

(b) Wherever the "Department" is cited, the term shall refer to the New Jersey Department of Human Services; wherever the "Division" is cited, it shall refer to the New Jersey Division of Mental Health and Hospitals. Subsequent to a period of public review and comment, this chapter shall become effective on November 3, 1980; it will be incorporated into guidelines for the Division's ongoing site visit, monitoring, program development and evaluation activities for community mental health grants and contracts. Compliance with this chapter shall be required one year from its effective date, as of July 1, 1981. It is anticipated that total compliance will necessitate, in some instances, a reorganization of service components and priorities by participating agencies. It is for that reason that the Department is extending the implementation and compliance deadline for one year, in order to allow for local phase-ins and for technical assistance to be provided by the county mental health boards and the Division.

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

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

10:37-1.2 Scope

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

SUBCHAPTER 2. STATE COMMUNITY MENTAL HEALTH CITIZENS ADVISORY BOARD

10:37-2.1 Membership

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

(b) The term of each member shall be for three years, commencing on July 1 and terminating on June 30; provided, however, that of the new members appointed three shall

be appointed for a term expiring two years, and four for a term expiring three years from July 1 following the date of appointment. Members of the present Community Mental Health Citizens Advisory Board serving on the effective date of the amendatory act shall continue to serve until the expiration of their current terms.

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

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

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

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

10:37-2.2 Functions

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

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

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

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

10:37-2.3 Power to establish committees

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

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

10:37-2.4 Scope of authority

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

SUBCHAPTER 3. COUNTY MENTAL HEALTH BOARDS

10:37-3.1 Establishment and composition

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

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

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

1. Consumers of mental health services;
2. Local boards of health;
3. School boards;
4. Interested lay people;
5. Parent-teacher association;
6. County professional/medical associations;
7. County advocacy groups; and
8. Such other members as the appointing authority may deem necessary.

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

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

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

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

10:37-3.2 Membership

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

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

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

10:37-3.3 Attendance

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

10:37-3.4 Conflicts of interest

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

1. A paid or unpaid employee/volunteer of an agency under the county mental health board's jurisdiction or funded by the Division;
2. A consultant of an agency under the county mental health board's jurisdiction or funded by the Division;
3. A member of the governing body of an agency under the county mental health board's jurisdiction or funded by the Division;
4. A member of a formal advisory body of an agency under the county mental health board's jurisdiction or funded by the Division.
5. Person engaged in issuing any policy or contract of individual or group business of any agency under the county mental health board's jurisdiction or those agencies' affiliate, subsidiary, or parent organization.
6. Persons who are members of the immediate household or a direct business associate of a person described above.

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

10:37-3.5 Roles, functions, and responsibilities

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

1. Elect annually a chairperson;
2. Meet at least eight times each year;
3. Comply with the Open Public Meetings Act;
4. Establish, and at least annually review, formal procedures concerning the composition of the Board and setting forth rules of order by which the Board shall operate;
5. Submit public notices and minutes of said meeting to the Division of Mental Health and Hospitals.

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

1. Initiate and implement a planning process, encouraging participation from, at a minimum, other mental health planning authorities (for example, Health Systems Agency representatives) funded providers of services, clients, and interested citizens.
2. Develop a plan of mental health services for the county. At a minimum, that plan shall identify:
 - i. The county mental health authority(ies) and their respective roles and functions;
 - ii. The manner in which the plan was completed;
 - iii. A needs assessment section which reviews:
 - (1) The State and county identified target groups, and the reason they have been so identified;
 - (2) Services that are perceived by the community as being critical to meet the needs of identified State/county target groups;
 - (3) The availability or unavailability of those services identified in (b)2iii(2) above.
 - iv. A set of goals and objectives which will provide a framework for addressing the needs of State and locally identified target groups;
 - v. An action plan which designates the means and steps by which goals and objectives will be achieved.
3. Submit completed County Mental Health Plan to the Division within specified deadlines, for review and approval. If a county has a Charter form of government, the County Mental Health Board must submit the County Mental Health Plan to the County Executive or his/her

designate, for review and approval, prior to submission to the Division.

