CHAPTER 121
LICENSURE STANDARDS FOR MENTAL HEALTH CASE MANAGEMENT AND COMMUNITY SUPPORT SERVICES

SUBCHAPTER 1. LICENSURE OF MENTAL HEALTH CASE MANAGEMENT AND COMMUNITY SUPPORT SERVICES

8:121-1.1 Scope and purpose

(a) (No change.)

(b) No mental health program shall operate, unless it is licensed by the Commissioner of the Department of Health as a mental health program and has a purchase of service contract or an affiliation agreement with the Division of Mental Health and Addiction Services or is licensed by the Commissioner of the Department of Health as a health care facility.

1. (No change.)

2. "Mental health program" means a program of mental health services not licensed by the Department as a health care facility or integrated outpatient facility and which is subject to rules adopted by the Department and is provided by either:

i. An agency that has a purchase of service contract or an affiliation agreement with the Division; or

ii. An entity that provides nonresidential, non-inpatient mental health service(s).

3. (No change.)

4. Provisions of this chapter shall not apply to:

i.-v. (No change.)

vi. A mental health program licensed by the Department as a health care facility or integrated outpatient facility, provided that each site of such program holds a separate Department license or is specified on the main facility's Department license.

(c)-(d) (No change.)

8:121-1.3 Level 1 standards

(a) The following rules shall be Level 1 standards for mental health programs:

1.-5. (No change.)

6. Staffing requirements for family support services at N.J.A.C. 10:37I-5.9(b);

Recodify existing 10.-13. as 7.-10. (No change in text.)

Recodify existing 17.-18. as 11.-12. (No change in text.)

8:121-1.6 Applicable standards

(a) (No change.)

(b) Mental health programs shall comply with the applicable standards for the following mental health services that they provide:

Recodify existing 5.-7. as 1.-3. (No change in text.)

(c)-(e) (No change.)

HUMAN SERVICES

(a)

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Behavioral Health Program Service Standards

Adopted Repeals: N.J.A.C. 10:37E and 10:37F

Adopted New Rules: N.J.A.C. 10:36

Proposed: August 18, 2025, at 57 N.J.R. 1779(a).

Adopted: January 14, 2026, by Sarah Adelman, Commissioner, Department of Human Services.

Filed: January 14, 2026, as R.2026 d.043, with **non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30:6.3).

Authority: N.J.S.A. 26:2B-7 et seq., in particular 26:2B-13; 26:2BB-5 through 6; 26:2G-1 et seq., in particular 26:2G-5; 26:2G-21 et seq., in particular 26:2G-25; 30:1-12 et seq.; 30:9A-10; and 30:9A-21; and Reorganization Plan 001-2018.

Effective Date: April 6, 2026.

Expiration Date: April 6, 2033.

Summary of Public Comments and Agency Responses:

The official comment period ended on October 17, 2025. Comments were received from:

CPC Integrated Health, Roger Borichewski, MSW, LCSW, Vice President, Quality & Risk Mgt.

Collaborative Support Programs of New Jersey, Heather Simms, Deputy Director of Advocacy & Peer Services.

Legacy Treatment Services, Ann Miamidian, MSEd, CCP, Chief Compliance Officer.

Neurocrine Biosciences, Inc., Frankie Berger, Director, Public Policy.

New Jersey Association of Mental Health and Addiction Agencies, Inc., Debra L. Wentz, Ph.D.

New Jersey Association for the Treatment of Opioid Dependence, Maiysha Ware, Pres.

New Jersey Peer Coalition, Elena Kravitz, Board Chair.

New Jersey Prevention Network, Victoria Nagel, LCADC, CCS, LPS, NCC, ACS, BC-TMH, Director of Clinical Training & Workforce Dev.

Preferred Behavioral Health Group, Christine Bender, MSW, LSW, CPHQ, Director of Quality and Compliance.

Vital Strategies Overdose Prevention Program, Derek Carr, JD, Legal Technical Advisor, Overdose Prevention Program/Public Health Programs.

1. COMMENT: The Division of Mental Health and Addiction Services ("Division" or "DMHAS") received numerous comments of general support for the new rules, including some of the following:

"… [T]he Division's proposed rule on behavioral health program (BH program) service standards, including service standards for BH programs that provide opioid treatment program (OTP) and other SUD treatment services, would expand and enhance critical, lifesaving access to agonist medications among New Jerseyans with OUD. The proposed rule would also strengthen the integration of services to treat co-occurring mental health and substance use disorders and support patient-centered care across much of the SUD treatment continuum."

"… [s]upport DMHAS's alignment of OTP program standards with Federal OTP rules (42 CFR Part 8) and DEA requirements, and appreciate the explicit 'more-restrictive-governs' clause for conflicts."

Further comments included support focused on the Division's efforts to move toward integrated services, including:

"… [s]trongly support[s] the Division's intent to integrate mental health and substance user regulations under a unified behavioral health framework."

"… [c]ommend the efforts of the Division of Mental Health and Addiction Services (Division) to modernize standards and strengthen integrated behavioral health services for New Jersey residents."

Lastly, there were comments that praised the Division's rule as a means of modernizing the standards for services, including:

"… [s]trongly support[s] the Department's efforts to streamline and modernize behavioral health standards."

RESPONSE: The Division appreciates the comments in support of this new rule establishing minimum rules and standards of care for behavioral health (BH) treatment programs and services, which will move the system towards more integrated and unified standards for quality care.

2. COMMENT: A couple of commenters recommended clarification and review of various terms and definitions, and consideration of alignment between N.J.A.C. 10:36 and 8:43K, Manual of Standards for Licensure of Outpatient and Integrated Care Facilities (proposed separately by the Department of Health), with respect to the usage of terms and definitions. The commenters also pointed out that some terms are used in one chapter, but not in the other chapter, and that sometimes there may be differences in how certain terms are defined in the two chapters.

RESPONSE: The Division has reviewed the terms and definitions used at N.J.A.C. 10:36 and declines to make any changes at this time. With respect to the usage of some terms at N.J.A.C. 10:36 and not N.J.A.C. 8:43K, or differences in definitions, the Division notes that the terms and definitions at N.J.A.C. 10:36 reflect usage and application with respect to

the minimum rules and standards of care that govern the provision of BH treatment programs and services, as opposed to the licensing of facilities. Further, the Division recognizes that there may be differences in some definitions of terms, but does not find that those differences result in any inconsistency in definitions, but rather reflect usage of the term in a BH programmatic context.

3. COMMENT: A few commenters noted the applicability of the new chapter to BH programs providing services to adults, the exclusion of individuals under 18 years old, and requested clarification regarding the licensing and monitoring of mental health and substance use disorder (SUD) programs providing services to juveniles following the repeal of N.J.A.C. 10:37E and 10:161B by the Department of Human Services (the Department) and Department of Health (DOH), respectively.

RESPONSE: The Division appreciates the need for clarification regarding the licensing, monitoring, and regulation of mental health and SUD programs for juveniles. At this time, the Division declines to change the rules to apply to individuals under 18 years old because the licensing, monitoring, and regulation of mental health and SUD programs for juveniles are outside the jurisdiction of the Division. Accordingly, the Division will share these comments with DOH and the Department of Children and Families, the State agencies responsible for the licensing, monitoring, and regulation of mental health and SUD programs providing services to juveniles in New Jersey.

4. COMMENT: Two commenters noted that the new chapter does not address inspections, and recommended aligning inspection frequency for mental health and substance use programs at a consistent interval. One commenter also noted that DOH inspects mental health programs every three years and SUD programs every two years.

RESPONSE: Inspections of BH programs, including the frequency of inspections, are within the jurisdiction of DOH, the State agency responsible for licensing facilities that provide BH services in New Jersey. To the extent commenters are seeking to submit comments on inspections as addressed by DOH at N.J.A.C. 8:43K, then the commenters must submit their comments on inspections directly to DOH. Accordingly, the Division will share these comments about inspections with DOH. However, BH programs must comply with any monitoring activities conducted by the Department and Division; see, for example, N.J.A.C. 10:36-3.3.

5. COMMENT: One commenter requested "clarification on the timeline for final adoption of N.J.A.C. 8:43K and guidance on interim expectations" to assist BH programs in preparing for compliance and integration of physical health care into BH services.

RESPONSE: The DOH proposed new N.J.A.C. 8:43K, Manual of Standards for Licensure of Outpatient and Integrated Care Facilities, on April 21, 2025. Therefore, the notice of proposal and adoption of N.J.A.C. 8:43K, including a timeline for the final adoption of N.J.A.C. 8:43K and interim guidance on physical health care, is outside the jurisdiction and responsibility of the Division. However, the Division will share this comment with DOH for their awareness.

6. COMMENT: One commenter requested that reviews of biopsychosocial assessments be reduced to annual reviews, and another commenter requested that biopsychosocial assessments be conducted at "intake only" and any reviews be removed in their entirety. Both commenters indicated such changes are necessary to reduce administrative burdens and avoid duplication with "ongoing treatment planning and clinical review processes."

RESPONSE: The Division declines to change the frequency of reviews for biopsychosocial assessments and disagrees with the commenters that the review frequency is duplicative and burdensome. The Division believes that the frequency of reviews for biopsychosocial assessments for outpatient, intensive outpatient, and partial care services is appropriate, reasonable, and reflects best practice for patient care and treatment. The review frequency, as defined for each level of care, ensures that the biopsychosocial assessment reflects a patient's current clinical status and is responsive to a patient's evolving clinical needs over the course of treatment.

