and determine the extent to which gatekeepers/referral agencies are screening referrals in the community prior to referral to the County or State psychiatric hospital. The hospital shall determine what percentage of admissions are by-passing mental health centers in each Service Area.

ii. Hospital admission staff shall provide feedback to gatekeeper agencies that refer inappropriately. Hospitals and community mental health centers shall coordinate their community C & E efforts to impact on appropriate agencies and to lower the number of inappropriate referrals to the State and county psychiatric hospital(s).

iii. If deficiencies in the community screening process persist, the hospital, Regional Staff of the Division, and the County Mental Health Board shall formally identify the deficiencies and shall work with the community mental health center/clinic in that Service Area to improve community-based screening efforts, gatekeeper response, and Inpatient service utilization patterns.

iv. Referrals of voluntary clients should not be made to a State or County psychiatric hospital if there are vacant beds in a local general hospital Inpatient Program Element. (See N.J.A.C. 10:37-5.8 on "Inpatient Care.")

3. Post admission and pre-discharge:

i. Admission notification procedure:

(1) The hospital shall send an Admission Notification Form to the designated Outpatient agency in each Service Area for every client who voluntarily signs an information release form. Hospital records shall

record the numbers and percentage of forms sent, not sent, clients signing information release forms, and clients not signing.

(2) The hospital staff shall encourage clients to sign an information release form and explain possible benefits of the client's involvement in unified services and joint hospital-community discharge planning.

(3) Designated OPD agency records shall minimally include the number received, date client contacted in hospital, level of functioning assessment, and Individual Service Plan (ISP) with specific objectives and time-frames.

ii. Level of Functioning (LOF) Assessment:

(1) The hospital shall complete a Level of Functioning Assessment for every client admitted to the hospital, after crisis stabilization has occurred. The LOF assessments should be utilized as one of the bases for in-hospital program planning and pre-discharge service procurement.

iii. Individual Service Plan (ISP) (see N.J.A.C. 10:37-6, Article VIII):

(1) An Individual Service Plan (ISP) shall be completed for all clients no later than seven days after the date of admission, in cooperation with the designated OPD agency.

(2) The ISP should be directly related to the LOF assessment.

(3) The ISP shall identify in-hospital as well as post-discharge service needs.

(4) A qualified mental health professional shall be assigned primary service procurement and case management responsibility, during each

client's hospitalization, insuring that the ISP is developed, implemented, and modified as client needs change.

(5) The community mental health center liaison, or DYFS when appropriate, shall assume key service procurement responsibility at the point of discharge.

(6) To the maximum extent feasible, the ISP process shall:

(A) Involve an inter-disciplinary team effort;

(B) Be inter-agency, minimally including hospital staff, Bureau of Transitional Services staff, Community Mental Health Center liaison and DYFS staff when appropriate;

(C) Directly involve the client, if possible, in identifying needs, interests, objectives, and time frames;

(D) Produce a comprehensive needs assessment including clinical needs, social, financial, vocational, housing, and educational (for children) needs, as well as identification of natural support resources.

4. Transitional units/residence on hospital grounds:

i. The hospital shall formalize eligibility and referral procedures for identified hospital living units/residences which are transitional in nature, and prepare clients for placement in the community.

ii. Programs shall be tailored to meet the clients' levels of functioning; service plans should reflect this.

iii. The hospital shall regularly reassess the participating clients' Level of Functioning, in order to minimize length of stay.

iv. The hospital shall clearly delineate the differences between transitional units if more than one exist. The relationship between these units/residences and Residential Care (RES) Program Elements in the community should be delineated in County affiliation agreements.

v. The hospital shall insure that program planning involves off-ground community orientation activities.

vi. Programs shall include "Daily Living Education" (See Division Service Dictionary.)

vii. Both the hospital and the designated Service Area community mental health center shall insure a logical continuum from hospital transitional unit(s) to available community-based resources by jointly coordinating program and discharge planning.

5. Discharge:

i. The hospital shall send Discharge Notification Forms for all discharged clients, signing release of information forms, to the Service Area's designated OPD agency.

ii. The hospital discharge summary shall minimally indicate the LOF of the client at the time of discharge, the clinical and other follow-up services needed, the Level of Care required and that of actual placement, and the agency(ies)/individual(s) responsible for placement and service procurement-- as stated on the Individual Service Plan. (See N.J.A.C. 10:37-6, Article VIII.)