4. In the event that:

- i. A county mental health plan is approved by the Division, the county plan shall provide the framework for mental health funding and program development in that particular county.
 - ii. An approved plan is not submitted by the county, the framework for mental health activity in that particular county shall be provided by the goals and objectives of the Division, contained within its Annual State Plan.
5. The initiation of the planning process, and subsequent completion of the plan, shall be conducted within the general policies and principles of the Division.
6. The county mental health authority(ies) should take an active planning role in coordinating the services of other county offices and departments relating to mental health services.

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

1. Receive, review, comment and, where necessary, solicit the following:
 - i. Initial and continuation funding applications for:
 - (1) State hospitals;
 - (2) County hospitals;
 - (3) Community Mental Health Projects regardless of revenue source.
 - ii. Certificate of Need applications for Mental Health Agencies;
 - iii. Affiliation agreements.
2. Receive, review and advise the Division of Mental Health and Hospitals on requested Service Area changes/redelineations.
3. Facilitate consumer advocacy and self-help groups.
4. Respond to client grievances as identified in N.J.A.C. 10:37-4.3.
5. Review and recommend funding allocations to agencies within the county, consistent with the approved County Mental Health Board Plan.

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

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

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

10:37-3.6 Professional Advisory Committee (PAC)

(a) The County Mental Health Board shall:

1. Appoint annually, members of its Professional Advisory Committee, minimally including a representative from each mental health agency receiving financial support from the Division. Two or more individuals connected with the same agency, either as employee and/or board member, may serve simultaneously as members; in such cases, however, it shall be the responsibility of the County Mental Health Board to maintain a balance of representation, with no particular agency(ies) operationally dominating the PAC. Membership of the Professional Advisory Committee shall include the State and county psychiatric hospitals, the county welfare board and the Division of Youth and Family Services. The PAC should also include county criminal justice, Division of Mental Health Advocacy, Division of Vocational Rehabilitation, Substance Abuse Programs, a Municipal Welfare Board and the county mental health association.

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

2. Approve rules and procedures for its PAC;

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

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

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

10:37-3.7 County Mental Health Administrators

(a) By State law, all County Mental Health Boards may, with the approval of the Board of Freeholders, create the position of Mental Health Administrator. The Division strongly encourages the creation of this position in every County and suggests additional staff for the mental health board, also including one non-clerical position for every 300,000 people living in a particular county.

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

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

(d) Minimum qualification shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iii. Facilitating the development of self-help groups.

10:37-3.8 Reimbursement

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

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

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

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

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

10:37-3.9 County administration of services

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

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

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

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

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

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

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

SUBCHAPTER 4. CONSUMER REQUIREMENTS FOR ALL COMMUNITY MENTAL HEALTH PROGRAM ELEMENTS

10:37-4.1 Direct involvement

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

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

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

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

10:37-4.2 Designed responsibility of agencies

(a) Each State-funded mental health program shall develop and submit to the County Mental Health Board and to the Division an acceptable Consumer Affirmative Action

Plan as part of its Fiscal Year 1982 funding application or contract.

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

1. Membership on the governing body of the agency for two or more consumers except as indicated otherwise in N.J.A.C. 10:37-6, Article VI;
2. Opportunities for consumers and advocacy groups to review and have input into the development of the agency's annual service plan and funding requests;
3. Opportunities for agency consumers to meet with governing board to discuss Service Area needs, annual program plans, formal program evaluations and other issues of concern;
4. Adequate notice of the availability of the opportunities outlined in (b)1 through 3 above, with notices posted at the agency's program sites.

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

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

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

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

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

10:37-4.4 Designated responsibilities of State Community Mental Health Citizens' Advisory Board

(a) For Consumer Membership see N.J.A.C. 10:37-2.

(b) Consumers and advocacy organizations shall be given an opportunity for review and involvement in the development of the annual State Mental Health Plan.

(c) The Division shall hold at least one meeting annually for the express purpose of gaining consumer input into the development of the annual State Plan. Adequate notice shall be given, as cited in N.J.A.C. 10:37-4.3(b).

10:37-4.5 Client rights

(a) This section shall apply to all State-funded mental health Program Elements. Inpatient Units, including 24-hour Supervised Treatment Homes providing crisis intervention services for children, are also required to comply with laws governing the treatment of persons admitted to inpatient psychiatric facilities, including but not limited to N.J.S.A. 30:4-24, 30:4-24.1, 30:4-24.2 and 30:4-24.3.