Further, review of the biopsychosocial assessment is not duplicative to care planning; rather, this review and any needed updates are an essential tool that informs a patient's BH care plan. Moreover, the review frequency is not burdensome; a "review" of a patient's biopsychosocial assessment does not require that the assessment be performed again; rather, this review only requires documentation in a patient's treatment record that their biopsychosocial assessment was reviewed, and if necessary, was updated to reflect the patient's current needs and status.

7. COMMENT: One commenter noted that "[t]he proposed regulations continue to require nine hours of weekly service for [intensive outpatient]" addictive disorder services and suggested "a more flexible model" to support an individualized approach to a patient's clinical needs.

RESPONSE: Pursuant to the American Society of Addiction Medicine (ASAM) criteria, intensive outpatient (IOP) addictive disorder services consist of a minimum of nine hours per week. The ASAM Criteria is a nationally recognized and standardized set of guidelines that uses a person-centered approach to assist in determining the appropriate level of care and placement for an individual with an addictive disorder. The Division believes defining a *minimum* contact hour requirement of nine hours for IOP is appropriate, reasonable, and consistent with ASAM criteria. Therefore, the Division declines to make any changes to the requirement at N.J.A.C. 10:36-7.4(a)1 that a patient receiving IOP addictive disorder services must receive "a minimum of nine contacts hours or more a week."

8. COMMENT: Two commenters recommended establishing a mental health intensive outpatient level of care at N.J.A.C. 10:36 as a "step down" option between partial care and outpatient levels of care to align with care models and improve client access to appropriate levels of service.

RESPONSE: The Division appreciates the recommendation to include mental health intensive outpatient as a level of care at N.J.A.C. 10:36 and may consider the recommendation in a future rulemaking. At this time, the standards proposed by DOH for intensive outpatient mental health pursuant to N.J.A.C. 8:43K, Manual of Standards for Licensure of Outpatient and Integrated Care Facilities, shall apply to intensive outpatient mental health services.

9. COMMENT: Two commenters expressed concerns that N.J.A.C. 10:36-5.11(f), which requires a BH program to "provide education on, and facilitate assistance with, execution of psychiatric advance directives to the patient prior to their discharge," could be interpreted to "pressure" patients to complete a psychiatric advance directive (PAD), and requested amendments to ensure that PADs are "voluntary" and are not an "administrative requirement" or "a condition of discharge or service access."

RESPONSE: The Division declines to change N.J.A.C. 10:36-5.11(f) and disagrees that it needs clarification to ensure that PADs are voluntary in nature. The standard only requires that BH programs provide education to patients about PADs and facilitate assistance with execution of the patient's PAD prior to their discharge from services. The standard does not mandate the execution of PADs by patients, but rather ensures that patients are informed about PADs and that patients interested in developing a PAD prior to their discharge have access to the necessary information, assistance, and forms to create their PAD.

10. COMMENT: Two commenters recommended that the Division: (1) "[e]ncourage or require peer involvement in PAD education and facilitation"; (2) fund and train peer-run organizations to provide PAD workshops and technical assistance; and (3) integrate PAD education or awareness into peer-led wellness, crisis-alternative, and recovery education/relapse prevention programs.

RESPONSE: Although the Division recognizes the value of peer involvement in PAD education and facilitation, the Division declines to prescribe standards mandating the use of peers in PAD education and facilitation. Also, peers and peer support services are outside the scope of this rulemaking and are addressed by DOH at N.J.A.C. 8:43K; see, for example, N.J.A.C. 8:43K-6.6. However, nothing in this rule precludes peer staff from providing support and guidance to others on their recovery journey, including with respect to PADs, so long as peer support services are consistent with the standards set by DOH. Further, the Division notes that funding of peer organizations is outside the scope of this rulemaking.

11. COMMENT: Two commenters expressed concern about the potential "misuse of PADS in SUD" treatment services, and recommended that the Division amend the rule to state that PADs cannot be used "to mandate medication-assisted treatment or conditional participation;" "[s]hould emphasize harm-reduction, relapse-prevention,

and voluntary engagement;" and "[m]ust respect the [patient's] right to revoke or amend [a PAD] at any time."

RESPONSE: The Division declines to make any changes in response to this comment. There is no need for further clarification at N.J.A.C. 10:36 because PADs are psychiatric in nature, express and reflect patient preferences about treatment, and may be revoked or amended by patients pursuant to law. See N.J.S.A. 26:2H-106.a. As such, a PAD cannot be used to mandate any form of treatment, including medication-assisted treatment or SUD treatment. Of course, a PAD may be used by a patient to reflect their preference for SUD care, as this will assist caregivers in understanding a patient's wishes in this regard. Further, a patient's right to revoke or amend their PAD is governed and protected by State law. See N.J.S.A. 26:2H-106.d.

