1. Each agency receiving State mental health funding for IPU programs, and other mental health agencies in that Service Area, shall use that State-funded local IPU whenever feasible, rather than refer Service Area residents to county and State psychiatric hospitals for admission.

2. Affiliation agreements must be executed by IPU programs, with the Service Area's public psychiatric facilities and with other State-funded mental health agencies in the Service Area. Agreements shall clearly outline admission criteria and procedures and those circumstances for which transfers among the local, county and State inpatient units shall be appropriate.

(b) Admissions:

1. There shall be a well-defined, written admissions policy, including admissions criteria and referral procedures for the IPU program; once developed, these criteria and procedures shall be widely distributed to all Service Area mental health and mainstream referral agencies. Such criteria shall be developed jointly with the Division, the County Mental Health Board, and the State and county psychiatric hospitals, as part of a formal affiliation process. Private psychiatric hospitals and V.A. hospitals may be included in the process of system unification when desirable and appropriate.

2. Inpatient Programs must be made available to Service Area residents meeting the admission criteria. Service Area residents shall receive services as a first priority; an emergency admission of an out-of-Service Area client, however, shall be possible.

3. Clients previously hospitalized in either a State or county psychiatric facility cannot be denied admission to a local IPU, nor automatically be referred to the State or county facility, solely because of his/her hospitalization history in a State or county facility.

4. Admission to Inpatient programs shall be in compliance with laws governing the voluntary and involuntary commitment of adults and children.

10:37–5.56 Funding requirements

(a) State-funded IPU programs must house the unit in a facility licensed by the Department of Health and/or approved by the Department of Human Services.

(b) IPU programs shall be eligible for public mental health funding as part of a formal continuum of services, demonstrated by affiliation agreements approved by the Division and the County Mental Health Board.

(c) Any agency receiving Capital Improvement Program (Bond Issue) funds for renovation and/or construction of an IPU Program shall serve involuntary, as well as voluntary, clients as stipulated in N.J.A.C. 10:37–5.18(c) and (d).

1. Programs receiving Capital Improvement Program funds for renovation or construction of an IPU or 24–hour supervised treatment home for children must serve both voluntary and involuntary clients as authorized by law.

(d) State-funded IPUs shall operate at an 85 percent utilization rate until such time that there are no voluntary commitments from a Service Area to a county or State psychiatric hospital. Through a formal affiliation agreement, between the public psychiatric hospital(s) and the State-funded local IPU, no voluntary admissions should be accepted to the public psychiatric hospital, if there are vacant, local IPU beds in a client's Service Area.

10:37–5.57 Population priorities

(a) See N.J.A.C. 10:37–5.2.

(b) IPU services should be made available to individuals who cannot cope successfully in the community at a time of crisis, are feeling severe emotional distress, and/or are dangerous to themselves or others.

10:37–5.58 Services to be provided

(a) Assessment and evaluation:

1. Every IPU client shall be assessed as to his/her Level of Functioning and Environment/Natural Support Systems. These assessments, in addition to the client's perceptions of his/her needs and emotional distress, should serve as bases for the development of a comprehensive Individual Service Plan (ISP). (See N.J.A.C. 10:37–6, Article VIII.)

2. IPU staff shall attempt to utilize and involve the client's natural supports whenever possible.

3. With the client's consent, staff should also identify living arrangements and employment circumstances, to try to effect a leave of absence without the unnecessary loss of a job or residence.

4. Other assessments and evaluations, as defined in the Division's Service Dictionary, may be made as appropriate.

(b) The following services are to be provided:

1. Health-related;

2. Therapy; and

3. Counseling.

4. Service procurement (Including discharge planning for appropriate community-based mental health, socialization, employment, housing and related social services) where possible.

