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

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

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

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

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:37F-1.2 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Inserted definitions "Active treatment", "Advanced practice nurse", "Certified Psychiatric Rehabilitation Practitioner", "Clinician", "Community Mental Health Associate", "Direct care staff", "Educational services", "Individualized recovery plan", "Interdisciplinary treatment team (IDTT)", "Licensed professional counselor", "Licensed associate counselor", "Mental health services worker", "Off-site interventions", "Partial care (PC)", "Pre-vocational services", "Programs of assertive community treatment (PACT)", "Qualified addictions staff", "Registered nurse (RN)", "Rehabilitation counselor", "Skill development", "Social worker", "Special minimum wage certificate", "Therapeutic subcontract work activity", "Therapeutic token economies", "Valued role" and "Vocational services"; in definition "Division", substituted "Services" for "and Hospitals"; deleted definitions "Partial care services (PC)" and "Psychoeducation services"; and rewrote definition "Provider agency (PA)".

SUBCHAPTER 2. PARTIAL CARE STANDARDS

10:37F-2.1 Admission criteria

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

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

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

1. Demonstrate impaired functioning, that leads to a need to learn critical skills in order to achieve valued community roles and community integration, in at least one

of the following domains on a continuing and intermittent basis, for at least one year:

i. Personal self-care;

ii. Interpersonal relationships;

iii. Work;

iv. School;

v. Ability to live in the community; or

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

2. Be 18 years of age or older;

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

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

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

i. Schizophrenia or Other Psychotic Disorders (298.9);

ii. Major Depressive Disorder (296.xx);

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

iv. Delusional Disorder (297);

v. Schizoaffective Disorder (295.7); or

vi. Affective Disorders (300.xx);

6. Have a covered psychiatric disorder diagnosis consistent with codes, Axis I - V, of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), incorporated herein by reference as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the individuals are at high risk of psychiatric hospitalization as a result; and

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

i. Acute service need:

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

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

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

ii. A Global Assessment of Functioning Scale score of between 11 and 70, as found in the Diagnostic and Statistical Manual of Mental Disorders, page 32.

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

1. A primary diagnosis of substance use/dependence;

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

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

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

Amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Section was "Admission and intake". Rewrote (a)1; inserted new (b) and (c); deleted former (b) and (b)1; and recodified former (b)2 through (c)9 as N.J.A.C. 10:37F-2.2.

10:37F-2.2 Intake procedures

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

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

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

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

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

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

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

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

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

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

1. Basic demographic information, including emergency contact person;

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

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

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

5. Basic family and social supports;

6. Legal information relevant to treatment;

7. Basic substance dependency information;

8. Basic employment and educational history; and

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

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

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

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

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

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

Recodified in part from N.J.A.C. 10:37F-2.1 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Rewrote the section. Former N.J.A.C. 10:37F-2.2, Assessment and service planning, recodified to N.J.A.C. 10:37F-2.3 and 10:37F-2.4.

10:37F-2.3 Assessment

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

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

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

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

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

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

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

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

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

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

ix. Substance abuse; and

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

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

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

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

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

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

i. Diagnosis (Axis I-V) in conformance with the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV (available from the American Psychiatric Association, 1400 K St., NW, Washington, DC 20005), incorporated herein by reference, as amended and supplemented;

ii. Recommendations for treatment, including treatment modality;

iii. Medical history;

iv. Medication history and present regimen;

v. Mental status;

vi. Presenting psychiatric and non-psychiatric problems;

vii. Substance abuse history;

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

ix. Family psychiatric history; and

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

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

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

Recodified in part from N.J.A.C. 10:37F-2.2 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Section was "Assessment and service planning". Rewrote (a); recodified (b) through (d) as N.J.A.C. 10:37F-2.4. Former N.J.A.C. 10:37F-2.3, Services to be provided, recodified to N.J.A.C. 10:37F-2.5.

10:37F-2.4 Recovery planning

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

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

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

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

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

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

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

4. To assure family participation in developing the IRP and revisions, the PA shall seek the input of family members at each service planning milestone, provided that the consumer has given written consent to release information related to the treatment of his or her mental illness;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Each weekly progress note shall address:

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

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

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

iv. Significant events that occurred during that week.

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

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

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

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

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

Recodified in part from N.J.A.C. 10:37F-2.2 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Section was "Assessment and service planning". Recodified (a) as N.J.A.C. 10:37F-2.3; and rewrote the section. Former N.J.A.C. 10:37F-2.4, Termination, transfer and referral of clients, recodified to N.J.A.C. 10:37F-2.6.

10:37F-2.5 Services to be provided

(a) The PA shall provide, or arrange for, a range of services to effectively address the holistic needs of the consumer. Service provision shall be coordinated with other service providers. Services must not exceed a 1:12 staff-to-consumer ratio based upon the active daily census and direct care staff, except as indicated in (b)4 below.

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

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

continued efforts to engage individuals to participate in program services;

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

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

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

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

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

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

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

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

4. Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills. Skill development can be accomplished through either individual or group instruction; however, the direct staff-to-consumer ratio in such circumstances shall not exceed 1:10. Examples would include, but not be limited to:

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

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