N.J.A.C. 10:37F

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 37F. PARTIAL CARE SERVICES STANDARDS

Title 10, Chapter 37F -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

N.J.S.A. 30:1-12, 30:9A-10, and 30:9A-21.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: September 24, 2021.

See: *53 N.J.R. 1842(a)*.

CHAPTER HISTORICAL NOTE:

Chapter 37F, Partial Care Services Standards, was adopted as R.1995 d.565, effective November 6, 1995. See: 26 N.J.R. 4547(a), *27 N.J.R. 4305(b)*. Pursuant to Executive Order No. 66(1978), Chapter 37F, Partial Care Services Standards, expired on November 6, 2000.

Chapter 37F, Partial Care Services Standards, was adopted as new rules by R.2001 d.165, effective May 21, 2001. See: *32 N.J.R. 3927(a)*, *33 N.J.R. 1610(b)*.

Chapter 37F, Partial Care Services Standards, was readopted as R.2006 d.389, effective October 13, 2006. See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 37F, Partial Care Services Standards, was scheduled to expire on October 13, 2013. See: *43 N.J.R. 1203(a)*.

Chapter 37F, Partial Care Services Standards, was readopted as R.2014 d.059, effective March 13, 2014. See: *45 N.J.R. 2378(a)*, *46 N.J.R. 625(a)*.

In accordance with *N.J.S.A. 52:14B-5.1*, Chapter 37F, Partial Care Services Standards, was scheduled to expire on March 13, 2021. Pursuant to Executive Order Nos. 127 (2020) and 244 (2021) and P.L. 2021, c. 103, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally declared in Executive Order No. 103 (2020) is extended through January 1, 2022. Chapter 37F, Partial Care Services Standards, was readopted with technical changes, effective September 24, 2021. See: Source and Effective Date. See, also, section annotations.

Annotations

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 37F, Partial Care Services Standards, expires on September 24, 2028.

End of Document

N.J.A.C. 10:37F-1.1

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§ 10:37F-1.1 Scope and purpose

(a) The rules in this chapter shall apply to all providers of partial care services (PC) for adults.

(b) The purpose of PC services is to assist individuals with severe mental illness to achieve community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse. The role of PC is therefore to facilitate consumer integration into the community, not to become a permanent outcome although it is recognized that some consumers may need the support of PC for long periods of time. This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programming which provide, but are not limited to, counseling, case management, psychoeducation, pre-vocational services, social and leisure services, and psychiatric services, and shall be available to eligible individuals on an hourly basis for up to five hours per day at least five times per week.

History

HISTORY:

Amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

In (a), substituted "providers" for "Division funded"; and rewrote (b).

Annotations

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N.J.A.C. 10:37F-1.2

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§ 10:37F-1.2 Guiding principles

(a) The following concepts of recovery and wellness shall serve as the guiding principles in the delivery of partial care services:

1. Consumers should have a basis to expect that, as a result of their involvement with this program, they will be able to better manage their illness and improve the quality of their life;

2. Partial care programs shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs;

3. The environment in which partial care services are delivered shall encourage hope and emphasize individual dignity and respect;

4. As recovery is most often a process, not an event, the provider shall address the needs of people over time and across different levels of disability;

5. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitation and supportive services that a person may need;

6. As a recovery-oriented system, the partial care program shall offer a high degree of:

i. Accessibility; and

ii. Sustainable effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery over a long period of time;

7. Whenever possible, the services shall be provided within the person's own community setting, using the person's natural supports; and

8. The service system shall help the person achieve an improved sense of mastery over his or her condition and shall assist the person in regaining a meaningful, constructive sense of membership in the community.

(b) The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM) is incorporated by reference, as amended and supplemented, into this chapter. Copies of the DSM may be obtained from the American Psychiatric Association, 800 Maine Ave., SW, Ste. 900, Washington D.C. 20024.

History

HISTORY:

New Rule, R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Former *N.J.A.C. 10:37F-1.2*, Definitions, recodified to *N.J.A.C. 10:37F-1.3*.

§ 10:37F-1.2 Guiding principles

Notice of readoption with technical change, effective November 1, 2021.

See: *53 N.J.R. 1842(a)*.

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N.J.A.C. 10:37F-1.3

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§ 10:37F-1.3 Definitions

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

"Active treatment" means a process initiated at the point of intake for a partial care program and consists of the assessment, treatment, psychiatric rehabilitation and discharge planning phases of mental health services. Active treatment includes an integrated, comprehensive, and complementary schedule of treatment services for the purposes of maximizing a consumer's independence and community living skills to promote community integration, achieving valued roles and reducing unnecessary hospitalizations.

"Advanced practice nurse" means an individual certified as an advanced practice nurse by the New Jersey State Board of Nursing.

"Certified Psychiatric Rehabilitation Practitioner" means an individual who has fulfilled all the eligibility requirements and passed a comprehensive, standardized written examination as defined by the Certification Commission for Psychiatric Rehabilitation.

"Clinician" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in a field such as psychiatry, psychology, social work, psychiatric nursing or rehabilitation counseling, including, but not limited to, a licensed professional counselor. In addition to the degree, the applicable training must be completed including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline as well as the applicable state license. A clinician may also have the credentials to be a qualified addictions staff person.

"Community Mental Health Associate" means a Community Mental Health Associate as defined by the Certification Board, Inc., 1200 Tices Lane, East Brunswick, NJ.

"Direct care staff" means those personnel whose primary function is face-to-face interaction with the consumer providing the therapeutic contact necessary to achieve the consumer's treatment goals.

"Division" means the Division of Mental Health and Addiction Services in the Department of Human Services.

"Educational services" means a formal educational course of study leading to a degree, certificate or graduation from an accredited institution or program and may include basic educational courses, special educational courses, General Education Diploma (G.E.D.), and pre-college preparation.

"Individualized recovery plan" (IRP) means a consumer directed, individualized treatment plan, based upon the comprehensive assessment, developed by the consumer in collaboration with family members, significant others and partial care staff that identifies clinical needs, current status and specific goals and objectives. The IRP identifies specific interventions, measurable outcomes and is revised on a regular basis to reflect the individual's current status and achievement of goals.

"Interdisciplinary treatment team (IDTT)" means a team of individuals consisting of a psychiatrist and/or an advanced practice nurse, clinician, rehabilitation and other counselor(s), consumer, family

member with consent, direct partial care staff, R.N. and others involved with meeting the consumer's treatment needs.

"Licensed professional counselor" means an individual licensed as a professional counselor as defined by Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners.

"Licensed associate counselor" means an individual licensed as an associate professional counselor as defined by Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners.

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience in mental health, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Off-site interventions" means planned mental health programming provided during hours of partial care at a location other than that of the program site in order to assist the individual to apply and/or practice critical community skills learned in the PC.

"Partial care (PC)" means an individualized, outcome-oriented mental health service, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program in a community setting to assist consumers who have serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives. Partial care services are offered to an individual age 18 or older with a primary psychiatric disorder that is accompanied by an impaired ability to perform living, learning, working or social roles. Partial care services support consumer stabilization and community integration and are alternatives to more intensive acute interventions. Partial care services provide active treatment and psychiatric rehabilitation for consumers who do not require inpatient hospitalization but require support and structured programming.

"Pre-vocational services" means interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as: responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and adherence to prescribed medication directions/schedules. Examples of interventions not considered pre-vocational include technical occupational skills training, specific college preparation not incidental to general community integration skills, and student education, including preparation of school-assigned class work or homework, and individualized job development.

"Programs of assertive community treatment (PACT)" means mental health rehabilitative services which are delivered in a self-contained treatment program provided by a service delivery team and managed by a qualified program director, that merge treatment, rehabilitation, and support services which are individualized and tailored to the unique needs and choices of the individual receiving the services.

"Provider agency (PA)" means a public or private organization which provides partial care services to adults with serious mental illness, as set forth in this chapter.

"Psychotherapy notes" means as defined in *45 CFR 164.501*.

"Registered nurse (RN)" means a registered professional nurse licensed by the New Jersey Board of Nursing.

"Rehabilitation counselor" means an individual licensed by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners (Licensed Rehabilitation Counselor or LRC), certified as a Certified Rehabilitation Counselor (CRC) by the Certification in Rehabilitation Counseling Board and/or possessing the education, training and experience sufficient to sit for either credential.

"Skill development" means acquiring the knowledge, attitudes and specific behaviors that lead to the mastery of the identified critical competency and its use when and where it is needed for valued community role functioning.

"Social worker" means an individual defined by the New Jersey Board of Social Work Examiners as either a Certified Social Worker (CSW), Licensed Social Worker (LSW), or Licensed Clinical Social Worker (LCSW).

"Special minimum wage certificate" means a certificate issued to a provider by the U.S. Department of Labor pursuant to 29 CFR § 525., which permits a worker with a disability to be paid at a rate below the rate that would otherwise be required by statute.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and pursuant to 29 CFR § 525., a "special minimum wage certificate" has been issued to the organization/program, by the U.S. Department of Labor.

"Therapeutic token economies" mean learning reinforcement strategies which are medically necessary, such as those which promote the consumer's progress in learning critical skills. Non-therapeutic token economy activities, such as those used for the recruitment of beneficiaries, are not medically necessary and therefore not therapeutic and are prohibited. Token economy activities, if provided, like other medically necessary plan of care activities, shall be implemented in accordance with an individual's plan of care.

"Valued role" means an individually chosen adult role, desired by individuals and respected by society, such as worker, professional, employee, volunteer, student, spouse/partner, parent, homemaker or any other normal adult role.

"Vocational services" mean those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-1.2* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Inserted definitions "Active treatment", "Advanced practice nurse", "Certified Psychiatric Rehabilitation Practitioner", "Clinician", "Community Mental Health Associate", "Direct care staff", "Educational services", "Individualized recovery plan", "Interdisciplinary treatment team (IDTT)", "Licensed professional counselor", "Licensed associate counselor", "Mental health services worker", "Off-site interventions", "Partial care (PC)", "Pre-vocational services", "Programs of assertive community treatment (PACT)", "Qualified addictions staff", "Registered nurse (RN)", "Rehabilitation counselor", "Skill development", "Social worker", "Special minimum wage certificate", "Therapeutic subcontract work activity", "Therapeutic token economies", "Valued role" and "Vocational services"; in definition "Division", substituted "Services" for "and Hospitals"; deleted definitions "Partial care services (PC)" and "Psychoeducation services"; and rewrote definition "Provider agency (PA)".

Amended by R.2009 d.182, effective June 1, 2009.

See: *40 N.J.R. 2184(a)*, *41 N.J.R. 2266(a)*.

Added definition "Psychotherapy notes".

Notice of readoption with technical change, effective November 1, 2021.

See: *53 N.J.R. 1842(a)*.

Modified by P.L. 2021, c.103, effective March 9, 2020.

See: *54 N.J.R. 308(a)*.

Annotations

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N.J.A.C. 10:37F-2.1

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§ 10:37F-2.1 Admission criteria

(a) First priority for admissions into PC services shall be given to persons with severe and persistent mental illness in accordance with target populations, as defined in *N.J.A.C. 10:37-5.2*.

1. The provider agency shall utilize the following inclusionary and exclusionary admission criteria, which are designed to assure the clinical appropriateness of each admission.

(b) Inclusionary criteria: In order to be considered eligible for partial care services, an individual must:

1. Demonstrate impaired functioning, that leads to a need to learn critical skills in order to achieve valued community roles and community integration, in at least one of the following domains on a continuing and intermittent basis, for at least one year:

i. Personal self-care;

ii. Interpersonal relationships;

iii. Work;

iv. School;

v. Ability to live in the community; or

vi. Ability to acquire and/or maintain safe, affordable housing and is at risk of requiring a more restrictive living situation;

2. Be 18 years of age or older;

3. Demonstrate or possess clinical evidence to justify the necessity for partial care services. This necessity must be confirmed by the psychiatrist or advanced practice nurse and interdisciplinary treatment team and documented in the record;

4. Demonstrate the need for psychiatric rehabilitation and active treatment of no less than two hours and no more than 25 hours weekly;

5. At the time of referral or as a result of psychiatric evaluation provided or arranged for by the PA, have at least one of the following primary DSM diagnoses:

i. Schizophrenia or Other Psychotic Disorders (298.9);

ii. Major Depressive Disorder (296.xx);

iii. Bipolar Disorders (296.xx, 296.89);

iv. Delusional Disorder (297);

v. Schizoaffective Disorder (295.7); or

vi. Affective Disorders (300.xx);

6. Have a covered psychiatric disorder diagnosis consistent with codes of the DSM, including some 301.XX codes if the personality disorder is considered in the severe range and the individuals are at high risk of psychiatric hospitalization as a result; and

7. At the time of referral, meet one or more of the following criteria:

i. Acute service need:

(1) One or more contacts with a screening center or emergency service mental health program;

(2) Two or more admissions to an inpatient behavioral health program including short term care facilities; or

(3) One psychiatric hospitalization of three months or longer; or

ii. A Global Assessment of Functioning Scale score of between 11 and 70, as found in the DSM.

(c) Exclusionary criteria: A consumer who presents any of the following criteria shall be excluded from participation in partial care services:

1. A primary diagnosis of substance use/dependence;

2. An imminent danger to self, others or property;

3. A primary diagnosis of "developmentally disabled"; or

4. Current participation in a PACT program, unless authorized in accordance with *N.J.A.C. 10:76*.

History

HISTORY:

Amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Section was "Admission and intake". Rewrote (a)1; inserted new (b) and (c); deleted former (b) and (b)1; and recodified former (b)2 through (c)9 as *N.J.A.C. 10:37F-2.2*.

Notice of readoption with technical change, effective November 1, 2021.

See: *53 N.J.R. 1842(a)*.

Annotations

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N.J.A.C. 10:37F-2.2

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§ 10:37F-2.2 Intake procedures

(a) The PA shall develop and implement an intake process that provides a basis for assessment of an applicant's eligibility for service and the formulation of an initial service plan to guide initial services which is mutually developed by the consumer and a staff member. All intake procedures shall be guided by a consumer's preferences and goals with regard to treatment and community living.

1. The initial contact shall serve to orient and engage new consumers in a culturally and linguistically appropriate manner, and facilitate continuity of service.

2. Intake procedures shall be designed to facilitate program participation at the earliest appropriate opportunity. Completion of the formal intake process shall not preclude an otherwise eligible consumer from participating in program activities or receiving services on a provisional or try-out basis.

3. The PA shall train staff regarding appropriate responses to inquiries for service and shall document such training.

4. The PA shall maintain a system to schedule face-to-face intake appointments within 14 calendar days.

i. The intake process for each consumer shall include a minimum of one face-to-face interview, during which the information listed at (b) below shall be obtained.

ii. If the consumer cannot be immediately scheduled, the PA shall contact the consumer within two working days to arrange for an initial intake appointment.

5. The intake process shall include an orientation to the program and an explanation of the consumer's rights and grievance procedure. The PA shall also post the grievance procedure in a prominent location within the agency and make copies of *N.J.A.C. 10:37-4.5*, Client rights, and 10:37-4.6, client complaint/agency ombuds procedure, available to consumers upon request.

6. The PA shall develop and implement written procedures that require the PA to maintain contact with any consumer who is waiting for service in order to ensure that each consumer's emergent needs are identified and met.

(b) In order to ensure that there is an adequate basis for a timely and accurate consumer assessment, the provider agency shall develop and maintain written policies and procedures which require that the following information be documented for all intake interviews:

1. Basic demographic information, including emergency contact person;

2. Presenting problems and reason for referral, including consumer interests and preferences in achieving valued community living, learning, working or social roles;

3. A medical history, including a brief history of the illness and previous services received at agency and elsewhere, a consumer self report of response to previous treatment, a completed current mental status evaluation, medication information; current mental health and social service providers; and any allergies;

4. A signed authorization for release of information, in accordance with all applicable legal requirements;

5. Basic family and social supports;

6. Legal information relevant to treatment;

7. Basic substance dependency information;

8. Basic employment and educational history; and

9. Risk factors (for example, under what circumstances the consumer may be a danger to self or others or present a risk of sexually predatory behavior).

(c) The PA shall develop and implement a written procedure that requires a review of all intakes that result in a determination that a consumer may be denied service.

(d) An initial service plan shall be completed during the intake process. This plan shall address the consumer's immediate needs and concerns, with special attention to urgent presenting problems, to meet immediate needs for food, clothing, shelter and medication.

1. The initial service plan shall be documented in the progress notes and shall include interventions utilized, such as prevocational or counseling services.

2. The initial service plan shall be revised as needed until the individualized recovery plan is developed.

3. The PA shall develop a formal procedure for updating the initial service plan, and create an individualized recovery plan that shall be completed within six weeks of intake and shall involve supervisory personnel.

History

HISTORY:

Recodified in part from *N.J.A.C. 10:37F-2.1* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Rewrote the section. Former *N.J.A.C. 10:37F-2.2*, Assessment and service planning, recodified to *N.J.A.C. 10:37F-2.3* and *10:37F-2.4*.

Administrative correction.

See: *41 N.J.R. 2483(b)*.

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N.J.A.C. 10:37F-2.3

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§ 10:37F-2.3 Assessment

(a) PA staff shall complete a written comprehensive assessment for each consumer prior to development of the individualized recovery plan. The comprehensive assessment provides the PA and consumer with an initial profile of the strengths and barriers related to community integration, achievement of chosen valued roles and which issues or problems must be addressed in what priority.

1. The PA's written procedures shall require that every comprehensive assessment include at a minimum, the assessment of the consumer's skill and resource strengths, and barriers to attainment of the consumer's self-expressed goals related to community integration and living, learning, working and social role recovery in the following areas:

i. The consumer's interest in and strengths and goals related to participation in the program;

ii. Social and leisure functioning including, but not limited to, ability to make friendships, communication skills and hobbies;

iii. Emotional and psychological characteristics including, but not limited to, mental status, trauma and abuse history, if applicable, understanding of their own illness, and coping mechanisms;

iv. A review of medical systems including, but not limited to, applicable allergic and adverse medication reactions and screening for current physical, emotional, sexual abuse and/or neglect;

v. Vocational and educational factors including, but not limited to, job history, task concentration and motivation for work;

vi. Activities of daily living including, but not limited to, transportation, budgeting, self care and hygiene;

vii. Living arrangements including, but not limited to, housing, entitlements and subsidies;

viii. Social supports including, but not limited to, family, friends, social and religious organizations;

ix. Substance abuse; and

x. Other important characteristics of the individual such as special skills, talents and abilities.

2. The written comprehensive assessment shall clearly indicate justification for the need for PC services.

3. The written comprehensive assessment shall clearly indicate the consumer's interest or the situational urgency with which a barrier must be addressed in order to prioritize its intervention in the individualized recovery plan.

4. The written comprehensive assessment shall describe both the skills and resources needed to attain the consumer's expressed goals and values roles, including quality of life based upon, but not limited to, consumer interviews, direct observation and information obtained from family members and other collaterals.

5. The written comprehensive assessment shall be completed within one month after acceptance to the program and prior to development of the individualized recovery plan.

6. The written comprehensive assessment shall include a documented psychiatric evaluation completed within two weeks of admission which shall reflect consideration of the following:

i. Diagnosis in conformance with the DSM;

ii. Recommendations for treatment, including treatment modality;

iii. Medical history;

iv. Medication history and present regimen;

v. Mental status;

vi. Presenting psychiatric and non-psychiatric problems;

vii. Substance abuse history;

viii. Relevant legal issues (that is, legal issues with implications for treatment);

ix. Family psychiatric history; and

x. The consumer's expressed interests, preferences, strengths and goal(s) related to valued community roles and quality of life.

7. The PA shall make reasonable efforts to involve the family and significant others in the assessment process to the extent possible.

8. The PA shall continue to conduct functional and resource assessments of those areas, goals and objectives prioritized from the comprehensive assessment and selected for formulation in the individualized recovery plan. These on-going assessments shall be completed prior to the three-month review of the IRP and shall be documented in the clinical record.

History

HISTORY:

Recodified in part from *N.J.A.C. 10:37F-2.2* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Section was "Assessment and service planning". Rewrote (a); recodified (b) through (d) as *N.J.A.C. 10:37F-2.4*. Former *N.J.A.C. 10:37F-2.3*, Services to be provided, recodified to *N.J.A.C. 10:37F-2.5*.

Notice of readoption with technical change, effective November 1, 2021.

See: *53 N.J.R. 1842(a)*.

Annotations

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N.J.A.C. 10:37F-2.4

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§ 10:37F-2.4 Recovery planning

(a) The individualized recovery plan is designed to assist the consumer in organizing, reviewing and modifying an array of treatment and rehabilitation services which supports his or her identified path to recovery. The IRP shall be based on specific areas of interest identified by the consumer and urgent problems or barriers that have been prioritized from the comprehensive assessment.

1. It shall be formulated and implemented at the completion of the comprehensive assessment, but no later than six weeks from the consumer's admission to the program.

2. Areas identified in the comprehensive assessment, but not initially addressed in the IRP at intake, should be reviewed and formulated at subsequent IRP reviews or when re-prioritized by the consumer and PA. The IRP shall reflect agreement and mutual understanding between the consumer and the program staff on goals to be achieved by the consumer and program activities to address these goals.

(b) The IRP, developed with the consumer, shall include the following:

1. Language that can be easily understood by the consumer;

2. The signatures of the consumer, primary case coordinator or counselor and direct care staff supervisor;

3. The psychiatrist's or advanced practice nurse's signature, which shall reflect the direction of the course of treatment;

4. To assure family participation in developing the IRP and revisions, the PA shall seek the input of family members or close personal friends at each service planning milestone; however, the PA may not disclose protected health information to family members or close personal friends, except as follows:

i. Protected health information may be disclosed to the extent permitted by a valid written authorization;

ii. If the consumer is present at the service planning milestone, or otherwise available prior to, protected health information may be disclosed at that meeting if it is directly relevant to the family member's or close personal friend's involvement with the consumer's care and one of the following apply:

(1) The consumer agrees to disclosure of the information at the time of service planning milestone;

(2) The consumer is provided with an opportunity to object to the disclosure at the service planning milestone and does not express an objection; or

(3) Based on the exercise of professional judgment, the PA reasonably infers from the circumstances at the service planning milestone that the consumer does not object to the disclosure. Absent countervailing circumstances, the consumer's agreement to participate in the service planning milestone with the family member or close personal friend present indicates that the consumer does not object to disclosure of protected health information that is

directly relevant to the family member's or close personal friend's involvement with his or her care; or

iii. If the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the PA may, in the exercise of his or her professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care;

5. The consumer's self-stated overall goals related to chosen, valued role(s) and specific plans to achieve these roles, with target dates for achievement, including further in-depth and ongoing assessment in the identified areas;

6. Specific interventions, strategies and activities to implement the IRP, including clear reference to necessary off-site services to assist in the transfer of learning;

7. Identification of staff responsible for implementing each intervention; and

8. A comment section under which the consumer states in his or her own words any concerns, agreements, or disagreements with either the development of or final IRP.

(c) Where protected health information is disclosed pursuant to (b)4ii or iii above, the PA shall document the basis for the disclosure. Disclosure in accordance with (b)4ii or iii above shall not authorize or otherwise provide a basis for future disclosures not in compliance with this section.

(d) Notwithstanding (a), (b) and (c) above, the PA shall not disclose to a consumer's family or close personal friends, psychotherapy notes related to treatment of the consumer without the consumer's valid written authorization, consistent with *45 CFR 164.508(a)*2.

(e) The PA shall include consumer and family (if the consumer consents) participation in service planning. The consumer's signature on the IRP shall indicate that the consumer was involved in the formulation of the plan or that the consumer reviewed and approved of the plan. If the consumer is not involved in the development of the plan or the consumer does not agree with any part of the plan, the consumer shall document his or her lack of participation or disagreement in the comments section of the IRP.

1. If the consumer refuses to give written authorization to release information, the team shall document in the consumer's record that efforts were made at each milestone to obtain such authorization.

(f) The IRP shall reflect any other service in which the consumer participates and coordinative efforts, if any, in achieving the treatment goals and objectives.

(g) The PA shall train staff in the formulation and implementation of an IRP.

(h) The comprehensive IRP shall be periodically reviewed to determine the consumer's need for continued services and revised as necessary.

1. The IRP shall be reviewed and revised within three months of its development, every three months for the first year, and every six months thereafter, unless goals or objectives change due to new information from the in-depth and ongoing assessment or a change in the consumer's circumstances. The IRP shall then be immediately changed to reflect this new information. A review of ongoing skill and resource assessments shall be made prior to the plan review. Documentation of the IRP reviews shall include signatures of the consumer, direct care staff, supervisor and psychiatrist.

2. IRP reviews shall reflect the consumer's changing needs and progress toward goals. Documentation shall include a determination of the need for continued PC services and any revisions in service provision. Consideration of the expected benefits of continued services and the risk of service termination shall be included.

3. The PA shall update the psychiatric evaluation at least every six months for every consumer receiving partial care services.

4. As the consumer progresses, treatment goals shall address a gradual reduction in services or a transition to less intensive services.

5. Maintenance of functioning shall be a legitimate service goal if it is appropriate to the consumer's needs.

(i) The PA shall write progress notes in the consumer's record at least weekly, as follows:

1. The PA staff shall document development of the IRP during the initial three-month period in the progress notes.

2. Each weekly progress note shall address:

i. The consumer's response to at least one specific treatment intervention identified in the IRP;

ii. A summary of PC activities in which the consumer participated during that week;

iii. The consumer's general level of participation and clinical progress in the program for that week; and

iv. Significant events that occurred during that week.

3. Within every three-month period, the progress notes shall reflect the consumer's progress towards all goals and objectives included within the IRP.

4. Progress notes shall contain documentation by P.A. staff of all known current medications prescribed to address both psychiatric and medical conditions. All medications and changes in the medication regimen shall also be documented by P.A. staff on a medication summary sheet.

5. Progress notes shall be legibly written, signed and dated.

6. Progress within group and other PA activities shall be documented through a weekly rating of the consumer's progress and participation which may also include the consumer's perspective. These ratings can be contained within the body of the weekly progress note in the form of a written narrative or a rating scale which is distinct from any overall progress or historical account of the week.

i. Overall progress and participation for the week should be reflected in the weekly progress note.

History

HISTORY:

Recodified in part from *N.J.A.C. 10:37F-2.2* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Section was "Assessment and service planning". Recodified (a) as *N.J.A.C. 10:37F-2.3*; and rewrote the section. Former *N.J.A.C. 10:37F-2.4*, Termination, transfer and referral of clients, recodified to *N.J.A.C. 10:37F-2.6*.

Amended by R.2009 d.182, effective June 1, 2009.

See: *40 N.J.R. 2184(a)*, *41 N.J.R. 2266(a)*.

Rewrote (b)4; added new (c) and (d); and recodified former (c) through (g) as (e) through (i).

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:37F-2.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 37F. PARTIAL CARE SERVICES STANDARDS > SUBCHAPTER 2. PARTIAL CARE STANDARDS

§ 10:37F-2.5 Services to be provided

(a) The PA shall provide, or arrange for, a range of services to effectively address the holistic needs of the consumer. Service provision shall be coordinated with other service providers. Services must not exceed a 1:15 staff-to-consumer ratio based upon the active daily census and direct care staff, except as indicated in (b)4 below.

(b) The PA shall directly provide the following core services:

1. Engagement strategies shall be designed to connect with consumers over time in order to develop a commitment on their part to enter into therapeutic relationships supportive of the individual's recovery. This service may include, but is not limited to, activities such as initial contacts with potential program participants, as well as continued efforts to engage individuals to participate in program services;

2. Activities designed to assist a consumer to identify, achieve and retain personally meaningful goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. Examples of such goals include, but are not limited to, returning to work or school, returning to adult care-giving or parenting roles, resuming roles as a spouse or significant other, becoming a member of a religious community, or becoming a neighbor;

3. An Illness Management and Recovery Program, which is comprised of a broad set of strategies and activities that help consumers collaborate with practitioners to identify and pursue personally meaningful recovery goals and which founded upon a core set of interventions that include: psycho education, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring, and relapse prevention techniques. This is accomplished by helping people to develop coping strategies and skills that reduce the individual's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations, and reduce distress to the point that the consumer is able to enjoy an improved quality of life. They are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services will be provided directly to consumers and in support of family members and/or other significant individuals important to the consumer. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms and personal stress and strengthen life skills and abilities to attain their recovery goals;

ii. Psycho education that provides factual information, recovery practices, including evidence-based models, concerning mental illness that instills hope and emphasizes the potential for recovery. Such services will be geared toward the consumer developing a sense of mastery over his or her illness and life, and shall also be effective in reducing relapse and rehospitalizations. It may also provide support to the consumer's family and other members of the consumer's social network to help them manage the symptoms and illness of the consumer and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan that offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery,

including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors that have triggered return of persistent symptoms in the past and adaptive problem solving techniques shall be applied to avoid recurrences in the future. As this process of mastery over the illness evolves, the practitioner will explore and develop a new sense of personal identity with the consumer, and examine with him or her the potential for growth beyond the mental illness;

iv. Dual disorder education which provides basic information to consumers, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of one's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Consumers will be provided with adequate information in an understandable format regarding medications' relative effectiveness and safety in order to make an informed decision. Interventions, such as medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support consumers' in adhering to their medication regimens. Practitioners will specifically review with the consumer how medication management issues will impact their personal recovery goals and will be responsible for involving family members whenever possible; and

vi. Wellness activities that are consistent with the consumer have self-identified recovery goals. Wellness activities may address common physical health problems, such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition. Other wellness services may address goals, such as constructive use of leisure time and fulfilled spirituality and creativity pursuits;

4. Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills. Skill development can be accomplished through either individual or group instruction; however, the direct staff-to-consumer ratio in such circumstances shall not exceed 1:12. Examples would include, but not be limited to:

i. Cognitive skills such as researching and recording information, decision making, identifying preferences and values, selecting clothing, interviewing, scheduling appointments, budgeting, personal nutrition planning, etc.;

ii. Physical skills such as showering, grooming, cooking, cleaning personal space, shopping, taking public transportation, parenting, etc.; and

iii. Emotional skills such as negotiating, communicating, asking for help, avoiding risks to sobriety, greeting others, conversing, identifying psychiatric cues, planning for psychiatric emergencies, etc.;

5. Prevocational services, which are an array of strategies and interventions that assist in acquiring general work behaviors, attitudes and skills in response to the interests and needs of consumers who are thinking about and/or intending to take on the role of worker and which may be used in other life domains.

i. Prevocational intervention or strategies selected are based upon an assessment of consumer interest, needs, skills and supports and reflected in the consumer's individualized recovery plan.

ii. Prevocational activities might include, but not be limited to:

(1) Understanding and choosing work settings;

(2) Gathering and researching job information;

(3) Clarifying occupational values and interests;

(4) Defining work preferences;

(5) Identifying personal work criteria;

(6) Exploring barriers to working;

(7) Identifying and defining critical work skills;

(8) Researching personal work supports and resources;

(9) Identifying psychiatric illness management strategies related to working;

(10) Simulated work activities such as work units to address work hardening, concentration, attending and other skills; and

(11) Learning methods to respond to criticism, negotiating for needs, dealing with interpersonal issues, and adherence to medication requirements.

iii. Therapeutic subcontract work may be provided within the context of partial care as prevocational therapy if already provided.

(1) Therapeutic subcontract work activity is the production, assembly and/or packing tasks for compensation obtained by the organization under a contract with a vendor for which individuals with disabilities performing the tasks are paid under a wage and hour certificate, typically less than minimum wage.

(2) The consumer's individual service plan shall stipulate that the therapeutic subcontract work is a form of intervention intended to address the individual as identified in the consumer's assessment.

(3) The therapeutic subcontract work shall be facilitated by a qualified mental health services worker.

(4) The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health service worker.

(5) The staff-to-consumer ratio shall not exceed a ratio of 1:12 qualified mental health services worker to consumer;

6. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as defined in *N.J.A.C. 10:37-6.53* and *6.54*;

ii. Knowledge and documentation of each consumer's current medication treatment/therapies;

iii. Providing a mechanism for staff to share clinical information regarding medication utilization; and

iv. Educating beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and established procedures for responding to crisis situations;

7. Goal-oriented verbal counseling, which may include individual, group and family modalities to address the emotional, cognitive and behavioral symptoms of mental health illness or for engaging, motivating, stabilizing and the related effects on role functioning including consumers with a co-occurring mental health and substance use disorder. Goal-oriented verbal counseling may also include motivational interviewing, connecting skills and cognitive behavioral therapy;

8. Age-appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, recognition of directions and safety warnings. Such basic computing, reading or writing skills are considered incidental and not student education;

9. Social/leisure services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community social and

recreational opportunities, planning for leisure time, practicing social interaction, recreational, spiritual and cultural activities;

10. Psychiatric services, which include assessment and ongoing treatment supervision; and

11. Other planning activities may include the development of an advance directive, that meets the requirements of P.L. 2005, c. 233 with specific instructions on what steps need to be taken in the event of a relapse and the development of a personal wellness and recovery action plan (WRAP).

(c) The PA shall develop written descriptions of services, outlines and curricula for activities and interventions directly provided. Clinical records, schedules, rating forms of group and other activities, logs and other documents shall serve as evidence that these services have been provided.

(d) Off-site interventions can be provided as long as the consumer is accompanied/supervised by staff and the following conditions are met.

1. The off-site interventions shall be:

i. Individualized for each consumer and non-stigmatizing;

ii. Integrated as a subordinate component of the consumer's IRP, which clearly states each specific off-site intervention and how the intervention relates to the overall achievement of the consumer's specific goals and objectives in the service plan, particularly in assisting to generalize skills to community settings. Services that are solely recreational or diversional in nature shall not be considered a PC activity;

iii. Properly documented in the consumer's record to include when the off-site activity commenced and terminated; and

iv. Limited to a defined and measurable period of time.

2. Off-site services provided weekly shall be generally less than 10 percent of an individual consumer's average active programming time in PC during the previous month. If off-site activities are greater than 10 percent additional justification is required in the consumer's record and may be subject to program audit by the Division. In no case may the time be more than 20 percent.

3. The consumer must sign in at the site of the partial care program prior to participating in any off-site activity and sign out of the program after completion of the off-site activity.

4. Transportation to and from the off-site activity shall not be counted as partial care program activity time requirement unless the following are met:

i. The PA has a staff person in the vehicle functioning as a counselor, and there are no more than four consumers in the vehicle. If there are more than four consumers, then a second staff person must accompany the counselor and function as a driver; and

ii. The staff conducts activities during the period of transportation that meet all the requirements for allowable activities of a partial care program.

(e) The PA shall provide or arrange services based on individual consumer need. The PA shall participate in service planning, resolve identified issues, and advocate on behalf of the consumer, as appropriate, for all services that are not provided directly. At a minimum, the following services shall be provided or arranged:

1. Basic services, which may include assisting consumers to procure needed food, clothing, shelter, or income benefits;

2. Health and medical care services, which may include assisting in procurement of, treatment or education about health care and medication;

3. Natural support system services, which may include consultation and education with families, friends or landlords, facilitating self-help groups, or helping consumers connect with community institutions;

4. Financial literacy, which may include money management, saving strategies and budgeting;

5. Other prevocational services, which may include sheltered employment, job training, or volunteer work;

6. Other vocational services in community work settings such as supported employment, transitional employment, consumer owned and operated entrepreneurial businesses, technical occupational skills training, college preparation, individualized job development and marketing to employers based upon the individual consumer need when the consumer has achieved the prevocational skills listed in his or her IRP or requests such services;

7. Consumer-outreach and linkage services designed to facilitate new consumers' participation in the program, to re-engage consumers who have discontinued participating in the program or to effectively link them with other programs that would meet their needs, and to promote continuity of programming for consumers who are hospitalized during the course of their participation in the program. These services shall include, but are not limited to, arranging needed transportation to the program site, relating to other agencies, and contacting and visiting consumers who have discontinued participating in the program;

8. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach that combines mental health and addiction into a unified, comprehensive and blended philosophy that provides prevention, intervention and treatment techniques that simultaneously address the needs from both disorders. Service may include, but is not limited to: a "no wrong door" approach to care, education and life skills management, motivational (staged) treatment, case coordination across systems, dual focus assessment and interventions, milieu of recovery, wellness and empowerment, use of recovery oriented tools and models such as wellness recovery action plan (WRAP), illness management recovery (IMR), integration of self help and 12-step into clinical technique;

9. Educational services, which may include basic education courses, special education courses, G.E.D. classes and pre-college preparation to enter community roles identified in the IRP;

10. Residential services, which may include assisting consumers to secure community residences, board and care homes, private homes or apartments with support, emergency shelters, cooperative apartments or crisis housing; and

11. Accessing acute care services, which may include screening, crisis intervention and inpatient services.

(f) The PA shall develop procedures regarding medications to include:

1. Identification of each consumer's medication needs;

2. Documentation of each consumer's current medications;

3. A mechanism for sharing relevant clinical information with medication providers;

4. Medication education for consumers and families, where relevant; and

5. Provisions for education of staff and other involved caregivers regarding adverse reactions and potential side effects, procedures to respond to such reactions and the consumer's right to refuse or consent to medication.

(g) The PA shall develop written descriptions, outlines and curricula for activities and interventions of services directly provided or arranged for. Clinical records, schedules, logs and other documents shall serve as evidence that these services have been provided.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.3* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Rewrote the section. Former *N.J.A.C. 10:37F-2.5*, Management functions, recodified to *N.J.A.C. 10:37F-2.7*.

Amended by R.2012 d.049, effective March 5, 2012.

See: *43 N.J.R. 2110(b)*, *44 N.J.R. 592(a)*.

In (a), substituted "1:15" for "1:12"; in the introductory paragraph of (b)4, substituted "1:12" for "1:10"; recodified former (b)5iv and (b)5v as (b)5iii(4) and (b)5iii(5); and in (b)5iii(5), substituted "staff-to-consumer" for "staff to consumer", "1:12" for "1:10", and a semi-colon for the period at the end.

Annotations

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Chapter Notes

N.J.A.C. 10:37F-2.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:37F-2.6 Termination, transfer and referral of consumers

(a) Procedures for termination, transfer and referral of consumers shall be documented and shall ensure that the continuing service needs of consumers are met.

(b) Discharge criteria shall be identified at the time of admission and shall include the steps necessary to facilitate community integration. The criteria shall be documented in the initial service recommendations and individual recovery plans.

(c) For consumers being transferred to another service, a brief, succinct transition summary shall be prepared at the time of discharge communicating critical information and shall be forwarded to the receiving agency.

1. Prior to forwarding the transition summary to the receiving agency, the PA shall obtain the consumer's consent, unless the receiving agency had been named by the consumer in the original written authorization completed at intake or unless transfer is for the purpose of treatment and both agencies are funded by the Division.

(d) Discharge criteria shall be limited to the following specific reasons for termination from the program:

1. The consumer has achieved the service plan goals and needs no further treatment;

2. The consumer can be more effectively served by and has been linked to another program, agency or institution;

3. The consumer has either refused repeatedly to participate in major components of the program or stopped attending the program;

4. The consumer demonstrates dangerous, criminal, or other aggressive behavior that is unresponsive to interventions; or

5. The consumer has moved to a location that makes continued participation in the program impossible.

(e) When the consumer has stopped attending the program, significant outreach efforts to re-engage the consumer prior to termination, such as repeated telephone calls, correspondence and home visits shall be documented in the clinical record.

(f) Termination decisions shall be finalized only with approval of the direct care staff supervisor.

(g) Every effort shall be made to consider the consumer's preferences for continuing services and to include the consumer in the development of the discharge plan.

(h) The discharge plan shall include arranged follow-up care or justification for no follow-up care.

(i) A termination or transfer summary shall be written and maintained, separate from the progress notes. The summary shall be completed within 30 days of termination or transfer and include:

1. The presenting problem;

2. The admission date and date of service termination;

3. The course of treatment and consumer's status upon discharge;

4. The reason for termination;

5. The medication prescribed upon discharge;

6. To the extent known, the consumer's perspective on his or her experience in the program, and the consumer's stated reasons for leaving, if applicable; and

7. The discharge plan.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.4* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Section was "Termination, transfer and referral of clients". Substituted "consumers" for "clients" and "consumer" for "client" throughout; inserted new (b) and (c); recodified (c)1 through (c)6 and associated subparagraphs as (d) through (i) and associated subparagraphs; in (d), deleted "criteria shall be developed. These" preceding "criteria"; in (d)5, substituted "that" for "which"; in (g), (i)3 and (i)6, substituted "consumer's" for "client's"; and in introductory paragraph of (i), inserted "be completed within 30 days of termination or transfer and". Former *N.J.A.C. 10:37F-2.6*, Quality assurance activities, recodified to *N.J.A.C. 10:37F-2.8*.

Annotations

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N.J.A.C. 10:37F-2.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:37F-2.7 Management functions

(a) In addition to meeting the management requirements as promulgated in *N.J.A.C. 10:37D*, the PA shall also perform the following management functions:

1. Data on consumer characteristics, such as diagnosis, cultural and communication issues and service needs in addition to partial care; program utilization; and outcomes shall be collected, analyzed and used for program design;

2. Consumer input from consumer satisfaction surveys, exit interviews and other mechanisms shall be utilized by management;

3. Structured and informal opportunities for consumer input and participation, such as consumer management, organization or town meetings, shall be provided;

4. Staff input regarding program design, development, or changes shall be solicited through supervisory meetings, team meetings, and other mechanisms utilized by management;

5. Staff and consumer involvement and participation in larger "systems-oriented" activities, such as conferences, seminars, workshops, or membership in local, State, or national organizations shall be encouraged whenever possible;

6. The PA shall conduct regularly scheduled meetings for staff and consumers to discuss program issues; and

7. The PA shall develop written policies and procedures regarding the release of confidential consumer information within the program and among other consumers and staff. These policies and procedures shall comply with all related Federal and State statutes and any Department rules.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.5* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Substituted "consumer" for "client" throughout; in (a)1, substituted "partial care" for "Partial Care"; in (a)6 and (a)7, substituted "consumers" for "clients". Former *N.J.A.C. 10:37F-2.7*, Therapeutic environment, recodified to *N.J.A.C. 10:37F-2.9*.

Annotations

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Chapter Notes

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N.J.A.C. 10:37F-2.8

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:37F-2.8 Quality assurance activities

(a) In addition to meeting the quality assurance requirements as promulgated in N.J.A.C. 10:37-9, the PA shall address the following areas:

1. Consumer outcome measures shall be monitored based on consumer-identified and program-identified goals; and

2. Consumer satisfaction and family satisfaction, and efforts to engage consumers, shall be monitored.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.6* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

In (a)1 and (a)2, substituted "Consumer" for "Client"; in (a)1, substituted "consumer" for "client"; and in (a)2, inserted "family satisfaction" and substituted "consumers" for "clients". Former *N.J.A.C. 10:37F-2.8*, Staffing, recodified to *N.J.A.C. 10:37F-2.10*.

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:37F-2.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:37F-2.9 Therapeutic environment

(a) The PA shall provide a safe environment, normalized to the extent possible, that shall serve to enhance interaction among staff and consumers.

1. The PA facility shall conform to all Federal, State and local laws and shall provide evidence of satisfactory inspections.

2. The PA shall document that monitoring and follow-up on all safety and health issues identified by inspections or by the PA has occurred.

3. The PA shall document evidence of regular cleaning and maintenance of the facility.

4. Staff trained in CPR and first aid shall be available during program operation.

5. The PA shall have procedures for responding to emergency situations, including assaultive and suicidal behavior and ideation, acute decompensation, and medical emergencies.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.7* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

In the introductory paragraph of (a), substituted "consumers" for "clients".

Annotations

Notes

Chapter Notes

N.J.A.C. 10:37F-2.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

§ 10:37F-2.10 Staffing

(a) The PA shall be sufficiently staffed with personnel, who are licensed, when required, appropriately credentialed, culturally competent and sufficiently trained to provide PC services as set forth in this chapter. Staff may be engaged on a full time, part time or consulting basis, provided that services are adequate to meet the program needs of participating consumers.

(b) The PA shall, at a minimum, employ the following staff titles with the following responsibilities:

1. The program director shall:

i. Have primary responsibility for program operation, development and management;

ii. Be available for crisis consultation and management and for coordination with outside practitioners; and

iii. Possess a master's degree in a human service field and five years experience in mental health services, with two years supervisory experience or possess a professional credential, such as: licensed clinical social worker, licensed professional counselor, licensed associate counselor, licensed rehabilitation counselor, licensed clinical alcohol and drug counselor, licensed psychologist, advanced practice nurse or master of science in nursing with the requisite number of years of experience.

2. The medical director or supervising psychiatrist shall:

i. Be a physician licensed to practice in the State of New Jersey and board certified or eligible in general psychiatry;

ii. Provide needed medical input into the development of the program;

iii. Be directly affiliated with the program;

iv. Assume professional responsibility for the treatment and services provided and assure that the treatment and services are medically appropriate;

v. Supervise the treatment provided to each consumer;

vi. Provide input into treatment and service plans;

vii. Provide initial psychiatric assessment and ongoing psychiatric review at least two times per year;

viii. Provide consultation to program staff on an ongoing basis;

ix. Be available and provide inservice training to program staff; and

x. Assure that all psychiatric and medical services that are provided by the program, meet accepted standards of medical practice.

3. The direct care on-site staff supervisor shall:

i. Have primary responsibility for supervision of direct care staff; and

ii. Possess a master's degree in a mental health, rehabilitation or human services field, or a bachelor's degree and a minimum of two years experience in providing mental health services; or possess a relevant professional credential, such as: licensed clinical social worker, licensed professional counselor, licensed associate counselor, licensed rehabilitation counselor, licensed clinical alcohol and drug counselor, licensed psychologist, or master of science in nursing.

4. The primary case coordinator or counselor shall:

i. Have primary responsibility for service coordination, provision or arrangement of services needed, personal advocacy, and development, review and updating of individual treatment and service plans; and

ii. Possess a bachelor's degree in a human services field, or an associate's degree and two years experience in providing human services, or five years of human service experience, or possess a relevant professional credential, such as Certified Psychiatric Rehabilitation Practitioner, bachelor's degree in social work, certified rehabilitation counselor, certified alcohol and drug counselor, bachelor's degree in rehabilitation, or bachelor of science in nursing.

5. The mental health services worker shall:

i. Have primary responsibility for the provision and coordination of program services; and

ii. Possess a bachelor's degree or associate degree in psychosocial rehabilitation or mental health services, or possess related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives, or possess one of the following credentials: Certified Psychiatric Rehabilitation Practitioner or Community Mental Health Associate.

(c) Each PA shall designate staff to take primary responsibility for providing pre-vocational and integrated treatment for co-occurring mental health and substance abuse disorders services. Such designated staff members shall possess the qualifications for the primary case coordinator or counselor position and shall have training and experience in providing the specialized service.

1. Qualifications for the primary staff providing pre-vocational services must include one year's experience in providing services such as supported employment or job coaching, vocational evaluation, welfare to work, community rehabilitation services, transitional employment, other work experience programs for consumers and recent relevant training or possess one of the following: certified rehabilitation counselor, licensed rehabilitation counselor, master's or bachelor's degree in rehabilitation counseling, Certified Psychiatric Rehabilitation Practitioner, or vocational instructor as defined by the New Jersey State Board of Education.

i. Qualified staff shall maintain their knowledge and expertise by continuing to receive recent, relevant training and continuing education.

ii. Staff who provided pre-vocational services prior to November 6, 2006, but who did not have one year of experience as of that date, shall be permitted to remain in their positions, but are required to attend the training and continuing education referenced in *N.J.A.C. 10:37F-2.10(c)*1i.

iii. Staff who are either hired or who are moved into pre-vocational service positions shall fulfill the one-year experience requirement.

2. Qualifications for the primary staff providing integrated treatment for co-occurring mental health and substance use disorder services must follow the requirements as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners.

(d) The PA may employ students and volunteers, in addition to required staff as set forth in this chapter.

(e) The PA shall make continuing education available in order to ensure that staff has the competencies necessary to deliver the core program areas.

History

HISTORY:

Recodified from *N.J.A.C. 10:37F-2.8* and amended by R.2006 d.389, effective November 6, 2006.

See: *38 N.J.R. 1990(a)*, *38 N.J.R. 4694(b)*.

Rewrote (a), (b)1iii, (b)2i, (b)3ii, (b)4ii, (b)5ii and (c); in (b)2v, substituted "consumer" for "client"; in (b)3, inserted "on-site"; and added (e).

Annotations

Notes

Chapter Notes