5. Daily living education.

6. Recreation.

7. Information and referral.

8. Education (For Children's Inpatient and 24-Hour Supervised Treatment Homes).

10:37-5.59 Service approaches

(a) Inpatient Treatment/Service Approaches

1. IPU programs shall include a wide range of services and treatment modalities. These shall include medical psychiatric services, such as individual and group therapies, neuroleptics, etc. and various psychological interventions, such as behavioral modification and structured group processes, as defined within the context of psychosocial therapeutic milieu.

2. Appropriate interdisciplinary staff shall be an ongoing part of treatment and service planning for each client. Selected staff members from other community mental health program elements (for example: Partial Care, Outpatient, etc.) should also become a part of the treatment team, as needed, for continuity of care purposes.

3. IPU Individual Service Plans (ISPs) shall be designed to relieve the client from present discomfort and to provide the client with the coping skills necessary to function in the community. The treatment/service plan shall be explicit in describing how/why the client could not cope in the community and what will be done, during the stay, to help the client to function more adequately upon discharge. (See N.J.A.C. 10:37-6, Article VIII.)

4. When appropriate, families and/or other support system members shall be encouraged to participate in goal setting, treatment planning, program services, and discharge planning.

5. When clients known to DYFS are admitted, the IPU shall notify and involve DYFS in program and discharge planning, as soon as possible.

6. Upon completion of needs assessments, if a client under the age of 18 is in need of DYFS services, referral to the appropriate District Office of DYFS should be completed.

7. The services of the various professional disciplines shall be integrated through regular staff conferences initiated for the purpose of needs assessment, services and discharge planning, and ongoing involvement of clients.

8. A daily schedule of group and individual program/service options shall be made available to each client and shall be developed with client participation whenever possible.

9. For clients who are discharged within 48 hours of admission, emphasis shall be on reinforcing the client's natural support system, where appropriate, and on treatment and discharge planning, described in (a)3 above.

(b) Records: IPU programs shall comply with the requirements for medical/service records as specified by the Joint Commission on the Accreditation of Hospitals and the Division. (See N.J.A.C. 10:37-6, Article XIII.)

(c) Client involvement:

1. Each client shall be involved in determining service goals, modalities of treatment and timetables, to the extent that his/her condition permits. Participation should be documented by having the client's signature on the plan. (See N.J.A.C. 10:37-6, Article VIII.)

2. Client participation in community-based activities (for example: Partial Care, vocational programs, or visits to a future residence), shall be encouraged and facilitated. Clients shall also be given opportunities to reorient themselves to their home community while still an inpatient.

3. See N.J.A.C. 10:37-4.

(d) Discharge planning:

1. Unified Services requirements applicable to State and County psychiatric hospitals shall also apply to community-based IPU programs. (See N.J.A.C. 10:37-6, Article XVIII.)

2. Discharge planning shall begin as soon after admission as feasible.

3. An Individual Service Plan (ISP) shall include linkages with appropriate community mental health and related social services. The ISP shall identify comprehensive service needs. (See N.J.A.C. 10:37-6, Article VIII.)

4. A review of the client's condition should be made after 24 hours in order to certify/justify the initial stay. A treatment plan shall be developed within 72 hours and be reviewed after one week. Each client's treatment plan should be updated as often as possible. A formal review of a client's treatment plan after the first week should minimally be made on the 14th and 28th day of enrollment. Subsequently the Individual Service Plan shall be reviewed and updated every two weeks up to three months, and every three months thereafter. In each review, justification for continued hospitalization, if necessary, should be recorded.

5. If a client is readmitted, the Unit should ascertain and document where a breakdown in the individual's community and natural support systems, his/her personal adaptive capabilities, and/or emotional or physical condition occurred, so as to avoid subsequent breakdowns.

10:37-5.60 Staff

(a) To adequately evaluate and meet the needs of clients, IPU programs shall have available a sufficient number of appropriate and qualified clinical, administrative, and support staff.

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 timeframes 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.

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);

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.

