iv. Previous and current physical health problems, and observation of physical appearance as it may relate to the client's mental condition;

v. Abuse, neglect, and domestic violence history;

vi. Family situation, including the constellation of the family group; the current living situation; and social, ethnic, cultural, emotional, and health factors;

vii. Educational and work history;

viii. Identification of the community resources currently utilized by the client;

ix. Evaluation of the developmental age factors of the client in programs serving minors;

x. Psychological assessments, when clinically indicated; and

xi. Evaluations of any language, self-care, and other areas of functioning which relate to the client's mental condition.

2. The professional staff shall fully consider the client's preferences when formulating the service plan and shall ensure that the client participates in the development of his or her treatment plan. Level of participation shall be documented in the client record. Exceptions shall be documented, with specific reasons, as to the client's non-participation. If a client does not participate, the specific reasons for the non-participation shall be documented.

3. Service plans shall be developed by appropriately licensed or credentialed professionals. For clients who are receiving medications, a physician shall participate in the development of the service plan, meet with the client regularly and review and approve the client's service plan.

4. The service plan shall contain goals, timeframes, measurable objectives that relate to the goals and specific criteria for termination or reduction of services. Service plans for clients receiving solely medication monitoring services need only address the reason for medication monitoring. For all clients receiving medication, the service plan shall identify the medication, dosage, and frequency of administration and indicate frequency of clinic appointments.

5. The service plan shall specify the following:

i. Anticipated staff interventions necessary to meet the client's needs;

ii. Frequency of service provided; and

iii. Any referrals for needed services that are not provided directly by the agency.

6. The service plan shall document any involvement of the family and significant others, and be in accordance with the legal requirements for client consent to family involvement.

7. The service plan shall be completed by the fifth session or within 60 days of the first face-to-face visit, whichever occurs first, except when documented that clinical circumstances dictate that a different time frame is in the client's best interests.

8. The service plan shall be reviewed at significant decision points in each client's course of treatment and the review shall be documented in either the progress notes or treatment plan revision. Significant decision points shall include, but need not be limited to, the transfer or discharge of a client, changes in medication, and any significant change in the client's condition or situation, including, at a minimum, adverse reactions to medications.

9. The clinician and client shall review the service plan together at least every three months for the first year of treatment and at least every six months thereafter. The clinician's supervisor shall review the plan after each review by the client and clinician. For those clients who require only medication monitoring services, the service plan shall be updated by the physician and client, if appropriate, every six months.

vi. The individual's final multi-axial diagnoses, as derived from the most recent edition of the Diagnostic and Statistical Manual, published by the American Psychological Association, 750 First St. NE, Washington, DC, 20002–4242, tel. 202–336–5500.

10:37E–2.5 Termination of services

(a) The OP program shall establish and implement policies and procedures to address the termination of services to clients.

1. When it is determined that termination of services to a client is clinically appropriate, professional staff shall assess further client needs and make appropriate referrals and linkages.

2. Individuals shall not be terminated due to non-attendance without prior specific efforts to engage the client which shall be documented in the client's clinical record.

3. A termination summary shall be documented in the client record within 30 days following termination. This shall include, at a minimum, the following:

i. Primary presenting problem;

ii. Significant findings;

iii. Treatment provided and response to treatment;

iv. Clinical condition at termination;

v. The recommendations and arrangements for further treatment, including prescribed medications, dosage and possible side effects and any referrals made; and

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vi. The individual's final multi-axial diagnoses, as derived from the most recent edition of the Diagnostic and Statistical Manual, published by the American Psychological Association, 750 First St. NE, Washington, DC, 20002–4242, tel. 202–336–5500.

10:37E–2.6 Staffing requirements

(a) The PA shall employ staff who are licensed, when required, appropriately credentialed and sufficiently trained to provide OP services.

1. No counseling or therapy services requiring professional training, licensure or certification shall be provided by any staff member not appropriately trained, licensed or certified to provide such services. Unless licensure or certification provisions permit otherwise, counseling or therapy services shall be provided by individuals with at least a masters degree in a recognized mental health discipline.

(b) The OP Program Director shall manage OP operations and provide OP staff clinical supervision. This individual shall possess, at a minimum, an earned masters degree in a human services field, and five years experience in mental health services with two years supervisory experience.

10:37E–2.7 Utilization review

(a) In addition to meeting the quality assurance requirements as promulgated in N.J.A.C. 10:37–9, the PA shall also monitor and evaluate utilization of OP resources.

(b) At a minimum, the following data shall be routinely collected and analyzed:

1. Wait for service data:

i. The length of time from referral to intake interview from a designated screening center or a psychiatric emergency service with a written affiliation agreement with a designated screening center for medication monitoring; referrals from inpatient settings for medication monitoring; and referrals from other sources;

ii. The length of time from intake interview to initiation of ongoing therapy, categorized by referrals for medication monitoring and referrals from inpatient settings for medication monitoring; and referrals from all other sources;

iii. Monthly number of clients on the waiting list.

2. Caseload size per therapist; and

3. Percentage of direct service time and indirect service time spent by each therapist each month.