(1) See Division's Service Dictionary for detailed definition of "Service Procurement."

iii. Every effort shall be made to place clients in their home county. If this is not possible, reasons shall be documented, and the client may be placed in an adjacent county.

(1) If out-of-Service Area placement is necessary, the community agency OPD liaison staff from that receiving Service Area should be involved in the development of the ISP, within three to ten days of a new admission and one month before discharge for a long-term client. Out-of-county and region placements shall not be made unless due to client preference or level of care required. (See N.J.A.C. 10:37-5.29(b)2.)

(2) All alternatives within the client's own Service Area must be exhausted before placement elsewhere, unless the client does not want to return to his/her Service Area. Out-of-Region placements shall not be made.

6. Readmission:

i. The hospital and Service Area community mental health center designated as being responsible for in-hospital liaison and post-discharge service procurement shall, upon readmission, attempt to ascertain why the client's coping mechanisms and/or community support system did not succeed and what should be done during this hospitalization to improve chances for successful community living.

10:37-6.105 through 10:37-6.107

(Reserved)

10:37-6.108 Unusual incident reporting system

(a) Every Agency funded to provide services in a Mental Health Program Element shall submit reports, as required by the Division regarding incidents that may, or already have, adversely affect(ed) the health or safety of client(s). An explicit description of the types of incidents that must be reported and an appropriate reporting format shall be developed by the Division and disseminated to all participating agencies.

(b) Any incident that includes an allegation of child abuse and/or neglect must be immediately reported to the Division of Youth and Family Services (DYFS), in compliance with N.J.S.A. 9:6-8.10. Abuse or exploitation in rooming/boarding/nursing homes shall be reported to the County Welfare Agency.

(c) This section does not, however, negate the necessity of making entries into a client's clinical record concerning accidents and injuries. (See N.J.A.C. 10:37-6.74(a)11.)

Subchapter 7.

(Reserved)

Subchapter 8. Conditions Governing State Grants for Construction

Assistance for Community Mental Health Facilities

10:37-8.1 Scope and purpose

This subchapter applies to State grants for construction assistance for community mental health facilities. The program for disbursement of these funds shall be designated as the "Community Service Capital Improvement Program."

10:37-8.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings.

"Community-based" refers to those programs and/or facilities which are not located on the grounds of, or operated by, a State or county psychiatric institution, unless approved through a written waiver by the Division.

"Community psychiatric inpatient service" means community-based psychiatric inpatient services whether free standing or hospital based, satisfying the requirements of N.J.A.C. 10:37-5, Article VII.

"Construction of facilities" means the planning, erection, acquisition, improvement, rehabilitation, reconstruction, development and extension of facilities, including the acquisition of real property necessary for said purposes.

"Outpatient and other services" means those community-based services described in N.J.A.C. 10:37-5.1 and 10:37-5, Article II through Article IX.

10:37-8.3 Program priorities

(a) Priority will be given to facilities which provide the following services:

1. Screening/crisis intervention;
2. Residential care;

3. Community psychiatric inpatient; and
4. Outpatient and other services that meet critical needs identified in State, regional and county plans.

10:37-8.4 Capital construction priorities and local matching requirements

Preference will be given to grant requests which propose acquisition and minor rehabilitation of residential structures for use in providing screening/crisis intervention and residential care facilities. In the case of community psychiatric inpatient, outpatient and other service facilities, preference will be given to grant requests which propose reconstruction and/or extension of existing facilities. The matching requirements for screening and residential services will be determined by the Division of Mental Health and Hospitals.

10:37-8.5 Eligible agencies

Any community-based public or private nonprofit New Jersey agency is eligible to receive construction assistance.

10:37-8.6 Allowable costs

(a) Construction assistance for acquisition will be available only in those cases in which the acquired facility expands the current service capability of the sponsoring agency.

(b) Construction assistance may include project development expenditures for certain non-construction items such as architectural, engineering, legal and other fees. Equipment, with the exception of fixed equipment or fixtures considered necessary for

facility operation, is not an allowable cost. The determination of allowable non-construction costs will be made by the Division and Department representatives on a case basis.

10:37-8.7 Applicable procedure

- (a) Applications for Community Service Capital Improvement Program must be filed on the official forms provided.
- (b) Sponsoring agencies shall submit applications for these grants to the Division and the appropriate county mental health board.
- (c) The county mental health boards shall review and comment on all grant applications.

10:37-8.8 Condition

- (a) Compliance with all applicable Federal, State, and local provisions for permits, certificates, approvals and assurances.
- (b) A formal commitment of local match resources, if required by the Division.
- (c) A formal commitment to provide services for a minimum time period agreed upon by the Division and the sponsoring agency. This time period will be determined through the use of a formula based on the amount of the State capital funds grant from the project.
- (d) Consistency with the New Jersey Comprehensive Mental Health Services Plan and Divisional philosophy pertaining to normalization, unified services, level of functioning and client advocacy.
- (e) Submission of fiscal assurances as requested by the Division.

10:37-8.9 State approval

(a) After review by the Division and the Department's Capital Facilities planning staff, the Commissioner shall approve State financial participation in the development of those capital improvement proposals which comply with the regulations of the Department.

(b) The Commissioner shall grant final approval of all capital improvement program contracts executed with agency sponsors.

10:37-8.10 Interim inspections

The Department shall have the right to conduct inspections at various stages of construction for purposes of reviewing construction progress, work quality and project expenditures.

10:37-8.11 Payment schedules

The Division and the sponsoring agency shall negotiate a reasonable payment schedule.

10:37-8.12 Records and reports

Each project shall establish and maintain appropriate methods for conducting fiscal affairs. Adequate records shall be accessible, and reports shall be submitted to the Division as requested.

10:37-8.13 Contract property

The Department shall maintain an equitable interest in all property erected, acquired, improved, rehabilitated, reconstructed, developed or extended as specified in the construction contract.

Subchapter 9. Quality Assurance

10:37-9.1 Introduction

(a) The rules within this subchapter are designed and intended to provide a framework for provider agencies (PAs) to use when developing a quality assurance (QA) program. The standards set forth in this subchapter require PAs to implement a process of ongoing monitoring and evaluation, through the following activities:

1. Development of a written QA plan;
2. Description of how the plan is to be implemented;
3. Identification of important components of all QA programs;
4. Follow-up on problems or opportunities to improve care identified through QA activities; and
5. Evaluation of the impact of the QA program.

(b) The rules do not delineate specific aspects of care to be monitored. These shall be established by each PA, based on the individual PA's mission, goals and objectives.

(c) Additional QA standards specific to particular program elements may also be included in program element rules throughout this chapter.

10:37-9.2 Scope and purpose

(a) This subchapter applies to PAs as defined in N.J.A.C. 10:37-9.3.

(b) PAs shall implement a QA program which provides an ongoing loop of information about important aspects of care.

(c) The standards set forth in this subchapter, when implemented, shall provide PAs with information about their ability to provide responsive, outcome oriented treatment to clients by generating data about the following:

1. Whether clients receive services appropriate to their needs;
2. Whether clients are attaining individual program goals;
3. Whether programming is flexible enough to meet the changing needs of clients;
4. Whether clients are receiving the services that are documented on their treatment plans;
5. Whether clients are receiving services they do not need;
6. Whether clients are receiving services they want;
7. Whether clients are staying in service for an appropriate period of time, commensurate with their needs;
8. Whether there is client participation in treatment and in evaluating the quality of service; and
9. Whether staff are qualified to provide particular services to clients and whether their skills are enhanced through continuing education.

10:37-9.3 Definitions

The words and terms in this subchapter shall have the following meanings, unless the context clearly indicates otherwise:

"Adverse medication reactions" means any response to a drug that is unintended, occurring at doses used for prophylaxis, diagnosis or therapy, which demonstrates a deviation from the expected pharmaceutical, therapeutic or chemical action of the drug. Minor adverse medication reactions result in a need for an antidote or therapy. Moderate adverse medication reactions require a change in drug therapy and/or specific treatment. Severe adverse medication reactions are potentially life threatening, cause permanent damage or require intensive medical care.

"Appropriate(ness)" means the right treatment in the right amount/frequency, to the right patient at the right time by the right staff performed the right way.

"Division" means the Division of Mental Health and Hospitals.

"Drug usage evaluation" means a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to assure that they are provided appropriately, safely and effectively.