Case Notes

Right to treatment in least restrictive setting. See Scott v. Plante, 641 F.2d 117 (3rd Cir.1981) certiorari granted, vacated 102 S.Ct. 3474, 458 U.S. 1101, 73 L.Ed.2d 1362, on remand 691 F.2d 634. In re Hospitalization of Patterson and Bohuk, 156 N.J.Super. 91, 98, 383 A.2d 467 (App.Div.1978), certification denied, 77 N.J. 469, 391 A.2d 484 (1978).

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 siblings 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.

Amended by R.1997 d.203, effective May 19, 1997.
See: 28 N.J.R. 3859(a), 29 N.J.R. 2471(a).
In (a), inserted "and the potential ... non-prescribed drugs" and added the last sentence; in (b), substituted "sample format" for "standard format" and inserted third sentence; in (b)3, inserted "and special precautions, for example, hypothermia"; added (b)8; in (c), deleted "psychotropic" preceding "medication is prescribed", inserted ", whenever a significant change ... or chemical abuse", and inserted references to certified nurse practitioner/clinical nurse specialist; added (d) through (f); and made nonsubstantive changes.

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, inqui-

ries 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 patients 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.

Amended by R.1997 d.203, effective May 19, 1997.
See: 28 N.J.R. 3859(a). 29 N.J.R. 2471(a).
In (a)5, substituted "Anti-convulsants" for "Anti-parkinsonian agents"; rewrote (b); added (c) through (i); and made a nonsubstantive change.

Case Notes

Right to refuse medication. See Rennie v. Klein, 476 F.Supp. 1294 (D.N.J.1979) stay denied in part, granted in part 481 F.Supp. 552, modified, remanded 653 F.2d 836, certiorari granted, vacated 102 S.Ct. 3506, 458 U.S. 1119, 73 L.Ed.2d 1381, on remand 720 F.2d 266 (decided on statutory grounds.)

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) All certificates, applications, information and records directly or indirectly identifying persons who are receiving or have received mental health services from a provider licensed by the Department, or for whom such services were sought, shall be kept confidential and shall not be disclosed by any person, except under the following circumstances:

1. Upon authorization of the consumer:

i. For adult consumers: Upon the written authorization of the consumer, or his or her legal guardian or authorized representative, if any.

ii. For consumers who are minors:

(1) A minor, 14 years or older, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service pursuant to R. 4:74-7A(c), may authorize the disclosure of his or her records in the same manner as an adult;

(2) The minor's parent or legal guardian may authorize the disclosure of the minor'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, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service pursuant to R. 4:74-7A(c), shall render the authorization of the parent or guardian void; or

(3) Disclosure of the clinical records of a minor, 14 years or older, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service pursuant to R. 4:74-7A(c), is permitted only upon written authorization of the minor; however, a parent or guardian, upon proper inquiry, shall be told the minor patient's current medical condition if the minor does not object to such disclosure;

2. Pursuant to a court order directing disclosure, upon its determination that disclosure is necessary for the conduct of its proceedings before it and that failure to make such disclosure would be contrary to the public interest; or

3. To carry out any of the provisions of Title 30 or Article 9 of Chapter 82 of Title 2A of the New Jersey Statutes (N.J.S.A. 2A:82-41), or as required by other Federal or State law.

(b) Consumer records may also be disclosed to the following persons, upon presentation of appropriate credentials, under these circumstances:

1. Employees of the agency who are involved in the care of the consumer provided, however, that when a consumer enters treatment(s) he or she will be informed that agency staff will have access to his or her records.

(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.

Case Notes

Identity of legal clients need not be disclosed to satisfy reporting requirements of Division of Mental Health and Hospitals. In re: Advisory Opinion No. 544 of the New Jersey Supreme Court Advisory Committee on Professional Ethics, 103 N.J. 399, 511 A.2d 609 (1986).

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.

Case Notes

See: In re W.S. 152 N.J. Super. 298, 377 A.2d 969 (Cty. Ct. 1977) (decided on statutory grounds.)

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. Hospitals 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 predischarge 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: