xi. Only harvest [snapping turtles] **American Snapping Turtles** with a minimum carapace length of [12] **13** inches **as measured along the curve of the carapace**;

xii. Submit a written explanation for the failure to trap or harvest [snapping turtles] **American Snapping Turtles** within **an** approved permit timeframe; and

xiii. Report sightings of any State endangered or threatened species of turtle by completing **a New Jersey Wildlife Tracker form available online at** [and submitting a Division Sighting Report Form; available at http://www.state.nj.us/dep/fgw/ensp/pdf/rptform.pdf] **https://dep.nj.gov/njfw/conservation/reporting-rare-wildlife-sightings/**.

(e) Those species of frogs and turtles listed [as State endangered or threatened] **on the State List of endangered species at N.J.A.C. 7:25-4.13 or the List of regulated nongame species at N.J.A.C. 7:25-4.17** may not be pursued, taken, killed, or possessed**, except where allowed by special permit issued by the Division**. [The possession of other species of frogs and turtles not regulated in this Code is regulated under N.J.S.A. 23:2A-6.]

HUMAN SERVICES

(a)

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Behavioral Health Program Service Standards

Proposed Repeals: N.J.A.C. 10:37E and 10:37F

Proposed New Rules: N.J.A.C. 10:36

Authorized by: Sarah Adelman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 26:2B-7 et seq., in particular 26:2B-13; 26:2BB-5 through 6; 26:2G-1 et seq., in particular 26:2G-5; 26:2G-21 et seq., in particular 26:2G-25; 30:1-12 et seq.; 30:9A-10; and 30:9A-21; and Reorganization Plan 001-2018.

Calendar Reference: See the Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2025-106.

Submit comments by October 17, 2025, to:

Lisa Ciaston, Legal Liaison
Division of Mental Health and Addiction Services
PO Box 700
Trenton, New Jersey 08625-0700
or electronically at: DMHAS.RuleComments@dhs.nj.gov

The agency proposal follows:

Summary

As the Department of Human Services ("Department" or "DHS") is providing a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

In State fiscal year 2011, the Division of Mental Health and Addiction Services ("Division" or "DMHAS") was created by merging the Division of Mental Health Services and the Division of Addiction Services. In 2017, the Division was transferred from the Department to the Department of Health (DOH) pursuant to Reorganization Plan 001-2017. In 2018, the Division was returned to the Department in accordance with Reorganization Plan 001-2018. Consistent with the 2018 Reorganization Plan, and in the Division's role and designation as the State Mental Health Authority and Single State Agency for Substance Use, the Division is responsible for the development, coordination, and operational support of a comprehensive mental health and addiction services system, including a continuum of community-based prevention, early intervention, treatment, and recovery services. The Division is further responsible for providing monitoring and oversight of the community-based system through the establishment of regulatory standards that implement the State's public policy objectives for, and ensure safe and adequate delivery of, behavioral health (BH) treatment services in New Jersey.

The proposed repeals and new rules represent a transformative redesign of the Division's rules applicable to community-based behavioral health programs with an emphasis on consolidating and simplifying program standards, while simultaneously establishing standards consistent with current practices. Further, consistent with Executive Order No. (E.O. No.) 63 (2019), this rulemaking "contribute[s] to the overall high quality of life in the State" and "carr[ies] out the government's ongoing mission of promoting the health, safety, and welfare of New Jersey." To that end, this rulemaking sets forth streamlined program standards that reduce regulatory burdens on, and allow more flexibility for, behavioral health provider agencies, while at the same time, supporting the provision of behavioral health treatment services to New Jersey residents in a safe, quality manner.

Thus, the Department is proposing new N.J.A.C. 10:36, Behavioral Health Program Service Standards, because the Commissioner of the Department of Human Services has determined that this rulemaking is necessary in order to ensure that New Jersey residents have access to behavioral health treatment care and services. In this rulemaking, the term "behavioral health" is used to generally refer to the treatment of mental illness and/or addictive disorders.

The Prevalence of Behavioral Health and Co-Occurring Disorders

As recent as 2023, in the United States, 48.5 million people, or 17 percent of the population, aged 12 or older, had a substance use disorder (SUD) in the past year; 58.7 million people (22.8 percent) aged 18 or older had any mental illness (AMI) in the past year; and 14.6 million people (5.7 percent) aged 18 or older had a serious mental illness (SMI) in the past year. Substance Abuse and Mental Health Services Administration (SAMHSA), 2024, *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and* Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59), Center for Behavioral Health Statistics and Quality.

Furthermore, many individuals have a co-occurring disorder (COD), that is, the condition of having at least one mental health disorder and at least one SUD. In 2023, of the 58.7 million adults aged 18 or older with an AMI, 20.4 million had a SUD; and of the 14.6 million adults with a SMI, 6.8 million had an SUD. *Ibid*.

Indeed, "[p]eople with SUDs are more likely than those without to have co-occurring mental disorders." SAMHSA, 2021, *Substance Use Disorder Treatment for People with Co-Occurring Disorders, Advisory* (HHS Publication No. PEP20-06-04-006). Similarly, studies have found that up to 56 percent of individuals with the most serious mental illnesses have a co-occurring SUD within their lifetime. SAMHSA, *Integrated Treatment for Co-Occurring Disorders: Building Your Program,* DHSS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, 2009, at pp. 2 and 4. Yet, according to results from the 2017 National Survey on Drug Use and Health, only 12 percent of adults with a co-occurring SMI and SUD received both mental health and specialty SUD treatment, and only eight percent of adults with an AMI and a SUD received both mental health and specialty SUD treatment. National Association of State Mental Health Program Directors, *Assessment #8: Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?*, Aug. 2019, at p. 3.

Historically, the system of outpatient mental health and SUD services have been siloed, leading to separate and disjointed care for individuals with a COD. For example, many individuals with a COD receive treatment for their mental illness at one provider agency, and treatment for their SUD at another provider agency. However, an individual with a COD has an improved chance of recovery from both disorders when they receive treatment for their mental illness and SUD in an integrated fashion from the same provider. See SAMHSA, *Building Your Program, supra,* at p.2.

For those individuals with a COD, the integration of mental health and SUD treatment "leads to a better quality of care and health outcomes for those living with co-occurring disorders by treating the whole person." SAMHSA, *The Case for Screening and Treatment of Co-Occurring Disorders*, at www.samhsa.gov/co-occurring-disorders. These improved

health outcomes include improvement in psychiatric symptoms and functioning, reduced or discontinued substance use, improved quality of life, decreased hospitalization, and reduced medication interactions. *Ibid.* From a foundational level, integrated treatment for COD means mental health and SUD treatment services are provided in an integrated manner with integrated treatment plans by providers with knowledge of both SMI and SUDs so that patients do not have to attend different mental health and SUD programs. See SAMHSA, *Building Your Program, supra, at p. 1*.

Behavioral Health Program Service Standards Overview

As the statistics above demonstrate, there is a significant need for behavioral health services. This rule addresses behavioral health services provided to patients with a diagnosis of a mental illness and/or an addictive disorder in a community outpatient setting licensed by DOH pursuant to facility licensing standards at N.J.A.C. 8:43K. In addition to any DOH facility's licensing standards applicable to behavioral health provider agencies, behavioral health provider agencies must adhere to the program standards set forth in this rulemaking that apply to the level, or levels, of care offered by their provider agency, and for which they are licensed by DOH to provide in their facility. These program standards will be referenced in DOH's facility licensing standards. More specifically, this rule delineates the minimum program standards for the following levels of care: outpatient mental health (MH) and/or addictive disorder; intensive outpatient addictive disorder; mental health partial care; addictive disorder partial care; and opioid treatment programs. (Standards for residential SUD treatment facilities are governed at N.J.A.C. 8:111, and standards for MH residential and supervised housing programs are governed at N.J.A.C. 10:37, 10:37A, and 10:37B.)

Through this new chapter, the Division is adopting a more comprehensive and consolidated regulatory structure for the regulation of behavioral health program services. This chapter will not only allow for more streamlined programmatic standards that will minimize regulatory burdens on provider agencies, but also promote an integrated behavioral health care service model through program standards that allow appropriately licensed behavioral health provider agencies greater flexibility in the provision of behavioral health services to patients. Indeed, while the Division has always encouraged integrated behavioral health services and fostered initiatives to address the needs of individuals with a COD, this chapter strengthens those efforts by promoting integrated behavioral health services through rulemaking. The Division has worked diligently on this regulatory scheme to support an integrated approach to the provision of behavioral health services by bringing mental health and addictive disorder services together to better meet the needs and improve the quality of care provided to New Jersey residents, especially those New Jersey residents with a COD.

Although behavioral health programs in New Jersey may elect to provide mental health, addictive disorder, or a combination of both mental health and addictive disorder services, the Division believes this chapter will encourage and support implementation of an integrated behavioral health services model of care so that New Jersey residents with CODs receive treatment in a more holistic and integrated manner to better improve their long-term outcomes and recovery, and have an opportunity to receive care and treatment through a single behavioral health provider agency.

In summary, with this chapter, the Division seeks to ensure the safe delivery of quality behavioral health care and treatment services, as well as foster the growth of integrated behavioral health services to better meet and improve individualized behavioral health-related needs and outcomes for New Jersey residents.

Proposed New Rules—Subchapter Summary

This new chapter sets forth a new consolidated and streamlined regulatory structure with program standards applicable to behavioral health programs that provide services to patients with a mental illness and/or an addictive disorder in a community outpatient setting. The rules address general program operational requirements; staffing requirements; core program service standards; and, program level-of-care specific standards. Specifically, this new chapter delineates minimum program standards for the following levels of care: outpatient mental health and/or addictive disorder, intensive outpatient addictive disorder, mental health partial care, addictive disorder partial care, and opioid treatment programs.

A behavioral health provider must comply with the program standards that apply to the level, or levels, of care that they offer to patients, and for which they are licensed by DOH to provide to patients in their facility pursuant to N.J.A.C. 8:43K. These program standards will be referenced by DOH in their facility licensing standards at N.J.A.C. 8:43K.