(b) Each client shall be made aware of the rights and privileges in receiving mental health services. Each agency shall establish a policy statement in this regard.

(c) Notice of the client's rights set forth in this chapter and any rules governing the conduct of clients with respect to an agency shall be given to each client within five days of admission. Such notice shall be in writing, and shall be supplemented by an offer to discuss or explain the written description. Explanations shall be in a language which the client understands. If the client cannot read the provisions of the notice, it shall be read to him/her.

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

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

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

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

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

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

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

- i. If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d(2).
3. The right to treatment in the least restrictive setting, free from physical restraints and isolation, provided, however, that a client in Inpatient Care may be restrained or isolated in an emergency pursuant to the provisions of N.J.S.A. 30:4-24.2d(3). (See N.J.A.C. 10:37-6, Article XV.)
4. The right to be free from corporal punishment.
5. The right to privacy and dignity.
6. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.
7. In inpatient or other residential care:
- i. The right to normal opportunities for interaction with members of the opposite sex;
- ii. The right of a client to wear his/her clothes; to keep and use his/her personal possessions including toilet articles; and to keep and be allowed to spend his/her own money for expenses and purchases;
- iii. The right to have access to individual storage space for his/her private use;
- iv. The right to see visitors each day;
- v. The right to have reasonable access to and use of telephone, both to make and receive confidential calls;
- vi. The right to have ready access to letter writing materials, including stamps, and the right to mail and receive unopened correspondence;
- vii. The right to regular physical exercise several times a week;
- viii. The right to be outdoors at regular and frequent intervals, in the absence of medical considerations;
- ix. The right to practice the religion of his/her choice or abstain from religious practices. Provisions for such worship in Inpatient Care shall be made available to each person on a nondiscriminatory basis.
- x. The right to receive prompt and adequate medical treatment for any physical ailment.
8. The rights in N.J.A.C. 10:37-4.5(h)1-4 may not be denied under any circumstances;
9. The rights in N.J.A.C. 10:37-4.5(h)5-7 may be denied to clients in Inpatient Care for good cause, in any instance in which the Director of the Program Element feels that it is imperative to deny any of these rights; provided, however, that under no circumstances shall a client's right to communicate with his/her attorney, physician or the courts be restricted.
- i. Any such denial of a client's rights shall take effect only after a written notice of the denial, which includes an explanation of the reason for the denial has been filed in the client's record.
- ii. Any such denial of a client's rights shall be effective for a period not to exceed 30 days and may be renewed for additional 30-day periods only by a written statement entered by the Director of the Program Element in the client's treatment record which indicates the detailed reason for such denial or renewal.
10. Every client in Inpatient Care is entitled to a writ of habeas corpus upon proper petition by himself, by a relative, or a friend to any court of competent jurisdiction in the county in which she/he is detained and shall further be entitled to enforce any of the rights stated by civil action or other remedies otherwise available by common law or statute.

10:37-4.6 Client complaint/agency ombuds procedure

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

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

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

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

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

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

(d) Responsibilities of Agency Ombudsperson:

1. The responsibilities of the Agency Ombudsperson shall be:

- i. To receive client complaints;
- ii. To act as an advocate for clients who make complaints; and
- iii. To attempt to negotiate resolutions of issues raised by clients (Complaints shall be investigated and negotiated within five working days.)

2. The Agency Ombudsperson shall submit a written report of findings, resolutions and/or recommendations to the Agency Director and to the client within seven working days of the complaint. If the complaint has been resolved to the client's satisfaction, the grievance process shall end at this point.

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

1. Receive and review complaints within three working days of a request by a client or Agency Director;
2. Submit a written report of its findings and recommendations to the Agency Director within five working days of complaint.
3. Report to the Division of Youth and Family Services complaints or allegations of abuse and/or neglect, in accordance with N.J.S.A. 9:6-8.10.

(f) Internal Agency complaint resolution:

1. The Agency shall permit and encourage clients who object to a decision of a therapist, counselor, or service procurer, to consult with, and to obtain the opinion of, a second such person either within or without the Agency.
2. If a complaint has not been resolved by the Agency Ombudsperson to the client's satisfaction, the client may request review by the Agency Director. If an Internal Agency Review Committee has been established in the Agency, either the client or the Agency Director may request review by that Committee. The Director shall make the final Agency-level decision regarding the complaint, in a due process manner, as quickly as possible.