"Follow-up" means reassessment of a problem at an appropriate interval to determine whether proposed solutions have been implemented and have remained effective.

"High risk" means any activity or intervention that could result in serious consequences or could deprive clients of substantial benefit, including providing care that is not indicated, or failing to provide care that is indicated.

"High volume" means an aspect of care which occurs frequently or affects large numbers of clients.

"Incident" means an unexpected event that places a client(s) or staff member(s) at risk.

"Indicator" means a defined, measurable, objective dimension of the quality and appropriateness of care which is based on current knowledge and clinical experience. Indicators are structures of care (for example, resources), processes of care (for example, procedures, techniques), or outcomes of care (for example, failure to improve).

"Infection control" means a program that includes the surveillance, prevention and control of infections.

"Justification for continued service(s)" means a determination, based on objective clinical criteria, that a client continues to require a specific service(s) or level of care.

"Length of stay review" means the point in treatment, on a timeline, at which a case should be reviewed to determine that the clinical needs of the client are being met and that proper utilization of resources is occurring.

"Life safety" means structures and activities related to provision of a safe, secure physical environment.

"Problem prone" means an aspect of care that has tended, in the past, to produce problems for clients and/or staff.

"Provider agency (PA)" means an agency contracted with, licensed by or funded by, the Division to provide specific, direct mental health services to clients.

"Quality assurance (QA)" means a program or set of activities designed to monitor, evaluate and improve care or services provided in order to enhance the health of clients and the effective use of resources.

"Quantitative review" means a review of a clinical record for timely completion of required documentation.

"QA oversight" means the function of ensuring implementation of the QA program and resolution of identified issues, but not necessarily carrying out monitoring and evaluation activities or corrective actions. This can be done by an existing committee or a separate committee established specifically for this purpose.

"Representative sample" means a selected subset of a larger group which exemplifies the characteristics of that group (that is, a cross-section).

"Risk management" means clinical and administrative activities designed to detect, prevent or reduce risks that could impair client care or client, staff or visitor comfort or safety.

"Routine/ongoing monitoring" means collecting and organizing data continuously according to a predetermined frequency; to check or observe.

"Sample size" means a number of cases or observations selected from a population for a specific sample (that is, a subset).

"Special case review" means clinical evaluation of and recommendations about the treatment of a difficult or high risk case by practicing mental health professionals (peers, supervisors, consultants) to the treating mental health professional(s).

"Thresholds for evaluation" means a pre-established level (number, percentage or proportion) in cumulative data that will trigger more intensive evaluation to determine whether an actual problem or opportunity to improve care exists (for example, 90 percent, one half, two out of six).

"Trend" means a recognizable pattern of occurrences; a straight line or other statistical curve showing the tendency of some function to increase or decrease over a period of time.

"Utilization review (UR)" means the process of using predefined criteria to evaluate the necessity of admissions and continued stays and whether clients are receiving the services best suited to their needs. UR monitors services to determine that an agency's services are necessary and cost effective, and that resources are efficiently utilized.

10:37-9.4 Quality assurance (QA) plan

(a) The scope, organization, monitoring, evaluation and problem correction activities of the QA program shall be written and will be referred to as the QA plan.

(b) The QA plan shall describe an ongoing, systematic process of monitoring and evaluation of important aspects of care with participation by all levels of staff.

(c) The QA plan shall include or cross-reference a description of indicators monitored in each program element. Indicators shall cover limited areas that are deemed to be high risk, high volume or problem prone.

(d) The QA plan shall include a description of outcome indicators monitored in each program element.

(e) The QA plan shall identify or cross-reference thresholds for evaluation for each indicator.

(f) The QA plan shall include procedures for monitoring problem correction.

(g) The QA plan shall describe monitoring activities to ensure client involvement in treatment.

(h) The QA plan shall describe the scope of client participation in the QA program.

(i) The QA plan shall describe reviews of open and closed client records for timely completion of required documentation.

- (j) The QA plan shall describe the process for reviews of open and closed client records to evaluate the quality and appropriateness of treatment.
- (k) The QA plan shall specify the required sample size for review of open and closed client records. The rationale for sample size selected shall also be described in the plan.
- (l) The QA plan shall describe the process, frequency, and criteria for selection of problem, high risk, difficult cases for Special Case Review. Special Case Reviews include, but are not limited to, incidents and adverse medication reactions.
- (m) The QA plan shall describe the organizational structure, including lines of authority and how the QA program fits into this structure.
- (n) The QA plan shall describe the persons responsible for QA activities.
- (o) The QA plan shall describe the extent of medical staff participation in the QA program.
- (p) The QA plan shall describe the organization and composition of the committee responsible for QA oversight.
- (q) The QA plan shall describe the required frequency of committee meetings in which QA oversight occurs.
- (r) In the case of hospital-based PAs, the QA plan shall describe the process for integration with the hospital QA program.
- (s) The QA plan shall describe how QA findings are effectively communicated to all relevant components of the organization.
- (t) The QA plan shall describe how supervision is utilized to identify and resolve QA issues.

(u) The QA plan shall describe how relevant findings are shared with clients.

10:37-9.5 Quality assurance (QA) implementation

(a) The QA plan shall be implemented.

(b) Data shall be routinely collected from ongoing monitoring activities and periodically evaluated and analyzed, based on thresholds.

(c) Documented reports of all ongoing monitoring and evaluation activities shall be produced. When ongoing monitoring reveals that more intensive evaluation is required, documentation shall include evidence of further assessment, conclusions drawn, and actions taken to improve care and to resolve identified problems. Examples of possible actions that can be taken are: implementation of inservice training, personnel action, changes in policies and procedures, administrative actions.

(d) Status of previously identified problems (follow-up) shall be documented. Problems identified and corrective actions taken shall be monitored for a prescribed time frame.

(e) To the extent that the QA process identifies issues that require medical staff input, review and response to such referrals shall be documented. These referrals may include questionable admissions and continued stays.

(f) Documentation and evidence of QA monitoring activities to ensure client involvement in treatment shall be provided, and shall include, at a minimum: each client's active and informed participation in his or her treatment plan; medication education; and application of clients' rights and the client grievance procedure.

(g) Documentation of monitoring of effectiveness of the PA's mechanisms to respond to client complaints and suggestions shall be provided.

(h) In the case of hospital based PAs, documented evidence of integration with the hospital QA program shall be available.

(i) There shall be evidence that relevant QA findings are effectively communicated to all relevant components of the PA, including clients.

(j) When the PA has developed the QA program, the following additional elements should be implemented:

1. Participation by medical staff on the QA oversight committee;
2. Documentation of analysis of aggregate QA findings to identify and address patterns and trends related to client characteristics, treatment and service utilization;
3. Utilization of responses to client satisfaction surveys and recommendations from clients and family members; and
4. Documentation of the use of applicable QA findings in ongoing staff development, supervision and performance evaluation.

10:37-9.6 Administrative support

(a) The PA administration shall require and support the QA program.

(b) PA administration shall review and approve the QA plan, as part of an annual QA plan review.

(c) QA reports shall be made available to the PA administration, as described in the QA plan.

(d) The annual appraisal of the QA program shall be submitted to the PA administration.

(e) There shall be documentation of administrative review of QA findings.

(f) When the PA has developed the QA program, the PA administration should also document use of QA findings for management decision-making and program planning (for example, link with goals and objectives, and long range or annual plans).

10:37-9.7 Quality assurance (QA) oversight

(a) A committee composed of a representative sample of individuals from the PA's program elements shall perform the function of oversight of organization-wide QA activities.

(b) Appropriate oversight functions shall include:

1. Annual review and reappraisal of the QA plan;
2. Review of problems which cannot be resolved at a program element level, recommending actions to resolve these problems, and following up to ensure correction takes place. These problems may reflect trends, patterns of performance, or problems that affect more than one program element;
3. Review and approval of program element QA indicators; and
4. Review and approval of revisions of QA policies and procedures.

(c) Minutes shall be kept of committee meetings in which QA oversight occurs. Client names shall not appear in minutes or circulated reports.

10:37-9.8 Utilization review (UR)

(a) Each QA program shall include a utilization review (UR) component which shall be described in the QA plan.

(b) The UR component of the QA program shall include a system, which shall include timeframes for review and which shall monitor the appropriateness of:

1. Admission, for at least 10 percent of all new clients each month; and

2. Continued stay, for at least 10 percent of the clients served by the PA during the previous year, with a representative sample from each program element.

(c) Written criteria shall be developed for admission and continued stay in each program element. These criteria shall be utilized during the UR activities described in (b) above.

(d) A written description for the processing of cases deemed inappropriate admissions and continued stays shall be developed. Action for inappropriate cases (those which do not meet criteria or receive approval by the medical reviewer) shall be effected through termination, transfer to an appropriate program or implementation of interventions necessary to facilitate termination.

(e) Criteria shall be developed for each program element for assessing length of stay. Level of functioning, severity of illness, diagnosis or other professionally accepted categories upon which length of stay norms are based shall reflect the clinical needs of the clients served by the PA and the PA's treatment philosophy.

(f) Continued service for a client who exceeds the identified length of stay norm shall be justified in the client's clinical record.

(g) Monthly UR statistical summaries shall be maintained and shall include the number of admission and continued stay reviews completed, as well as dispositions (for example, approvals, transfers, terminations).

(h) There shall be a written policy describing how UR findings and records are maintained to assure client and staff confidentiality. Client numbers and clinician codes are one acceptable method that can be used.

(i) There shall be a written conflict of interest policy that excludes a clinician who is involved in treatment of a client from making the determination of that client's appropriateness for continued stay.

(j) When the PA has developed the QA program, the PA should additionally document UR activities that address efficient use of staff and resources.

10:37-9.9 Risk management (RM)

(a) Each QA program shall include a risk management (RM) component which shall be described in the QA plan.

(b) The RM component of the QA program shall include the following activities:

1. Monitoring of implementation of PA's policies and procedures regarding medication (for example: documentation that staff are aware of medications prescribed for clients, dosage, frequency, side effects, and adverse medication reactions, frequency of laboratory tests when necessary);

2. Monitoring life safety;

3. An incident review and reporting procedure that will allow for the analysis of client and staff incidents to identify patterns and trends or opportunities to improve client care and staff safety and to reduce agency liability risks. Incident review shall include interviews of clients and staff involved in each incident. The PA shall ensure that clients and staff who report incidents are not adversely affected; and

4. Development of an infection control policy and monitoring of the implementation of the policy.

(c) Risk management reports shall document all RM activities. Conclusions, recommendations, actions to reduce risk or resolve problems and follow up of corrective actions taken shall be included in these reports.

(d) When the PA has developed the QA program, the following should be considered for inclusion in RM activities:

1. Monitoring of compliance with PA policies regarding confidentiality and release of information;

2. Identifying categories of potential risk in clinical aspects of care to clients;

3. Review of case-specific instances of potential risk; and

4. Documentation and implementation of a RM plan that fully describes the scope of the RM program and its integration with other QA activities.

10:37-9.10 Annual appraisal

(a) An annual appraisal of the QA program shall be conducted by the PA and documented.

(b) The annual appraisal shall include review of adequacy of monitoring, evaluation and reporting mechanisms, and evidence of solutions to identified problems.

(c) When the PA has developed the QA program, evidence of positive impact on client care and client input should also be included in the appraisal process.

{Note: Subchapter 10, Licensure of Mental Health Programs, has been moved to N.J.A.C. 10:190, Licensure for Mental Health Programs.}

Subchapter 11.

(Reserved)

{Note: Subchapter 12, Children’s Partial Care Programs, has been moved to N.J.A.C. 10:191, Children’s Partial Care Program Standards.}

APPENDIX A

Continuum of Mental Health Settings
 Client Enters System through Self, Other Agency,
 Gatekeeper Referral Screening

(Most Natural)		MENTAL HEALTH SERVICES				(Most Restrictive)	
Reinforcement and/or Develop of Non-Mental Health Natural Supports	Crisis Intervention (Preferably in Natural Environment)	Outpatient Program Element	Partial Care Program Element	24-hour Treatment/ Crisis Home for Children	Local Inpatient Program Element	County Psychiatric Hospital	State Psychiatric Hospital
Own Family/Home	Semi-Indep. Apt. Group Home	Transitional Resid. and/or Sheltered Care Boarding Home	DYFS Resid. Network for Children	Local IPU		Public Psychiatric Hospital	

RESIDENTIAL CARE/LIVING ARRANGEMENTS

{Note: Appendix B, Level I Standards, has been moved to N.J.A.C. 10:190-1.3.}