This rule is organized into eight subchapters. Following is a subchapter-by-subchapter summary of this new chapter.

Subchapter 1. Purpose and Scope

Proposed new N.J.A.C. 10:36-1.1, Purpose, describes the overall purpose of the chapter as setting forth the minimum rules and standards of care governing the provision of behavioral health treatment programs and services in New Jersey.

Proposed new N.J.A.C. 10:36-1.2, Scope and applicability, at subsection (a), explains that this chapter applies to all facilities licensed by DOH to provide behavioral health services to adults in an outpatient setting for the following levels of care: outpatient addictive disorder and/or mental health, intensive outpatient addictive disorder, partial care mental health, partial care addictive disorder, and opioid treatment programs. Proposed new N.J.A.C. 10:36-1.2(b) states that this chapter establishes the basis for the monitoring of behavioral health care programs and services by the Department and Division.

Subchapter 2. Definitions

Proposed new N.J.A.C. 10:36-2.1, Definitions, defines the following terms used in the chapter: "addictive disorder," "'admission' or 'admitted,'" "'American Society of Addiction Medicine criteria' or 'ASAM criteria,'" "behavioral health," "BH care plan," "BH program," "biopsychosocial assessment," "DEA," "Department," "'Department of Health' or 'DOH,'" "Division," "'document,' 'documented,' or 'documentation,'" "dosage," "'DSM' or 'DSM-5-TR,'" "evidence-based practices," "family members and/or other supportive persons," "FDA," "immediate needs assessment," "'inter-disciplinary team' or 'IDT,'" "medication," "mental illness," "'opioid use disorder' or 'OUD,'" "patient," "progress note," "psychiatric advance directive," "psychoeducation services," "regularly scheduled," "rehabilitative support services," "SAMHSA," "serious mental illness," and "treatment record."

Subchapter 3. General BH Program Operational Requirements

Subchapter 3, General Behavioral Health (BH) Program Operational Requirements, describes compliance with laws and rules, confidentiality requirements, submission of documents and data to the Department and/or Division, and provisions regarding application and standards related to the waiver of program standards.

Proposed new N.J.A.C. 10:36-3.1, Compliance with laws and rules, at subsection (a) sets forth that, to provide BH services, a BH program must have a contract or affiliation agreement with the Division and be licensed by DOH. Proposed new N.J.A.C. 10:36-3.1(b) requires compliance with all applicable Federal, State, and local laws, rules, and regulations, and with any applicable accrediting organizations. Proposed new N.J.A.C. 10:36-3.1(c) requires compliance with any and all rules established by DOH for the licensing of behavioral health programs, including licensing standards at N.J.A.C. 8:43K. Proposed new N.J.A.C. 10:36-3.1(d) states that the Division may refer any findings of non-compliance by a BH program with the standards set forth in this chapter, or any other regulatory compliance concerns, to DOH for review and, if appropriate, licensing action.

Proposed new N.J.A.C. 10:36-3.2, Patient confidentiality, mandates compliance with all applicable Federal and State confidentiality laws, rules, and regulations, including 42 CFR Part 2, HIPAA, and N.J.S.A. 30:4-24.3.

Proposed new N.J.A.C. 10:36-3.3, Submission of documents and data to DHS and/or DMHAS, at subsection (a), requires the timely reporting and submission of required data and information into DHS- and/or DMHAS-designated electronic databases and/or management systems, including the Division's New Jersey Substance Abuse Monitoring System, and any applicable capacity and referral system. Further,

attendance and participation in any mandatory DHS and/or DMHAS orientation and/or trainings for designated electronic databases and/or management systems is mandated. Proposed new N.J.A.C. 10:36-3.3(b) requires cooperation with any DHS and/or DMHAS monitoring activities and related requests for data and information. Proposed new N.J.A.C. 10:36-3.3(c) states that any failure to report or provide data and information, or to cooperate with any DHS and/or DMHAS monitoring activities, will be considered non-compliance by the behavioral health program, and may result in a referral to DOH for review and, if appropriate, licensing action.

Proposed new N.J.A.C. 10:36-3.4, Waiver, at subsection (a), describes certain conditions that must be satisfied when a behavioral health program seeks a waiver of standards in this chapter. Proposed new N.J.A.C. 10:36-3.4(b) requires that the behavioral health program provide any additional explanation, information, and documentation requested by DMHAS to evaluate the behavioral health program's waiver request. Proposed new N.J.A.C. 10:36-3.4(c) explains that all waiver requests must be reviewed and approved by the Assistant Commissioner. Proposed new N.J.A.C. 10:36-3.4(d) sets forth the conditions for granting of any waivers by the Assistant Commissioner and time periods for waivers. In addition, the subsection describes the contents of communications issued by the Division regarding the granting of any waiver. Proposed new N.J.A.C. 10:36-3.4(e) specifies that a waiver may be suspended or revoked at any time and provides examples of reasons that justify a suspension or revocation of a waiver.

Subchapter 4. BH Program Staffing Requirements

Subchapter 4, BH Program Staffing Requirements, sets forth general staffing requirements for BH programs. Proposed new N.J.A.C. 10:36-4.1 requires BH programs to comply with applicable staffing requirements set forth in DOH's facility licensing standards, including at N.J.A.C. 8:43K, and Federal standards, including 42 CFR Part, which applies to OTPs.

Subchapter 5. BH Program Core Service Standards

Subchapter 5, BH Program Core Service Standards, describes standards related to: the admission intake process; screening and assessment services and tools; BH care plan development and contents; safety plan development; counseling and/or therapy services; medication services, including medication education and monitoring requirements; psychoeducational and patient education services; administrative discharge; voluntary discharge; involuntary discharge; and discharge documentation and planning.

Proposed new N.J.A.C. 10:36-5.1, Admission intake process, at subsection (a), directs the BH program to implement an admission intake process and sets forth the minimum requirements for the admission intake process.

Proposed new N.J.A.C. 10:36-5.2, Screening and assessment services and tools, at subsection (a), requires that the BH program use evidence-based, nationally recognized, and peer-reviewed screening and assessment tools. Proposed new N.J.A.C. 10:36-5.2(b) compels the BH program to ensure that only staff possessing the appropriate clinical background, education, credentials, and qualifications shall perform evaluations using screening and assessment tools. Proposed new N.J.A.C. 10:36-5.2(c) describes the minimum screening and assessment services that must be implemented by the BH program. Proposed new N.J.A.C. 10:36-5.2(d) sets forth the minimum requirements for the timing of a patient's biopsychosocial assessment. Proposed new N.J.A.C. 10:36-5.2(e) requires completion of the immediate needs assessment at a patient's first visit. The subsection further requires the BH program to make appropriate referrals and/or linkages to address a patient's immediate needs and to document the immediate needs assessment and referrals in the patient's treatment record. Proposed new N.J.A.C. 10:36-5.2(f) sets forth the minimum requirements for the timing of a patient's screening for suicide risk.

Proposed new N.J.A.C. 10:36-5.3, BH care plan and planning, at subsection (a), describes the minimum BH care plan and planning process that must be implemented by the BH program. Proposed new N.J.A.C. 10:36-5.3(b) requires that the BH program maintain a copy of a patient's BH care plan in the patient's treatment record and provide a copy of the BH care plan to the patient upon their request and at the time of the patient's discharge. Proposed new N.J.A.C. 10:36-5.3(c) sets forth the minimum contents for the BH care plan. Proposed new N.J.A.C. 10:36-5.3(d) describes the minimum contents that the BH care plan must address at the time of a patient's discharge.

Proposed new N.J.A.C. 10:36-5.4, Safety plan, describes the conditions in which a safety plan must be developed for a patient. It further requires that the safety plan be incorporated within the patient's BH care plan.

Proposed new N.J.A.C. 10:36-5.5, Counseling and/or therapy services, at subsection (a), states that the BH program is responsible for providing counseling and/or therapy services to patients. Proposed new N.J.A.C. 10:36-5.5(b) requires that counseling and/or therapy services be based upon, and incorporate, evidence-based practices. Proposed new N.J.A.C. 10:36-5.5(c) requires that counseling and/or therapy services must only be provided by staff with the appropriate clinical background, education, credentials, and/or qualifications. Proposed new N.J.A.C. 10:36-5.5(d) describes that counseling and/or therapy services may consist of individual, group, and family counseling and therapy sessions and psycho-education sessions. Proposed new N.J.A.C. 10:36-5.5(e) requires that the frequency and type of counseling, therapy, and/or psycho-education sessions be tailored to a patient's severity, functioning, and response to treatment and be directed by the patient's interdisciplinary team. Proposed new N.J.A.C. 10:36-5.5(f) states that group counseling and/or therapy sessions must contain no more than 12 patients.

Proposed new N.J.A.C. 10:36-5.6, Medication services, at subsection (a), requires the BH program to provide, or arrange for, medication services for patients to treat behavioral health conditions. Proposed new N.J.A.C. 10:36-5.6(b) requires the BH program to provide medication education, medication management, and medication monitoring to patients and describes what each of these medication-related activities entails. Proposed new N.J.A.C. 10:36-5.6(c) requires that the BH program comply with applicable State and Federal laws, rules, regulations, and standards with respect to the administration, dispensation, ordering, and prescribing of medication used for the treatment of addiction disorders and/or mental illness. Proposed new N.J.A.C. 10:36-5.6(d) states that the BH program must maintain current procedures to ensure that medications are administered consistent with their approved product labeling.

Proposed new N.J.A.C. 10:36-5.7, Psychoeducational and patient education services, at subsection (a), requires that the BH program provide psychoeducation to patients. Proposed new N.J.A.C. 10:36-5.7(b) directs the BH program to offer psychoeducation services to family members and other supportive persons, as identified by the patient, and when appropriate, unless the patient objects, the services are clinically contraindicated, and/or the family members and/or supportive persons are unwilling to participate in the offered services. Proposed new N.J.A.C. 10:36-5.7(c) sets forth the minimum educational topics that must be provided to patients by the BH program.

Proposed new N.J.A.C. 10:36-5.8, Administrative discharge from the BH program, at subsection (a), explains that a BH program may administratively discharge a patient for unavailability and specifically describes unavailability as the patient being incarcerated, hospitalized, or lost to contact. Proposed new N.J.A.C. 10:36-5.8(b) requires that a BH program administratively discharge a patient by no later than 90 days from when the patient is unavailable to continue to receive services. Proposed new N.J.A.C. 10:36-5.8(c) delineates the reasonable efforts that the BH program must make prior to any administrative discharge of a patient.

Proposed new N.J.A.C. 10:36-5.9, Voluntary discharge from the BH program, at subsection (a), describes the specific conditions in which a BH program may voluntarily discharge a patient. Proposed new N.J.A.C. 10:36-5.9(b) delineates the actions that the BH program must take prior to any voluntary discharge of a patient.

Proposed new N.J.A.C. 10:36-5.10, Involuntary discharge from the BH program, at subsection (a), describes the specific conditions in which a BH program may involuntarily discharge a patient. Proposed new N.J.A.C. 10:36-5.10(b) states that a BH program cannot involuntarily discharge a patient who is experiencing, or has experienced, a relapse related to an addictive disorder. Proposed new N.J.A.C. 10:36-5.10(c) delineates the actions that the BH program must take prior to any involuntary discharge of a patient. Proposed new N.J.A.C. 10:36-5.10(d) requires that the BH program maintain documentation relating to the

patient's involuntary discharge in the patient's treatment record and describes the minimum requirements for this documentation.

Proposed new N.J.A.C. 10:36-5.11, Discharge documentation and planning, at subsection (a), requires that discharge planning begin upon the patient's admission to the BH program. Proposed new N.J.A.C. 10:36-5.11(b) requires that discharge planning be incorporated into the patient's BH care plan. Proposed new N.J.A.C. 10:36-5.11(c) states that the BH program must include family members and/or other supportive persons, as identified by the patient in discharge planning, when to do so would be beneficial to the patient, and unless clinically contraindicated, and consistent with applicable Federal and State confidentiality laws, rules, and regulations. Proposed new N.J.A.C. 10:36-5.11(d) requires that the BH program assist a patient with making appointments, when clinically appropriate, for recommended continued behavioral health services and to do so consistent with applicable Federal and State confidentiality laws, rules, and regulations. The subsection further describes documentation requirements regarding appointment assistance provided by the BH program.

Proposed new N.J.A.C. 10:36-5.11(e) requires that the BH program provide a safety, crisis, and/or relapse prevention plan, as clinically appropriate, to the patient prior to their discharge. Proposed new N.J.A.C. 10:36-5.11(f) requires that the BH program provide education on, and facilitate assistance with, execution of a psychiatric advance directive to a patient prior to their discharge. Proposed new N.J.A.C. 10:36-5.11(g) requires that the BH program provide discharge instructions to all patients prior to discharge. The subsection further sets forth a list of minimum contents for the discharge instructions and necessary reviews and signatures for the discharge instructions. Proposed new N.J.A.C. 10:36-5.11(h) requires that the BH program complete a discharge summary for each patient. It further sets forth the minimum contents for the discharge summary and process requirements, such as timing, filing, review, and signature, for the discharge summary. Proposed new N.J.A.C. 10:36-5.11(i) requires that the BH program make reasonable attempts to follow up with a patient following their discharge to ascertain whether the patient is engaged in treatment with another BH program or healthcare provider or to provide referrals for services.

Subchapter 6. Program Standards for Outpatient Addictive Disorder and/or Mental Health Services

Subchapter 6 describes minimum standards for the provision of outpatient services by a BH program, including: general requirements and standards, admission intake process timeframes, BH care plan development and review timeframes, and counseling and/or therapy services hours.

Proposed new N.J.A.C. 10:36-6.1, Outpatient services general requirements and standards, at subsection (a), describes the general requirements and standards applicable to the provision of outpatient addictive disorder and/or mental health services. Proposed new N.J.A.C. 10:36-6.1(b) sets forth a description of outpatient services.

Proposed new N.J.A.C. 10:36-6.2, Outpatient services admission intake process and timeframe, addresses the admission intake process and timeframe for completion of the admission intake process for outpatient services.

Proposed new N.J.A.C. 10:36-6.3, Outpatient BH Care Plan development and review timeframes, sets forth the requirements for a patient's BH care plan for outpatient services, including development, timeframe, and reviews.

Proposed new N.J.A.C. 10:36-6.4, Outpatient services counseling and/or therapy services and hours, describes counseling and/or therapy services and hours, including requiring that the BH program provide each patient admitted to outpatient services with regularly scheduled counseling, therapy, and/or psychoeducation sessions.

Subchapter 7. Program Standards for Intensive Outpatient Addictive (IOP) Disorder Services

Subchapter 7 describes minimum standards for the provision of intensive addictive disorder outpatient services by a BH program, including: general requirements and standards, admission intake process timeframes, BH care plan development and review timeframes, and counseling and/or therapy services hours.

Proposed new N.J.A.C. 10:36-7.1, IOP addictive disorders services general requirements and standards, at subsection (a), describes the general requirements and standards applicable to the provision of addictive disorder intensive outpatient services. Proposed new N.J.A.C. 10:36-7.1(b) sets forth a description of addictive disorder intensive outpatient services.

Proposed new N.J.A.C. 10:36-7.2, IOP addictive disorders services admission intake process and timeframe, addresses the admission intake process and the timeframe for completion of the admission intake process for addictive disorder intensive outpatient services.

Proposed new N.J.A.C. 10:36-7.3, IOP addictive disorders services BH care plan development and review timeframes, sets forth the requirements for a patient's BH care plan for addictive disorder intensive outpatient services, including development, timeframe, and reviews.

Proposed new N.J.A.C. 10:36-7.4, IOP addictive disorders services description of services and hours, describes counseling and/or therapy services, including the minimum number of contact hours, and services that must be provided by the BH program to each patient admitted for addictive disorder intensive outpatient services.

Subchapter 8. Program Standards for MH and/or Addictive Disorder Partial Care (PC) Services

Subchapter 8 describes minimum standards for the provision of partial care services by a BH program, including: general requirements and standards, admission intake process timeframes, provisional services during admission intake, screening and assessment services and tools, BH care plan development and review timeframes, counseling and/or therapy services hours, off-site activities and/or interventions, MH PC services staffing ratios, and rehabilitative support services.

Proposed new N.J.A.C. 10:36-8.1, PC services general requirements and standards, at subsection (a), describes the general requirements and standards applicable to the provision of partial care services. Proposed new N.J.A.C. 10:36-8.1(b) sets forth a description of partial care services.

Proposed new N.J.A.C. 10:36-8.2, PC services admission intake process and timeframe, delineates the minimum admission intake requirements and timeframe for completion of the admission intake process for partial care mental health and partial care addictive disorder services.

Proposed new N.J.A.C. 10:36-8.3, PC mental health services provisional services during admission intake, states that completion of the formal admission intake process does not preclude an otherwise eligible patient from participating in partial care mental health services program activities or receiving services on a provisional basis during a seven-day trial period.

Proposed new N.J.A.C. 10:36-8.4, PC services screening and assessment services and tools, describes and sets forth the screening and assessment requirements, including tools and timeframes, for partial care mental health and partial care addictive disorder services.

Proposed new N.J.A.C. 10:36-8.5, PC services BH care plan development and review timeframes, sets forth the timeframes for development and review of a patient's BH care plan for partial care mental health and partial care addictive disorder services.

Proposed new N.J.A.C. 10:36-8.6, PC services counseling and/or therapy services, describes the services that the BH program shall be equipped to provide to patients admitted for partial care mental health and partial care addictive disorder services.

Proposed new N.J.A.C. 10:36-8.7, PC services off-site activities and/or interventions, describes the conditions when off-site activities and/or interventions are permissible or impermissible for partial care mental health and partial care addictive disorder services.

Proposed new N.J.A.C. 10:36-8.8, PC services rehabilitative support services, requires that the BH program directly provide rehabilitative support services to patients and sets forth requirements related to the provision of rehabilitative support services and examples of rehabilitative support services.

Subchapter 9. Program Standards for Opioid Treatment Program (OTP) Services

Subchapter 9 describes minimum standards for the provision of OTP services by a BH program, including: general requirements and standards and involuntary discharge.

Proposed new N.J.A.C. 10:36-9.1, OTP services general requirements and standards, at subsections (a) through (e), describes the general requirements and standards applicable to the provision of OTP services. Proposed new N.J.A.C. 10:36-9.1(f) sets forth a description of an OTP.

Proposed new N.J.A.C. 10:36-9.2, OTP services involuntary discharge, delineates the requirements that an OTP must comply with for the involuntary discharge of a patient from the BH program.

Incorporation By Reference Documents

The following documents are incorporated into the chapter by reference, as amended and supplemented:

1. The "American Society of Addiction Medicine criteria" or "ASAM criteria" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer/discharge of individuals with addictive disorders, and is first incorporated at N.J.A.C. 10:36-2.1. The text, the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Volume 1: Adults, 4th ed., Hazelden Publishing (2023), and any subsequent amendments, editions, supplements, or volumes, contains the ASAM criteria; and

2. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) and is first incorporated at N.J.A.C. 10:36-2.1. The text, The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, American Psychiatric Association (2022), and any subsequent amendments, editions, supplements, or volumes, is the standard classification of mental disorders in the United States.

Proposed Repeals

The following chapters are proposed for repeal: N.J.A.C. 10:37E, Outpatient Service Standards (originally effective September 18, 1995), and 10:37F, Partial Care Services Standards (originally effective November 6, 1995). The new chapter replaces program standards found within the two aforementioned existing chapters for outpatient mental health services and partial care mental health services.

In addition, DOH has proposed N.J.A.C. 8:43K, which will set forth new facility licensing standards for behavioral health services and opioid treatment program services. As part of the DOH's rulemaking, it will repeal N.J.A.C. 10:161B, Standards for Outpatient Substance Use Disorder Treatment Facilities, which sets forth licensing and program standards for outpatient addictive disorder services, intensive outpatient addictive disorder services, partial care addictive disorder services, and opioid treatment program services.

Both new chapters, N.J.A.C. 10:36 and 8:43K, will replace the licensing and program standards found at N.J.A.C. 10:37E, 10:37F, and 10:161B. Thus, these three existing chapters are being repealed to avoid redundancy and conflict with the proposed new rules at N.J.A.C. 10:36 and 8:43K.

Social Impact

The proposed new chapter will have a positive impact by promoting more effective and efficient delivery of behavioral health services in the State, which benefits individual patients, their families, behavioral health provider agencies, the health care system, and the public in general. Behavioral health provider agencies will benefit from updated and streamlined standards for the delivery of behavioral health programming in New Jersey; patients will benefit from standards that promote access to safe and effective behavioral health services in New Jersey; and the Division will benefit from these standards because they provide an appropriate measure to use in determining whether service delivery meets basic minimum requirements. Moreover, the standards in this chapter are expected to encourage integrated behavioral health services, and provide for a more patient-centered and individualized approach to behavioral health treatment services that will benefit both patients and behavioral health provider agencies.

Economic Impact

The proposed new chapter may have an economic impact on behavioral health provider agencies. However, the costs, if any, may vary and are outweighed by the interest in ensuring access to appropriate behavioral health treatment services. Additionally, many of the proposed new minimum standards impose no new costs because they represent currently accepted and usual practice in the behavioral health services field.

Further, the proposed new rules represent a more streamlined approach to programmatic standards in an effort to reduce regulatory burdens and associated costs for behavioral health provider agencies. In addition, the proposed new rules encourage integrated care to better address the needs of individuals with mental health and addictive disorder conditions.

Federal Standards Statement

OTPs are subject to, and must comply with, Federal regulations that govern their operation and services, including regulations promulgated by SAMHSA, which is within the U.S. Department of Health and Human Services. Most particularly, SAMHSA sets forth regulations related to OTP accreditation, certification, and standards for the treatment of opioid use disorder (OUD) with medications for OUD at 42 CFR Part 8, Medications for the Treatment of OUD.

In accordance with N.J.S.A. 52:14B-22 and E.O. No. 63, the Division reviewed the Federal regulations promulgated by SAMHSA for OTPs, and recognizes that the Federal standards provide adequate and acceptable minimum program standards for operation of, and services at, OTPs in New Jersey, and as such, the Federal standards "sufficiently protect the health, safety and welfare of New Jersey citizens." N.J.S.A. 52:14B-22.

Therefore, the program standards applicable to OTPs in the Division's rules demonstrate a substantial departure from current program standards applicable to OTPs and are proposed for repeal by DOH at N.J.A.C. 10:161B, including at Subchapter 11, Opioid Treatment Services. The Division has taken substantial steps to reduce regulatory burdens for OTPs by aligning with and deferring to the Federal standards for OTPs in this new chapter. Notably, any Division rules applicable to OTPs are minimal, and related primarily to areas outside the subject matter covered by the Federal regulations for which there is a particular State interest in setting standards to ensure the health, safety, and welfare of New Jersey citizens, including those regulations described below.

1. OTPs must adhere to the "General BH Program Operational Requirements" set forth at Subchapter 3; these operational requirements are general standards related to legal compliance, confidentiality, data submission, and regulatory waivers.
2. OTPs must comply with standards related to administrative discharge, voluntary discharge and involuntary discharge set forth at Subchapter 5 (BH Program Core Service Standards). Specifically, N.J.A.C. 10:36-5.8, Administrative discharge from the BH program, 5.9, Voluntary discharge from the BH program, and 5.10, Involuntary discharge from the BH program, set forth minimum standards defining discharge criteria and addressing discharge processes.
3. OTPs must comply with service-level specific standards delineated at Subchapter 9, Program Standards for OTP Services. N.J.A.C. 10:36-9.1 addresses general requirements, including the need for compliance with applicable Federal laws and regulations. N.J.A.C. 10:36-9.2, OTP services involuntary discharge, sets forth additional minimum standards addressing involuntary discharge from an OTP, including standards related to management of medication for patients.

Significantly, the operational requirements at Subchapter 3, and the core standards related to discharge at N.J.A.C. 10:36-5.8, 5.9, and 5.10, apply to all BH programs because they set forth foundational, operational, and core standards that assist in ensuring the health, safety, and welfare of New Jersey residents. Further, any additional or supplemental standards applicable to OTPs at Subchapter 9 reflect standards that enhance and promote the safe and effective delivery of services to patients in OTPs operating in New Jersey.

In all, the standards applicable to OTPs in these new rules do not represent any material conflict or inconsistency with the Federal rules that apply to OTPs. And, although the Division believes the Federal standards are sufficient for purposes of regulation of OTPs, the Division also

believes the standards as described above and applicable to OTPs in this new chapter are justified and necessary to promote safe and effective services in OTPs, and ensure patients in OTPs operating in New Jersey are afforded the same quality of services and protections as patients receiving services in non-OTP BH programs.

Jobs Impact

The proposed new chapter is not expected to have any effect on jobs in the State of New Jersey.

Agriculture Industry Impact

The proposed new chapter will have no impact on agriculture in the State of New Jersey.

Regulatory Flexibility Analysis

The proposed new chapter will apply uniformly to all behavioral health provider agencies in New Jersey providing behavioral health program services, and licensed by DOH, in order to ensure the health, safety, and welfare of behavioral health service patients across New Jersey. Some behavioral health provider agencies (PAs) may be small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., however, DHS and DMHAS do not have a mechanism to determine the size of PAs, or their number of employees. As such, DHS/DMHAS does not know whether there may be some BH PAs that qualify as small businesses. They, and all other behavioral health provider agencies subject to the proposed new rules and repeals, will be required to comply with reporting, recordkeeping, and other compliance requirements.

Reporting, recordkeeping, and other compliance requirements include: reporting and submission of data into designated electronic databases and/or management systems (N.J.A.C. 10:36-3.3); completion and documentation of an immediate needs assessment at a patient's first visit (N.J.A.C. 10:36-5.2(e)); completion and maintenance of a BH care plan for each patient (N.J.A.C. 10:36-5.3); completion of a BH safety plan for patients, when applicable (N.J.A.C. 10:36-5-4); maintenance documentation relating to a patient's involuntary discharge in the patient's treatment record (N.J.A.C. 10:36-5.10(d)); provide a safety, crisis, and/or relapse prevention plan when clinically appropriate prior to a patient's discharge (N.J.A.C. 10:36-5.11(e)); provide discharge instructions to all patients prior to discharge (N.J.A.C. 10:36-5.11(g)); and complete a discharge summary for each patient (N.J.A.C. 10:36-5.11(h)).

The reporting, recordkeeping, and other compliance requirements imposed upon behavioral health provider agencies must be uniformly applied, regardless of provider agency size, to ensure that patients receiving behavioral health services throughout this State do so in accordance with basic minimum standards of quality. As this chapter is uniformly applicable to all behavioral health provider agencies regardless of size, no differing compliance requirements for small businesses are provided for in the proposed new chapter. However, the proposed new rules reflect a careful balance to minimize adverse economic impact on small businesses, while simultaneously ensuring and promoting safe and quality services. Notably, these requirements do not represent any significant increase or departure from current requirements applicable to behavioral health provider agencies, and, thus, are not expected to impose a significant impact on the regulated community. Nonetheless, the proposed new chapter sets forth waiver provisions, see N.J.A.C. 10:36-3.4, thus allowing behavioral health provider agencies an opportunity to request a waiver of standards that may present an economic or other hardship, so long as such a waiver does not affect program integrity or jeopardize the safety and general welfare of patients.

Housing Affordability Impact Analysis

The proposed new chapter will have an insignificant impact on the affordability of housing in New Jersey and there is an extreme unlikelihood that the new chapter will evoke a change in the average costs associated with housing because the new chapter concerns the provision of behavioral health program services.

Smart Growth Development Impact Analysis

The proposed new chapter will have an insignificant impact on smart growth and there is an extreme unlikelihood that the new chapter will evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, pursuant to the State Development and Redevelopment Plan in New Jersey because the new chapter concerns the provision of behavioral health program services.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:37E and 10:37F.

Full text of the proposed new rules follows:

CHAPTER 36
BEHAVIORAL HEALTH PROGRAM SERVICE STANDARDS

SUBCHAPTER 1. PURPOSE AND SCOPE

10:36-1.1 Purpose

The purpose of this chapter is to protect the health and safety of patients by establishing minimum rules and standards of care that govern the provision of behavioral health treatment programs and services to patients in New Jersey.

10:36-1.2 Scope and applicability

(a) This chapter applies to all facilities licensed by the New Jersey Department of Health pursuant to N.J.A.C. 8:43K, to provide behavioral health services to adults in an outpatient setting. Behavioral health consists of the following programs, services, and levels of care: outpatient addictive disorder and/or mental health, intensive outpatient addictive disorder, partial care mental health, partial care addictive disorder, and opioid treatment programs. Behavioral health services pursuant to this chapter are provided in an outpatient setting to patients who present and depart on the same day.

(b) The rules in this chapter constitute the basis for the monitoring of behavioral health care programs and services by the New Jersey Department of Human Services, Division of Mental Health and Addiction Services.

SUBCHAPTER 2. DEFINITIONS

10:36-2.1 Definitions

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

"Addictive disorder" means a clinical presentation that demonstrates signs and symptoms that substantiate diagnosis of an addictive disorder as defined in the DSM, such as a gambling disorder and/or substance use disorder.

"Admission" or "admitted" means accepted for treatment at the BH program.

"American Society of Addiction Medicine criteria" or "ASAM criteria" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer/discharge of individuals with addictive disorder. These ASAM criteria are set forth in the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Volume 1: Adults, 4th ed., Hazelden Publishing (2023), incorporated herein by reference, as amended and supplemented.

"Behavioral health," also referred to as "BH," means the treatment of mental illness and/or addictive disorders. It includes the support of individuals with a mental illness or an addictive disorder, or individuals with a co-occurring disorder, who are experiencing and/or in recovery from these conditions.

"BH care plan" means a plan of care developed collaboratively between the patient and patient's inter-disciplinary team that meets the requirements of this chapter, specifically, at N.J.A.C. 10:36-5.3.

"BH program" means behavioral health program services provided in or through a community outpatient setting to patients with a diagnosis of a mental illness and/or an addictive disorder. A BH program integrates a trauma-informed, culturally and linguistically appropriate approach in all aspects of service delivery and the patient care experience. A BH program provides services in one or more of the following service categories: (1)

outpatient addictive disorder and/or mental health; (2) intensive outpatient addictive disorder; (3) partial care mental health; (4) partial care addictive disorder; and/or (5) opioid treatment program services.

"Biopsychosocial assessment" means a multi-dimensional evaluation of the patient's biological, psychological and social history, and status, as applicable and as identified by the patient, and collateral sources, as appropriate, to inform the BH care plan.

"DEA" means the U.S. Drug Enforcement Administration.

"Department" or "DHS" means the New Jersey Department of Human Services in this chapter, unless otherwise specified.

"Department of Health" or "DOH" means the New Jersey Department of Health.

"Division" or "DMHAS" means the New Jersey Division of Mental Health and Addiction Services within DHS. The Division is the Single State Authority for Substance Abuse and the State Mental Health Authority.

"Document," "documented," or "documentation" means an electronic or written record.

"Dosage" means the quantity of a medication to be taken or applied all at one time or in fractional amounts within a given time.

"DSM" or "DSM-5-TR" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, incorporated herein by reference, as amended and supplemented, the standard classification of mental disorders in the United States, published by and available from the American Psychiatric Association.

"Evidence-based practices" means a treatment and/or intervention for specific problems that has demonstrated effectiveness through repeated empirical research.

"Family members and/or other supportive persons" means immediate kindred, domestic partner, legal guardian, legally authorized representative, or an individual granted a power of attorney. The term may also include those persons having a commitment and/or personal significance to the patient.

"FDA" means the U.S. Food and Drug Administration.

"Immediate needs assessment" means an assessment used to identify a patient's immediate needs related to food, shelter, and medications, as applicable.

"Inter-disciplinary team" or "IDT" means those BH program staff who work together to provide treatment planning and care to a patient.

"Medication" means a substance as defined by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39-1.2.

"Mental illness" means a mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (for example, serious mental illness).

"Opioid use disorder" or "OUD" means a cluster of cognitive, behavioral, and functional symptoms associated with a problematic pattern of opioid use that continues despite clinically significant impairment or distress within a 12-month period.

"Patient" means an adult individual, age 18 years or older, who is receiving behavioral health care services from a facility licensed by DOH pursuant to N.J.A.C. 8:43K and subject to this chapter. "Patient" may also mean a client or other terminology used by a licensed facility to refer to the individuals to whom it provides treatment.

"Progress note" means a written or electronic summary of the treatment and/or services, and the patient's response.

"Psychiatric advance directive" means a writing executed in accordance with the requirements of the New Jersey Advance Directives for Mental Health Care Act, N.J.S.A. 26:2H-102 et seq.

"Psychoeducation services" means a mutual exchange of information and education between qualified staff, and the patient, or the qualified staff and family members and/or other supportive persons, designed to increase the likelihood of family, supportive persons, and community support to the patient and to reduce the probability of patient decompensation. Information may address etiology and symptoms characteristic of the patient's mental illness and/or addictive disorder, effects of medication, coping skills, daily living skills, community resources and supports, and similar mental health or addiction service-related matters.

"Regularly scheduled" means services and/or activities that are offered as clinically indicated, such as weekly, monthly, quarterly, or as otherwise set, and subject to patient availability and willingness to participate.

"Rehabilitative support services" means any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within their scope of practice to promote the maximum reduction of physical or mental disability and restoration of a patient to their best possible functional level.

"SAMHSA" means the Substance Abuse and Mental Health Administration within the U.S. Department of Health and Human Services.

"Serious mental illness" means a diagnosable behavioral, mental, or emotional condition as defined in the DSM-5, and the condition substantially interferes with, or limits, on a persistent basis one or more major life activities, such as basic daily living (for example, eating or dressing); instrumental living (for example, taking prescribed medications or getting around the community); or participating in a family, school, or workplace.

"Treatment record" means a medical record and/or clinical treatment record, as applicable to a BH program pursuant to N.J.A.C. 8:43K.

SUBCHAPTER 3. GENERAL BH PROGRAM OPERATIONAL REQUIREMENTS

10:36-3.1 Compliance with laws and rules

(a) In order to provide behavioral health services, a BH program shall:

1. Have a contract or affiliation agreement with the DMHAS; and

2. Be licensed by DOH, as applicable, including pursuant to N.J.A.C. 8:43K.

(b) A BH program shall comply with all applicable Federal, State, and local laws, rules, and regulations, and with any applicable accrediting organizations.

(c) A BH program shall comply with any and all rules established by DOH for licensing purposes, including at N.J.A.C. 8:43K.

(d) The DMHAS may refer any findings related to a BH program's non-compliance with the standards set forth in this chapter, or any other regulatory compliance concerns, including those related to patient services or the quality of patient care provided by a BH program, to DOH for review and, if appropriate, licensing action, including licensure suspension/revocation and/or penalties.

10:36-3.2 Patient confidentiality

A BH program shall comply with all applicable Federal and State confidentiality laws, rules, and regulations, including 42 CFR Part 2, Federal Confidentiality of Alcohol and Drug Abuse Patient Records, 45 CFR Parts 160 and 164, HIPAA Privacy and Security Rules, and N.J.S.A. 30:4-24.3.

10:36-3.3 Submission of documents and data to the DHS and/or DMHAS

(a) A BH program shall timely report and submit any and all data and information as required by, and into, a DHS-designated and/or DMHAS-designated electronic database(s) and/or management system(s), including, but not limited to, the Division's New Jersey Substance Abuse Monitoring System and any other applicable capacity and referral system.

1. A BH program shall attend and participate in any mandatory DHS and/or DMHAS orientation and/or trainings for any DHS-designated and/or DMHAS-designated electronic database(s) and/or management system(s), or the like, as are applicable to the services provided by a BH program.

(b) A BH program shall cooperate with any and all DHS and/or DMHAS monitoring activities (for example, audits, complaint reviews, investigations), and provide any and all data and information requested by DHS and/or DMHAS as part of those monitoring activities.

(c) Any failure to report or provide data and information and/or cooperate with DHS and/or DMHAS monitoring activities by a BH program shall be considered non-compliance and may result in a referral to DOH for review and, if appropriate, licensing action, including licensure suspension/revocation and/or penalties.

10:36-3.4 Waiver

(a) A BH program may seek a waiver of one or more standards in this chapter; provided that the following conditions are satisfied:

1. The BH program shall submit the request for waiver(s), in writing, to the Assistant Commissioner of DMHAS, or their designee, at the following address: DMHAS, PO Box 362, Trenton, NJ, 08625-0362 or DMHAS.RuleWaiver@dhs.nj.gov; and, with a copy sent to: DOH, Office of Certificate of Need and Licensing, PO Box 358, Trenton, NJ, 08625-0358;

2. The BH program shall identify the specific rule(s) for which a waiver(s) is requested; and

3. The BH program shall provide an explanation justifying issuance of a waiver(s), including:

i. The specific reason(s) supporting issuance of a waiver(s), including, but not limited to, the type and degree of hardship that would result to the BH program if waiver(s) were not granted, and clear clinical and/or programmatic rationale for such waiver;

ii. An alternate proposal to ensure the safety of patients, staff, patient families, and the public, as appropriate, and to ensure program integrity and treatment services; and

iii. Specific documentation supporting the waiver request.

(b) A BH program shall provide such other additional explanation, information, and documentation, as requested by DMHAS for purposes of evaluating the waiver request.

(c) All waiver requests must be reviewed and approved by the Assistant Commissioner, or their designee.

(d) The granting of any waiver(s) shall be:

1. At the discretion of the Assistant Commissioner, or their designee, and in consultation with DOH, so long as the waiver(s) does not adversely affect the health, safety, welfare, or rights of patients, staff, patient families, or the public, does not adversely impact program integrity and treatment services, and is consistent with public policy;

2. For a time period as determined appropriate and specified by the Assistant Commissioner, or their designee, but subject to renewal upon BH program request; and

3. Communicated, in writing, to the requesting BH program, and indicating which specific rule(s) and standard(s) are waived, any applicable expiration date of the waiver(s), and any conditions or limitations placed on the waiver(s).

(e) The Assistant Commissioner, or their designee, may suspend or revoke the waiver(s) at any time for reasons including, but not limited to, the following:

1. That the waiver(s) is no longer consistent with the purpose and intent of this chapter or public policy;

2. That program integrity and treatment services are adversely affected as a result of the waiver(s); and/or

3. The health, safety, welfare, or rights of patients, staff, patient families, or the public are endangered.

SUBCHAPTER 4. BH PROGRAM STAFFING REQUIREMENTS

10:36-4.1 General staffing requirements

A BH program shall comply with any and all applicable staffing requirements set forth in DOH's facility licensing standards, including at N.J.A.C. 8:43K, and Federal standards, including at 42 CFR Part 8 (describing staffing requirements for OTPs).