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

(g) Responsibility of the County Mental Health Board:

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

(h) State-level review by the Division:

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

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

3. The Division Director shall review this report and submit recommendations to the Agency Director and the client within seven working days. The Division shall determine if any formal State remediation/funding compliance action is necessary based on the Agency's response to these recommendations.

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

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

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

SUBCHAPTER 5. PROGRAM ELEMENT REQUIREMENTS

10:37-5.1 Funding priorities

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

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

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

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

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

2. Service procurement:

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

Primary Service Procurer Coordinator for each client served in a State-funded Program Element.

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

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

- (1) Coordination of needs assessments;

- (2) Service planning and linkage, monitoring; and

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

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

10:37-5.2 Target populations

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

(b) State target populations:

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

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

3. Target Groups I and II are not mutually exclusive. Target Group II describes specific demographic categories of people; when these individuals meet any of the criteria

listed in Target Group I, they shall be prioritized above other people meeting Group I criteria. When services are delivered to non-Target Group I clients, these demographic groups shall also be prioritized.

4. Target Group I:

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

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

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

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

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

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

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

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

5. Target Group II:

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

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

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

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

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

(c) Additional target populations:

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

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

(d) Reporting:

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

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

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

10:37-5.54 Scope and purpose

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

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

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

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

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

10:37-5.55 Designation of responsibility

(a) Systemic use of local inpatient facilities:

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

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

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

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

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

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

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

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

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

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

10:37-5.61 Setting

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

(b) The program shall provide adequate activities space.

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

10:37-5.62 Length of stay

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

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

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

10:37-5.63 through 10:37-5.64 (Reserved)

10:37-5.65 Scope and purpose

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

1. Social action;
2. Community organization and class advocacy services, as well as;
3. Community education;
4. Information and referral;
5. Consultation; and
6. Evaluation of C & E programs. Emphasis shall be on improving community awareness and receptivity, in order to offer target populations greater self-determination and a better quality of life.

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

1. To promote the mental health and reduce the incidence of mental illness in a Service Area, paying particular attention to the target population's needs.
2. To initiate social action to change conditions in the community that restrict opportunities or pose obstacles

for target populations as noted in N.J.A.C. 10:37-5.2 and other vulnerable segments of the population.

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

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

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

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

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

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

10:37-5.66 Designation of responsibility

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

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

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

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

10:37-5.67 Funding requirements

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

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

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

10:37-5.68 Target agencies and populations

(a) The following are target agencies and populations:

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

i. Boarding/nursing homes;

ii. General hospital emergency room staff;

iii. Human service and health agencies;

iv. Schools;

v. Court system (judges, police, parole officers, correctional facilities);

vi. Police;

vii. Clergy;

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

i. Natural support groups (relatives, neighbors, landlords, etc.);

ii. Self-help groups;

iii. Generic service, civic, and community associations;

iv. Business/industry;

v. Realtors;

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

i. Community action agencies;

ii. Day care centers;

iii. Senior citizen programs;

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

10:37-5.69 Services

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

10:37-6.22 through 10:37-6.41 (Reserved)**10:37-6.42 Scope and purpose****(a) Scope:**

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

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

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

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

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

(b) Purpose:

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

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

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

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

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

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

10:37-6.43 Designation of responsibility

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

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

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

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

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

10:37-6.44 Required content**(a) Each ISP shall minimally include:**

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

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

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

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

2. Service/treatment goals and objectives:

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

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

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

3. Accountability:

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

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

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

i. The service needs of that client; and

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

3. Consider alternatives in the following sequence:

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

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

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

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

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

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

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

10:37-6.45 Required review and modification

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

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

(c) For non-inpatient programs, each ISP shall be reviewed no later than 90 days after service initiation and every six months thereafter, to justify service continuation. (See N.J.A.C. 10:37-6, Article XII.) When objectives have shorter time limits, more frequent reviews should occur.

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

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

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

10:37-6.46 through 10:37-6.48 (Reserved)

10:37-6.49 Least restrictive setting

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

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

10:37-6.50 through 10:37-6.52 (Reserved)**10:37-6.53 Medication education and counseling**

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

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

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

(c) Medication counseling should occur whenever a different medication is prescribed, whenever a significant change in dosage is made or whenever there is a history or suspicion of alcohol or chemical abuse. Counseling may be provided by a physician, nurse, certified nurse practitioner/clinical nurse specialist or by a community or consulting pharmacist; however, counseling should be coordinated with the physician or the certified nurse practitioner/clinical nurse specialist prescribing the client's medications.

(d) Agencies shall have policies to provide written and verbal information on medications, side effects and special precautions such as those that are heat related, to immediate family members, defined as parents, spouse, adult sib-

lings and adult children and, where appropriate, to others designated by the client as involved in a care giving role. A client's consent shall be obtained in order to release the aforementioned information. Written information shall be in a language understandable to the recipient. Provision of such information to the recipient shall be documented in the client's record.

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

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

10:37-6.54 Psychotropic medication

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

1. Anti-psychotics;
2. Anti-depressants;
3. Agents for control of mania and depression, such as lithium;
4. Anti-anxiety agents;
5. Anti-convulsants; and
6. Psychomotor stimulants.

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

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

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

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

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

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

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

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

10:37-6.55 through 10:37-6.72 (Reserved)

10:37-6.73 Scope and purpose

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

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

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

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

4. Be current and accurate.

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

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

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

10:37-6.74 Required contents for all records

(a) The contents of the record shall contain the following information:

1. The identifying and other data indicated on the Division's Unified Services Transaction Form for enrolled and terminated clients. (See Article XIV of this subchapter.)

2. Comprehensive assessment and evaluation (see Division's Service Dictionary for detailed description) of client needs, including level of functioning and a natural support resource inventory for all clients.

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

4. Individual service plan with updated revisions. (See Article VIII of this subchapter.)

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

6. Client and/or family consent for a service initiation, record sharing, evaluation, and/or research, as necessary.

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

8. Medications (see Article X of this subchapter).

9. Laboratory or other diagnostic procedures.

10. Unusual incidents, occurrences (see Article XIX of this subchapter) such as:

- i. Treatment complications;

- ii. Accidents or injuries;

- iii. Morbidity;

- iv. Death of a client; and

- v. Procedures placing the client at risk or causing pain/harm. (See Article XIX of this subchapter.)

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

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

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

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

10:37-6.75 Inpatients records: supplementary content requirements

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

1. Results of evaluations and services: Psychological testing, educational and socio-vocational evaluations, pathology and clinical laboratory examinations, radiology examinations, psychiatric and other medical treatment, and any other diagnostic or therapeutic procedure performed.

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

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

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

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

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

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

8. Telephone orders: Given by a physician only; shall be accepted and written by a licensed nurse only; such action shall be limited to urgent circumstances. Telephone orders shall be authenticated by the responsible physician

within 24 hours, specifying date of initial contact or admission to the program.

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

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

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

10:37-6.76 Policies and procedures regarding recordkeeping

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

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

1. The program fulfills its responsibility to safeguard and protect the record against loss and unauthorized alteration or disclosure of information;

2. The content and format of client records are uniform; and

3. Entries in the client record are dated and signed.

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

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

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

10:37-6.77 Retention of records

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

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

(c) A list of the destroyed records must be kept on file for an additional five years. This list should include the

client's name, case number and date of destruction. It should be signed by the staff person who supervised the records' destruction.

10:37-6.78 Record departments

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

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

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

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

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

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

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

10:37-6.79 Confidentiality of records

(a) These requirements govern the disclosure of information and records of persons who are receiving or have received State-funded mental health services. This section shall only apply to people for whom a formal client record has been established.

1. Disclosure of records and information to third parties: All information and records directly or indirectly identifying any person currently or formerly receiving services from an agency (client) shall be treated as confidential, and may only be disclosed in the following circumstances to persons presenting appropriate identification:

i. For adult clients: Upon the written consent of the client, or his or her legal guardian, if any.

ii. For clients who are minors:

(1) Disclosure upon the consent of a minor: A minor client, 14 years or older, may consent to the disclosure of his or her records in the same manner as an adult.

