is directly relevant to the family member's or close personal friend's involvement with the consumer's care and one of the following apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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.
Amended by R.2009 d.182, effective June 1, 2009.
See: 40 N.J.R. 2184(a), 41 N.J.R. 2266(a).
Rewrote (b)4; added new (c) and (d); and recodified former (c) through (g) as (e) through (i).

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

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

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

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

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

(1) Understanding and choosing work settings;

(2) Gathering and researching job information;

(3) Clarifying occupational values and interests;

(4) Defining work preferences;

(5) Identifying personal work criteria;

(6) Exploring barriers to working;

(7) Identifying and defining critical work skills;

(8) Researching personal work supports and resources;

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

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

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

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

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

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

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

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

v. The staff to consumer ratio shall not exceed a ratio of 1:10 qualified mental health services worker to consumer.

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

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

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

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

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

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

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

9. Social/leisure services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community social and recreational opportunities, planning for leisure time, practicing social interaction, recreational, spiritual and cultural activities;

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

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

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

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

1. The off-site interventions shall be:

i. Individualized for each consumer and non-stigmatizing;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Educational services, which may include basic education courses, special education courses, G.E.D. classes

and pre-college preparation to enter community roles identified in the IRP;

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

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

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

1. Identification of each consumer's medication needs;

2. Documentation of each consumer's current medications;

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

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

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

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

Recodified from N.J.A.C. 10:37F-2.3 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Rewrote the section. Former N.J.A.C. 10:37F-2.5, Management functions, recodified to N.J.A.C. 10:37F-2.7.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The presenting problem;

2. The admission date and date of service termination;

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

4. The reason for termination;

5. The medication prescribed upon discharge;

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

7. The discharge plan.

Recodified from N.J.A.C. 10:37F-2.4 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Section was "Termination, transfer and referral of clients". Substituted "consumers" for "clients" and "consumer" for "client" throughout;

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

10:37F-2.7 Management functions

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

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

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

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

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

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

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

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

Recodified from N.J.A.C. 10:37F-2.5 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
Substituted "consumer" for "client" throughout; in (a)1, substituted "partial care" for "Partial Care"; in (a)6 and (a)7, substituted "consumers" for "clients". Former N.J.A.C. 10:37F-2.7, Therapeutic environment, recodified to N.J.A.C. 10:37F-2.9.

10:37F-2.8 Quality assurance activities

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

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

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

Recodified from N.J.A.C. 10:37F-2.6 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
In (a)1 and (a)2, substituted "Consumer" for "Client"; in (a)1, substituted "consumer" for "client"; and in (a)2, inserted "family satisfaction" and substituted "consumers" for "clients". Former N.J.A.C. 10:37F-2.8, Staffing, recodified to N.J.A.C. 10:37F-2.10.

10:37F-2.9 Therapeutic environment

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

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

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

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

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

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

Recodified from N.J.A.C. 10:37F-2.7 and amended by R.2006 d.389, effective November 6, 2006.
See: 38 N.J.R. 1990(a), 38 N.J.R. 4694(b).
In the introductory paragraph of (a), substituted "consumers" for "clients".

10:37F-2.10 Staffing

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

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

1. The program director shall:

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

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