SUBCHAPTER 5. BH PROGRAM CORE SERVICE STANDARDS

10:36-5.1 Admission intake process

(a) A BH program shall implement an admission intake process that includes, at a minimum, the following:

1. A DSM diagnosis;

2. An assessment for addictive disorder and/or mental illness, as follows:

i. For patients being evaluated for treatment of an addictive disorder, a Level of Care assessment. A BH program shall use an evidence-based and nationally recognized addiction assessment tool, such as the ASAM criteria; or

ii. For patients being evaluated for treatment of a mental illness, a clinical assessment. A description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment shall be documented in the patient's biopsychosocial assessment;

3. A biopsychosocial assessment.

i. For patients with a mental illness, the biopsychosocial assessment shall include a description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment;

4. An immediate needs assessment;

5. Laboratory testing, for example, urine drug screens, as may be clinically indicated, and for patients with an SUD, the intake process may include a urine drug screen and other applicable and clinically indicated laboratory testing;

6. Screening for addictive disorders and mental illness for patients who screen as at risk for one or more behavioral health disorders;

7. Screening for physical health and substance withdrawal to identify physical health and/or withdrawal issues that require immediate medical intervention precluding admission to the BH program;

8. Screening for suicide risk; and

9. Screening for emotional and psychological trauma.

10:36-5.2 Screening and assessment services and tools

(a) A BH program shall use evidence-based, nationally recognized, and peer-reviewed screening and assessment tools.

(b) A BH program shall ensure that only staff possessing the appropriate clinical background, education, credentials, and qualifications shall perform evaluations using screening and assessment tools.

1. Subject to appropriate clinical supervision and consistent with their scope of practice, interns may perform evaluations using screening and assessment tools that do not require a clinical degree or license.

(c) A BH program shall implement, at a minimum, the following screening and assessment services:

1. Screening for addictive disorder and mental illness;

2. Assessment for addictive disorders and/or mental illness, as applicable, and as follows:

i. For patients being evaluated for treatment of an addictive disorder, a Level of Care assessment. A BH program shall use an evidence-based and nationally recognized addiction assessment tool, such as the ASAM criteria; or

ii. For patients being evaluated for treatment of a mental illness, a clinical assessment. A description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment shall be documented in the patient's biopsychosocial assessment;

3. A biopsychosocial assessment;

4. An immediate needs assessment;

5. Drug screening, as clinically appropriate and/or based on patient use drug patterns, as established by the BH program's policy;

6. Screening to identify physical health issues;

7. Screening for substance withdrawal;

8. Screening for suicide risk; and

9. Screening for emotional and psychological trauma.

(d) A BH program shall ensure that a biopsychosocial assessment is conducted:

1. At the time of the patient's admission to the BH program; and

2. At a minimum, reviewed and updated:

i. On a quarterly basis during the patient's first year of admission to the BH program; and

ii. Subsequently, on an annual basis, or earlier if clinically indicated.

(e) A BH program shall conduct and complete an immediate needs assessment at the patient's first visit to the BH program.

1. If a patient has any immediate needs, a BH program shall make appropriate referrals and/or linkages to assist the patient in addressing their immediate needs.

2. The immediate needs assessment and any related referrals, including the outcome and results of referrals and follow-up, shall be documented in the patient's treatment record.

(f) A BH program shall ensure that screening for suicide risk occurs, at a minimum, upon admission and subsequently, on an annual basis, or

more frequently, if clinically indicated, such as for patients with a history of suicide attempts or other risk factors.

10:36-5.3 BH care plan and planning

(a) A BH program shall implement a BH care plan and planning process that requires, at a minimum, the following:

1. The BH care plan shall be developed in a collaborative manner between the patient and the patient's IDT;

2. The BH care plan shall be developed with the participation of each member of the patient's IDT who is directly involved in the patient's treatment, and their participation shall be documented in the patient's treatment record;

3. The BH care plan shall be signed by an appropriately credentialed and/or licensed IDT member, and as permitted, within their scope of practice, who is directly involved in the patient's treatment and the patient.

i. If the patient is unavailable or unable to sign their BH care plan, then the BH program shall document the reason for the patient's unavailability or inability to sign their BH care plan in the patient's treatment record;

4. When beneficial to the patient, and unless clinically contraindicated, the BH program shall include family members and/or other supportive persons identified by the patient in BH care planning, so long as such inclusion is in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3; and

5. The patient's BH care plan shall be updated based on additional patient information and patient progress and participation in treatment.

(b) A BH program shall ensure that a copy of the BH care plan shall be:

1. Maintained in the patient's treatment record;

2. Provided to the patient upon their request; and

3. Provided to the patient at the time of discharge.

(c) The BH care plan shall address, at a minimum, the following:

1. The patient's needs and strengths and stated goals;

2. The goals and objectives for the patient's treatment with timeframes;

3. A description of applicable evidence-based treatment services and interventions, for the patient to address their symptoms and improve treatment outcomes;

4. A description of applicable non-clinical peer support services for the patient;

5. A medication history and list of current medications, including dosage, frequency, and side effects;

6. Identification of community resources being used by the patient;

7. Referral and/or linkages for the patient to other services and/or resources. This shall include, but not be limited to, any referrals or linkages to:

i. Medical and nursing services for patients with physical health needs, if such services are not provided directly by the BH program; and/or

ii. Vocational, educational, social, and/or other support services, if such services are not provided directly by the BH program;

8. Patient discharge planning and criteria;

9. Patient transition planning and criteria;

10. Be informed by any and all applicable assessments conducted for the patient (for example, INA, biopsychosocial assessment, psychiatric assessment); and

11. Documentation of any other service(s) in which the patient participates and, if applicable, in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(d) At the time of discharge, the BH program shall ensure that the patient's BH care plan addresses, at a minimum, the following:

1. The patient's needs post-discharge, including transition and medication needs, as applicable, including:

i. A list of the patient's current prescribed medication(s), along with the following information: dosage, quantity, date of any injections, and side effects; and

ii. Any referrals made for medication management;

2. Safety planning and harm reduction strategies (for example, drug use, safe sex); and

3. Referrals and/or linkages to other services and/or resources, including self-help groups, and peer wellness and recovery supports.

10:36-5.4 Safety plan

A BH program shall ensure that an evidence-informed safety plan is developed collaboratively with any patient experiencing suicidal ideation, any patient who is otherwise at risk for suicide, or any patient at risk of overdose to identify warning signs or triggers, and support their individualized coping strategies. The safety plan shall be distinct from a BH care plan, but shall be incorporated within the patient's BH care plan.

10:36-5.5 Counseling and/or therapy services

(a) The BH program shall be responsible for the provision of counseling and/or therapy services to patients, as applicable.

(b) The BH program shall ensure that counseling and/or therapy services are based upon and incorporate evidence-based practices (for example, cognitive behavioral therapy, illness management and recovery, motivational interviewing, recovery-oriented cognitive therapy).

(c) Counseling and/or therapy services shall only be provided by staff possessing the appropriate clinical background, education, credentials, and/or qualifications.

(d) Counseling and/or therapy services may consist of individual, group, and family counseling and therapy sessions and psychoeducation sessions.

(e) Counseling and/or therapy services and the frequency and type of counseling, therapy, and/or psychoeducation sessions shall be:

1. Tailored to each patient's clinical severity, functioning, and response to treatment; and

2. Be directed by the patient's IDT.

(f) Any group counseling and/or therapy sessions must contain no more than 12 patients.

10:36-5.6 Medication services

(a) A BH program shall provide or arrange for the provision of medication services to patients to treat behavioral health conditions.

1. A BH program that provides medication services directly must adhere to any licensing requirements and standards related to the administration, prescribing, and storage of medications as required by DOH.

2. A BH program that does not provide medication services directly must facilitate the provision of medication services to patients.

(b) A BH program shall ensure that patients prescribed medication as part of their treatment services receive medication education, management, and monitoring. A BH program shall provide:

1. Medication education consisting of information about the patient's prescribed medications, including benefits, side effects, and risks and especially medication-related risks, such as cardio-metabolic risks, metabolic syndrome with anti-psychotics, and methadone-induced cardiac arrhythmia, as may be applicable;

2. Medication management, including routine monitoring of patients for treatment response and treatment-related side effects; and

3. Medication monitoring, including monitoring of patient health indicators (for example, weight, blood pressure, blood glucose levels, lipids). As part of medication monitoring, a BH program shall collaborate and coordinate with the patient's healthcare provider, subject to and consistent with any and all applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(c) The BH program shall ensure medication used for the treatment of addiction disorders and/or mental illness is administered, dispensed, ordered, and/or prescribed in accordance with applicable State and Federal law, rules, regulations, and standards.

(d) The BH program shall maintain current procedures to ensure that medications are administered in accordance with their approved product labeling.

10:36-5.7 Psychoeducational and patient education services

(a) A BH program shall provide psychoeducation services to patients.

(b) A BH program shall offer psychoeducation services to family members and other supportive persons identified by the patient and when appropriate, unless the patient objects, psychoeducation services are clinically contraindicated, and/or the family/supportive persons are unwilling to participate in offered psychoeducation services.

(c) A BH program shall provide education to patients, including on the following topics:

1. The patient's diagnosis, and if the patient has:

i. An addictive disorder, then education about their addictive disorder;

ii. A mental illness, then education about their mental illness; and

iii. A co-occurring addictive disorder and mental illness, then education about both their addictive disorder and their mental illness;

2. Harm reduction for addictive disorders;

3. Overdose prevention and information about how to access opioid overdose reversal medication; and

4. Self-care and illness self-management.

10:36-5.8 Administrative discharge from the BH program

(a) A BH program may administratively discharge a patient from the BH program for unavailability. Unavailability means the patient is incarcerated, hospitalized, or lost to contact.

(b) A BH program shall administratively discharge a patient by no later than 90 days from when the patient is unavailable to continue to receive services.

(c) Prior to any administrative discharge, a BH program shall make reasonable efforts to:

1. Issue discharge instructions; and

2. Ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members, or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2, and N.J.S.A. 30:4-24.3.