(2) Disclosure upon the consent of a parent or legal guardian: A parent or legal guardian may authorize the disclosure of a minor client's records, provided that the minor shall be given prior notice and an opportunity to object to the disclosure. Objection by a minor, 14 years or older, shall render the consent of the parent or guardian void.

(3) Disclosure to a parent or legal guardian: Disclosure of the clinical records of a minor client, 14 years or older, to a parent or legal guardian is authorized only upon the written consent of the minor.

iii. Pursuant to a court order:

(1) The records of a minor shall be released upon request to the Division of Youth and Family Services in connection with investigations of whether the minor has been abused or neglected.

(2) The guardian of a deceased person who formerly received services from the agency, or such person's chosen executor, administrator or other personal representative of his or her estate, or if no such persons exist, a person otherwise empowered by court order, shall exercise control of the disclosure of such person's records.

(3) Employees of the agency who are involved in the care of the client may have access to the client's records. Provided, however, that when a client enters treatment(s) he will be informed that agency staff will have access to his or her records.

iv. Client records may also be disclosed to:

(1) Clinical records audit teams, monitoring and site review staff designated by the Division, the Office of Legislative Services;

(2) A person participating in a Professional Standards Review Organization; and

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

v. Whenever possible, names of clients shall be deleted from the records being reviewed under (a)iv above.

2. Conditions of disclosure to third parties:

i. When records are released pursuant to (a)1 above, the custodian of the records shall, by written notice, advise the person receiving the records that disclosure without the consent of the person who is the subject of the records, or as otherwise provided by law, is prohibited.

ii. Information and records disclosed to third parties shall be limited to that information which is relevant and necessary for the purpose of the disclosure, except as authorized by consent or required by law.

iii. A request for information regarding a client and the action taken upon the request shall be recorded in the client's clinical records.

iv. Clients or other persons consenting to the disclosure of records shall be informed of their right subject to (a)4 below to inspect the material to be disclosed.

v. Information disclosed shall be limited to information generated at the provider agency. However, the agency shall list the sources of nondisclosed information contained in the client's records.

3. Specificity:

i. Consent to disclosure of records shall be evidenced by a signed authorization. The authorization shall contain the following:

- (1) The name of the agency;
- (2) The name or title of the person or organization to which disclosure is to be made;
- (3) The name of the client;
- (4) The purpose of the disclosure and predictable outcome;
- (5) The information to be disclosed;
- (6) The date on which the consent is signed; and
- (7) The signature of the client or of a person authorized by law to sign for the client, following a statement that the undersigned understands the nature of the authorization and has been informed that she/he has the right to revoke consent at any time by written communication to the custodian of the records.

ii. Unless the time limit of expiration has been determined with the client and notes on the release form, client permission to release information automatically expires four months from the date the release is signed by the client. This shall not apply to quality assurance reviews and inspections by regulatory agencies cited in these regulations.

4. Client access to records:

i. In case of Family Therapy, if the records for all participants have been integrated, no single family member shall have access to those records unless all

participants over 14 years of age agree through a signed release form.

ii. A client currently receiving services from an agency is entitled to inspect and/or receive a copy of his or her own clinical records unless the client's treating clinician certifies to the Director of the agency that such would be seriously harmful to the client's treatment or health. A denial of access to records shall be limited only to the extent necessary to protect the client. Denial shall be accompanied by a verbal explanation to the client. Denial shall be documented in the client's records, as to the clinical data, findings, etc., that led to the denial of access.

iii. A client is entitled to inspect or receive a copy of his or her non-clinical records.

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

5. Modification of records:

i. A client may submit in writing to the Director of the agency a statement of reasonable length for the purpose of clarifying or correcting an allegedly ambiguous or incorrect statement in his or her clinical record. Such a statement shall become part of the client's clinical records.

ii. A client may request in writing to the Director of the agency an amendment of a clinical record and, not later than 30 days after the date of receipt of such request, the agency shall acknowledge in writing such request and, within 10 days thereafter:

(1) Make each correction, in accordance with the client's request, of any or all portions of a record which the client believes is not accurate or complete; or

(2) Inform the client of its refusal to amend the record or portions thereof, in accordance with such client's request; the reason for the refusal should be explained to the client and documented in the client's record.

6. Notice to clients: At the time that a formal client record is going to be initiated for ongoing service purposes, each client shall receive notice:

i. Of the specific conditions under which information may be disclosed without his or her consent;

ii. That he may request access to his or her records; and

iii. That he may supplement or request a modification of his or her clinical records.

10:37-6.80 through 10:37-6.82 (Reserved)

10:37-6.83 Scope and purpose

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

10:37-6.84 Designation of responsibility

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

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

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

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

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

(3) All data elements found on the USTF-1 (Acceptance) and USTF-2 (Termination), are required to be reported to the Division. The USTF-1 and USTF-2 must be completed and forwarded to the State as specified in the Division's Reporting Manual. Except in extraordinary situations, the forms should be mailed within 48 hours after acceptance or termination has occurred.

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

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

(7) Screening.

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

- (1) Caseload at beginning of quarter;
- (2) New admissions during quarter;
- (3) Re-admissions during quarter;
 - (A) From the current year;
 - (B) From a prior year;
- (4) Terminations;
- (5) Caseload at end of quarter; and

(6) Sub reports on all target populations as specified in N.J.A.C. 10:37-5.2 and program histories from data forwarded on the USTF-1 and USTF-2.

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

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

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

2. Contract service reports: All agencies receiving funds through the Division's Community Care or Title XX contracts shall be required to record the data on the Unified Services Transaction Form by December, 1980. Copies of the USTF-1 and USTF-2 must be kept as part of each client record and made available for site reviews and program audits. In addition, "Monthly Contract Information Summaries" and the "Monthly Contract Expenditure Reports" must be submitted directly to the Division.

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

10:37-6.85 through 10:37-6.87 (Reserved)

10:37-6.88 Services requiring prior approval

(a) As of July 1, 1981, no State-funded mental health program element shall be permitted to use psychosurgery, insulin therapy, electroconvulsive therapy, seclusion, and/or physical restraints, until such time as the Director of the Agency submits a written description of the proposed policies and procedures concerning the use of such modalities, and the Division of Mental Health and Hospitals approves them in writing. General, procedural approval must be sought and received prior to implementation. Any subsequent modification in procedures requiring prior approval must be re-submitted to the Division for approval.

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

10:37-6.89 through 10:37-6.98 (Reserved)

10:37-6.99 Training and staff development

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

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

1. Division principles;
2. Agency goals and objectives;
3. Table of organization of agency;
4. Job description;
5. Fire evacuation procedure; and
6. Emergency procedures (for example, unusual incidence procedures).

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

10:37-6.100 through 10:37-6.102 (Reserved)

10:37-6.103 Scope and purpose

To implement a Unified Service System, there must be clear guidelines for continuity of care and for the interaction

between the public psychiatric inpatient facilities and the community-based Program Elements responsible for residents of a given Service Area. The following regulations include requirements for each stage of hospitalization in which community and hospital interaction is essential.

10:37-6.104 Designation of responsibility

(a) County and State psychiatric hospitals shall have a recently negotiated affiliation agreement detailing community/hospital interaction procedures for every county that it serves. Each Chief Executive Officer shall designate one hospital staff person to coordinate all hospital/community interfacing and to be responsible for monitoring the implementation of Unified Services efforts with community agencies.

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

1. Admissions: Criteria for hospital admissions:

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

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

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

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

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

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

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

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

ii. Hospital admission staff shall provide feedback to gatekeeper agencies that refer inappropriately. Hos-

pitals and community mental health centers shall coordinate their community C & E efforts to impact on appropriate agencies and to lower the number of inappropriate referrals to the State and county psychiatric hospital(s).

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

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

3. Post admission and pre-discharge:

i. Admission notification procedure:

(1) The hospital shall send an Admission Notification Form to the designated Outpatient agency in each Service Area for every client who voluntarily signs an information release form. Hospital records shall record the numbers and percentage of forms sent, not sent, clients signing information release forms, and clients not signing.

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

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

ii. Level of Functioning (LOF) Assessment:

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

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

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

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

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

(4) A qualified mental health professional shall be assigned primary service procurement and case management responsibility, during each client's hospitalization, insuring that the ISP is developed, implemented, and modified as client needs change.

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

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

(A) Involve an inter-disciplinary team effort;

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

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

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

4. Transitional units/residence on hospital grounds:

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

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

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

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

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

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

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