10:36-5.9 Voluntary discharge from the BH program

(a) A BH program may voluntarily discharge a patient when the patient has:

1. Received the maximum benefit of their level of care and/or met all their treatment goals;

2. Received the maximum benefit of their level of care and is transitioning to another level of care; or

3. Elected to discontinue receiving services from the BH program.

(b) Prior to any voluntary discharge, a BH program shall:

1. Issue discharge instructions; and

2. Ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA and 42 CFR Part 2.

10:36-5.10 Involuntary discharge from the BH program

(a) A BH program may only involuntarily discharge a patient for one or more of the reasons listed in this subsection.

1. The patient is exhibiting serious episodes of assaultive, disruptive, and/or threatening behaviors towards staff or other patients;

2. The patient is refusing to participate in their treatment, and the BH program facilitates the patient's referral to another clinically appropriate level of care; or

3. The patient is unable to pay for services, and the BH program has made reasonable attempts to work with the patient and resolve their inability to pay.

(b) A BH program shall not involuntarily discharge a patient who is experiencing, or has experienced, a relapse related to an addictive disorder.

(c) Prior to any involuntary discharge, a BH program shall:

1. Attempt to address the patient's behavior, refusal to participate in services, and/or inability to pay for services.

i. For patients who are unable to pay for services, the BH program shall explore treatment funding sources, including those available at the local or State level, and consider alternate payment options, such as a payment plan, with the patient;

2. Have the BH program clinical supervisor conduct a review of the proposed involuntary discharge.

i. The BH program clinical supervisor shall document their approval of any proposed involuntary discharge in the patient's treatment record; and

ii. A patient shall not be involuntarily discharged without the prior written approval of the BH program clinical supervisor;

3. Provide written notice to the patient of the involuntary discharge, which shall include the reason(s) for the involuntary discharge and internal appeal procedures;

4. Issue discharge instructions;

5. Make reasonable efforts to ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA and 42 CFR Part 2; and

6. If the patient consents, then assist the patient with any linkages to services consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3. If the patient does not consent to assistance with linkages pursuant to this paragraph, then such refusal shall be documented in the patient's treatment record.

(d) The BH program shall maintain documentation relating to a patient's involuntary discharge in the patient's treatment record. At minimum, this documentation shall include:

1. Progress notes or other written documentation describing attempts to address the reasons for the patient's involuntary discharge, including the patient's behavior;

2. The BH program clinical supervisor's written approval of the patient's involuntary discharge;

3. A copy of the written notice to the patient of the involuntary discharge;

4. Copies of any written appeals filed by the patient; and

5. Copies of any documentation issued by the BH program in response to any appeal.

10:36-5.11 Discharge documentation and planning

(a) A BH program shall commence discharge planning upon admission of the patient to the BH program.

(b) A BH program shall incorporate discharge planning into the BH care plan.

(c) When beneficial to the patient, and unless clinically contraindicated, a BH program shall include family members and/or other supportive persons identified by the patient in discharge planning, so long as such inclusion is in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(d) A BH program shall assist the patient with making appointments, when clinically appropriate, for recommended continued behavioral health services, including medication management services, and in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

1. The BH program shall document efforts regarding appointment assistance in the patient's treatment record.

2. If a patient declines assistance with making appointments, then the BH program shall document this in the patient's treatment record.

(e) A BH program shall provide a safety, crisis, and/or relapse prevention plan, as clinically appropriate, to the patient prior to their discharge.

(f) A BH program shall provide education on, and facilitate assistance with, execution of psychiatric advance directives to the patient prior to their discharge.

(g) A BH program shall provide all patients discharged from the BH program with discharge instructions prior to their discharge, irrespective of whether the discharge is administrative, voluntary, or involuntary.

1. At a minimum, the discharge instructions shall include the following:

i. Recommendations and referrals for continued services;

ii. Recommendations and referrals for medication needs and management; and

iii. Information regarding the patient's current prescribed medications and instructions to ensure continuity of medication.

2. The discharge instructions shall be:

i. Reviewed and signed by an appropriately licensed and credentialed clinical member of the patient's inter-disciplinary team; and

ii. Reviewed with and signed by the patient. If the patient is unavailable or unable to sign their discharge instructions, then the BH program shall document the reason for the patient's unavailability or inability to sign their discharge instructions in the patient's treatment record.

(h) A BH program shall ensure that:

1. A discharge summary is completed for each patient discharged from the BH program, irrespective of whether the discharge is administrative, voluntary, or involuntary;

2. The discharge summary is completed within 60 days of a patient's discharge and is filed in the patient's treatment record;

3. The discharge summary is reviewed and signed by an appropriately licensed and credentialed clinical member of the patient's inter-disciplinary team; and

4. At a minimum, the discharge summary includes the following:

i. The patient's date of admission and date of last service;

ii. A summary of the patient's course of, and response to, treatment;

iii. The primary presenting problem;

iv. Any significant findings and the reason(s) for discharge;

v. The clinical condition at the time of discharge;

vi. Recommendations, arrangements, and referrals, if applicable, consistent with any Federal and State confidentiality laws, rules, and regulations, for further treatment and any referrals made, including for medication management;

vii. Information regarding prescribed medications, including dosage, quantity, and date of any injections;

viii. Any known medical conditions; and

ix. The patient's final DSM diagnoses.

(i) Following a patient's discharge from the BH program, the BH program shall make reasonable attempts to follow up with the patient in order to determine whether the patient is engaged in treatment with another BH program or healthcare provider or to provide referrals for services.

SUBCHAPTER 6. PROGRAM STANDARDS FOR OUTPATIENT ADDICTIVE DISORDER AND/OR MENTAL HEALTH SERVICES

10:36-6.1 Outpatient services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of outpatient services, including, as may be modified within this subchapter, by a BH program. In addition, a BH program providing outpatient services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) Outpatient services are organized services delivering regularly scheduled appointments, including for counseling, therapy, and medication management to, or on behalf of, patients based on their individualized clinical needs and severity.

10:36-6.2 Outpatient services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes the requirements set forth at N.J.A.C. 10:36-5.1.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-6.3 Outpatient BH care plan development and review timeframes

(a) A BH program shall implement a BH care plan and planning process that includes the requirements set forth at N.J.A.C. 10:36-5.3.

(b) The BH program shall develop a patient's BH care plan within 45 days of their admission intake interview.

(c) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-6.4 Outpatient services counseling and/or therapy services and hours

(a) A BH program shall implement counseling and/or therapy services that include the requirements set forth at N.J.A.C. 10:36-5.5.

(b) The BH program shall provide each patient with regularly scheduled counseling, therapy, and/or psychoeducation sessions.

SUBCHAPTER 7. PROGRAM STANDARDS FOR INTENSIVE OUTPATIENT (IOP) ADDICTIVE DISORDER SERVICES

10:36-7.1 IOP addictive disorders services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of IOP addictive disorder services, including as may be modified through this subchapter, by a BH program. In addition, a BH program providing IOP addictive disorders services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) IOP services are services that provide a range of treatment sessions in a structured environment, and include clinical intensive substance use counseling and psycho-educational (didactic) sessions.

10:36-7.2 IOP addictive disorders services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes the requirements set forth at N.J.A.C. 10:36-5.1.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-7.3 IOP addictive disorders services BH care plan development and review timeframes

(a) A BH program shall implement a BH care plan and planning process that includes the requirements set forth at N.J.A.C. 10:36-5.3.

(b) A BH program shall develop a patient's BH care plan within three visits, but not more than 30 days, of the patient's admission intake interview.

(c) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-7.4 IOP addictive disorders services description of services and hours

(a) In addition to the standards for counseling and therapy services set forth at N.J.A.C. 10:36-5.5, a BH program shall:

1. Provide each patient with IOP services of a minimum of nine contact hours or more a week; and

2. Provide each IOP patient with the following services as clinically indicated: individual counseling/therapy sessions, group therapy sessions, family sessions, psycho-education sessions, and medication services.

i. If a patient does not participate in any one or more services described in this section, then the BH program shall document attempts to engage the patient, outreach to the patient, and the patient's reasons for non-participation in the service(s).

(b) If a patient's attendance is frequently or consistently unreliable or sporadic without reasonable cause or excuse (for example, the patient does not attend their nine hours of IOP services for two consecutive weeks during a four-week period, pursuant to (a) above, then the BH program shall confer with the patient to review the patient's course of treatment and level of care that supports the patient's needs and continued engagement with treatment services.

SUBCHAPTER 8. PROGRAM STANDARDS FOR PARTIAL CARE (PC) MENTAL HEALTH OR ADDICTIVE DISORDER SERVICES

10:36-8.1 PC services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of PC mental health and/or addictive disorder services, including, as may be modified through this subchapter, by a BH program. In addition, a BH program providing PC mental health and/or addictive disorder services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) PC services are a broad range of licensed, individualized, rehabilitative, and structured treatment services and supports provided in a community setting, which promote patient stabilization and community integration.

10:36-8.2 PC services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes, at a minimum, the requirements set forth at N.J.A.C. 10:36-5.1 and the following:

1. For PC mental health services, a psychiatric assessment; or

2. For PC addictive disorder services, if the screening for mental illness required at N.J.A.C. 10:36-5.1(a)2 is positive for serious mental illness, then a psychiatric assessment must be conducted.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-8.3 PC mental health services provisional services during admission intake

Completion of the formal admission intake process shall not preclude an otherwise eligible patient from participating in PC mental health services program activities or receiving services on a provisional basis during a seven-day trial period.

10:36-8.4 PC services screening and assessment services and tools

(a) A BH program providing PC mental health or addictive disorder services shall adhere to the screening and assessment requirements set forth at N.J.A.C. 10:36-5.2, except as to subsections (d) and (e), which are replaced at N.J.A.C. 10:36-5.2(b) and (c), respectively.

(b) The BH program shall ensure that a biopsychosocial assessment is conducted:

1. Within 14 days of the first visit or at the second visit, whichever is later;

2. Reviewed and updated at least every six months, or earlier, if clinically indicated during the patient's first year of admission to the BH program; and

3. Subsequently, on an annual basis, or earlier, if clinically indicated.

(c) A BH program providing PC mental health services shall implement the following additional screening and assessment services:

1. A psychiatric assessment. The initial psychiatric assessment shall be conducted within 14 days of the first visit or at the second visit to the BH program, whichever is later; and, then reviewed and updated at least every six months, or earlier if clinically indicated.

(d) A BH program providing PC addictive disorder services shall implement the following additional screening and assessment services:

1. A psychiatric assessment as part of the admission intake process if the screening for mental illness required at N.J.A.C. 10:36-5.1(a)2 indicates risks or symptoms of serious mental illness; and, then reviewed and updated every six months, or earlier, if clinically indicated.

10:36-8.5 PC services BH care plan development and review timeframes

(a) A BH program shall develop a patient's care plan within 45 days of the patient's admission intake interview.

(b) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-8.6 PC services counseling and/or therapy services

In addition to the standards for counseling and therapy services set forth at N.J.A.C. 10:36-5.5, a BH program shall be equipped to provide regularly scheduled counseling, therapy, psychoeducation, and/or rehabilitative sessions, as clinically indicated for patients.

10:36-8.7 PC services off-site activities and/or interventions

(a) A BH program may provide off-site activities and/or interventions, so long as:

1. The activity or intervention is based upon and consistent with the patient's BH care plan;

2. The activity or intervention is a subordinate component of the patient's BH care plan; and

3. The clinical justification is documented in the patient's treatment record.

(b) Off-site activities and/or interventions that are solely recreational or diversional in nature shall not be considered a partial care activity or intervention.

10:36-8.8 PC services rehabilitative support services

(a) A BH program providing PC mental health or addictive disorder services shall provide rehabilitative support services directly to patients and comply fully with the standards set forth in this section for the provision of rehabilitative support services.

(b) A BH program shall ensure that rehabilitative support services are:

1. Based upon and incorporate evidence-based practices (for example, illness management and recovery);

2. Provided individually and/or in a group setting; and

3. Tailored to each patient's clinical needs.

(c) Rehabilitative support services may include:

i. Activities and/or interventions involving teaching the patient various physical, cognitive/intellectual, and behavioral skills related to identified goals in order to increase competency; and

ii. Skill teaching involving discussions with the patient about the skill, past experience in using the skill, what the skill entails, when to use the skill, benefits of learning the skill, breaking the skill down into its component parts, showing examples of how the skill is correctly used or performed, arranging opportunities to practice the skill in community settings, and providing education and feedback on skill performance.

(d) A BH program shall be equipped to provide rehabilitative support services including, but not limited to, skills related to:

1. Crisis intervention and response;

2. Daily living;

3. Development of a psychiatric advance directive;

4. Financial literacy;

5. General education;

6. Health and medical care;

7. Housing transition and tenancy sustenance;

8. Pre-vocation and vocational (for example, job interview preparation);

9. Recreational needs and opportunities;

10. Spiritual and cultural linkages and connections;

11. Relapse prevention;

12. Self-advocacy, including as related to legal needs;

13. Social networks and interactions; and

14. Transportation access and education.

SUBCHAPTER 9. PROGRAM STANDARDS FOR OPIOID TREATMENT PROGRAM (OTP) SERVICES

10:36-9.1 OTP services general requirements and standards

(a) N.J.A.C. 10:36-1, 2, 3, and 4 shall apply to the provision of OTP services. N.J.A.C. 10:36-5 shall not apply to the provision of OTP services, except that the standards at N.J.A.C. 10:36-5.8, 5.9, and 5.10 shall apply to the provision of OTP services.

(b) A BH program providing OTP services shall adhere to any supplemental program standards set forth in this subchapter.

(c) If there is any inconsistency between the program standards set forth in this subchapter and/or the standards set forth at N.J.A.C. 10:36-1, 2, 3, and 5, as applicable, then the program standards in this subchapter shall apply.

(d) A BH program shall comply with all Federal regulations and standards established by SAMHSA, including 42 CFR Part 8, and all Federal regulations and standards enforced by the DEA.

(e) If a conflict occurs between the standards set forth in this chapter and any Federal regulations and standards applicable to OTP services, including the Federal standards set forth at 42 CFR Part 8, then the more restrictive standards shall govern over the less restrictive standards.

(f) "Opioid treatment program" or "OTP" means a program engaged in OUD treatment of individuals with medications for OUD registered pursuant to 21 U.S.C. § 823(h)(1).

10:36-9.2 OTP services involuntary discharge

(a) In addition to the requirements for involuntary discharge set forth at N.J.A.C. 10:36-5.10, the BH program shall adhere to the supplemental standards governing involuntary discharge set forth in this section.

(b) Prior to a patient's involuntary discharge, a BH program shall:

1. Make reasonable efforts to facilitate the patient's admission at an alternate OTP, so long as the patient is agreeable and consistent with applicable Federal and State confidentiality laws, rules, and regulations;

2. Facilitate the patient's medically managed withdrawal from their opioid agonist medication, when appropriate;

3. Provide education on overdose and relapse prevention; and

4. Provide information about how to access opioid overdose reversal medication.

i. If the patient is not agreeable to or cooperative with any of the activities described in this subsection, then the BH program shall document the same in the patient's treatment record.

(c) If the patient elects to appeal their involuntary discharge through a BH program's internal appeal process, then the BH program shall maintain the patient's access to medication, pending the outcome of the BH program's internal appeals process.

1. If the patient is uncooperative with the BH program's attempts to maintain their access to medication, then the BH program shall document same in the patient's treatment record.

(d) To the extent that any standards at N.J.A.C. 10:36-5.10 require actions by a BH program clinical supervisor, including approvals, the OTP medical director, in lieu of a BH program clinical supervisor, may perform such actions consistent with the requirements set forth at N.J.A.C. 10:36-5.10 for BH program clinical supervisors.

CORRECTIONS

(a)

THE COMMISSIONER

Fiscal Management

Proposed Readoption with Amendments: N.J.A.C. 10A:2

Proposed New Rules: N.J.A.C. 10A:2-10.5 and 10.6

Proposed Repeals: N.J.A.C. 10A:2-1.2, 2.4, 6.3

Authorized By: Victoria L. Kuhn Esq., Commissioner, Department of Corrections.

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2025-104.

Submit written comments by October 17, 2025, to:

Kathleen Cullen
Administrative Rules Unit
New Jersey Department of Corrections
PO Box 863
Trenton, New Jersey 08625-0863
or email to: ARU@doc.nj.gov

The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1.c, N.J.A.C. 10A:2 was scheduled to expire on August 1, 2025. Pursuant to N.J.S.A. 52:14B-5.1.c(2), as the New Jersey Department of Corrections ("Department" or "NJDOC") submitted this notice of proposal to the Office of Administrative Law prior to that date, the chapter expiration date was extended 180 days to January 28, 2026. The Department has reviewed these rules and, with the exception of the proposed amendments, repeals, and new rules, has determined them to be necessary, reasonable, and proper for the purpose for which they were originally promulgated. The rules are, therefore, proposed for readoption with amendments, new rules, and repeals. The Department of Corrections has determined that the comment period for this notice of proposal will be 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the rulemaking calendar requirement.

Subchapter 1 describes the purpose and definitions for terms specific to the chapter, among other things. The Department proposes to repeal N.J.A.C. 10A:2-1.2, Scope, which specifies individual divisions or work unit responsibilities and could potentially lead to costly rule changes, should internal NJDOC responsibilities change or divisions or work units be reorganized.

Subchapter 2 sets forth rules for inmate accounts, including responsibilities, deposits, deductions, and savings accounts. The Department proposes to repeal N.J.A.C. 10A:2-2.4 because administrative rules are not procedures and internal facility procedures are for internal purposes only.

Subchapter 3 sets forth rules for expenditure of income from inmate welfare accounts and includes sources of income and accountability and expenditure.

Subchapter 4 is reserved.

Subchapter 5 sets forth rules for reporting loss of funds and written report requirements for loss of funds.

Subchapter 6 sets forth rules for inmate reimbursement for lost, damaged, or destroyed personal property, including filing a claim and decision-making factors for reviewing claim forms. The Department proposes to relocate N.J.A.C. 10A:2-6.3(a) to 6.1(a), as the second sentence and to change 15 calendar days to 21 calendar days to provide a longer period for inmates to file claims. The Department proposes to relocate N.J.A.C. 10A:2-6.3(a) to 6.1(c), as the second sentence, with no change in language. As a result of these relocations, N.J.A.C. 10A:2-6.3 is proposed for repeal and the "relocated" text is proposed as new sentences in the respective sections. At N.J.A.C. 10A:2-6.4, the Department proposes to replace "written procedures" with "process" and to replace "incorporated into the next revision of" with "included in" for added accuracy.

Subchapter 7 sets forth rules for restitution for items damaged or destroyed, including appeals, amounts of restitutions, and roles in decision making.

Subchapter 8 is reserved.

Subchapter 9 sets forth rules for gifts of money from inmate to inmate organizations, gifts of vehicles or parts, gifts for capital construction, gifts for research purposes, and gifts of medical supplies or equipment, among other considerations associated with gifts. Throughout the subchapter, the Department proposes to rename the Health Services Unit to the Health Compliance Unit.

Subchapter 10 sets forth rules for grants, including responsibilities, planning, processing, post-award compliance management, and reports. A Grants Manager Unit Supervisor has recently been assigned to oversee increases in grant activities and the addition of subgrants and the Department proposes to update the rules at N.J.A.C. 10A:2-10 to reflect those changes. New N.J.A.C. 10A:2-10.2(b) sets forth requirements for the Grants Manager Unit Supervisor. Proposed new N.J.A.C. 10A:2-10.5 sets forth the requirements for post-award compliance management of grant funding. Proposed new N.J.A.C. 10A:2-10.6 sets forth the requirements for subgrant management.

Social Impact

The rules proposed for readoption with amendments, new rules, and repeals will continue to provide the Department with guidelines for the management of inmate accounts, inmate welfare funds, reporting loss of