12. COMMENT: Two commenters "encouraged" the Division to integrate peer staff and peer support services throughout N.J.A.C. 10:36. One commenter made additional requests for peer integration, including requiring peer participation in program design, governance, and evaluations, and supporting career development for the peer workforce.

RESPONSE: Peers and peer support services are outside the scope of this rulemaking and are addressed by DOH at N.J.A.C. 8:43K; see, for example, N.J.A.C. 8:43K-6.6. To the extent the commenter is seeking to submit comments on peer staffing standards set forth by DOH at N.J.A.C. 8:43K, then the commenter must submit their comments on staffing directly to DOH. Accordingly, the Division will share these comments about peer staffing with DOH. Lastly, career development for the peer workforce is outside the scope of this rulemaking.

13. COMMENT: One commenter recommended alignment of the BH Program Service Standards "with nationally recognized clinical guidelines by explicitly adding routine screening for medication-induced movement disorders, such as tardive dyskinesia (TD), and cardiometabolic conditions associated with antipsychotic medications in sections addressing screening and assessment service and medication monitoring." Further, the commenter requested the standards at N.J.A.C. 10:36-5.2, Screening and assessment services and tools, 5.6, Medication services, and 8.4, PC services screening and assessment services and tools, be changed to include medication-induced movement disorders, such as TD, and cardiometabolic conditions.

RESPONSE: The Division declines to specifically require assessment and monitoring of medication-induced movement disorders and cardiometabolic conditions. Although the assessment and monitoring of medication-induced movement disorders, including TD, and cardiometabolic conditions, may be clinically appropriate, the intent of the standards at N.J.A.C. 10:36-5.2, 5.6, and 8.4 is to establish the minimum standards for screening and assessment services and tools, and medication services. Therefore, a BH program is not precluded from conducting assessment and monitoring for medication-induced movement disorders and cardiometabolic conditions in accordance with best practices and as may be clinically appropriate for individual patients.

14. COMMENT: One commenter stated that "[i]t is important that all mandated staffing, services and administrative tasks be aligned with and supported by billing options, with clear guidance" and recommended billing guidance be provided.

RESPONSE: The Division notes that the provision of billing guidance is outside the scope of this rulemaking, and reimbursement issues are within the purview of the Division of Medical Assistance and Health Services.

15. COMMENT: One commenter indicated that the reference to the New Jersey Substance Abuse Monitoring System (NJSAMS) as an example of an electronic database and management system at N.J.A.C. 10:36-3.3(a) implies application to all BH programs, including mental health programs, and recommended "including for substance use programs" be added to clarify the application of NJSAMS to BH programs.

RESPONSE: The Division believes that this standard is sufficiently clear, and it does not require clarification. Pursuant to N.J.A.C. 10:36-3.3(a), a BH program must timely report and submit data and information, as required, into an electronic database and/or management system, as applicable to their program services. Thus, behavioral health programs need only report and submit data and information into those electronic database and management systems that the Department and/or the Division identifies and requires that they use for reporting purposes. As the commenter noted, the reference to NJSAMS was an example of one such electronic database and management system designated by the Department and the Division for the management of data and information for BH programs providing addiction services. Further, it is the responsibility of the BH program to ensure that they are reporting and submitting data and information for the services that they are providing into the applicable system, as required and identified by the Department and/or the Division. If a BH program is unsure of the system(s) into which it must report and submit data and/or information, then the BH program should seek specific guidance from the Department and/or the Division.

16. COMMENT: One commenter expressed appreciation for the "clearly documented process" for the submission of waiver requests at N.J.A.C. 10:36-3.4.

RESPONSE: The Division thanks the commenter for its support.

17. COMMENT: One commenter noted that this rulemaking requires compliance with applicable staffing requirements set forth by DOH, including at DOH's proposed new N.J.A.C. 8:43K, and Federal standards. The commenter further submitted comments and/or recommendations to the staffing requirements set forth by DOH at N.J.A.C. 8:43K, including with respect to the following: program director, clinical supervisor, medical services supervisor, medical staff, and primary case coordinator. The commenter also requested the inclusion of one staff position in the staffing standards at N.J.A.C. 10:36, but the request was vague and ambiguous.

RESPONSE: The staffing standards for BH programs are within the jurisdiction of DOH, the State agency responsible for licensing facilities providing BH services in New Jersey. As such, the Division declines to include any additional staffing requirements at N.J.A.C. 10:36-4, BH Program Staffing Requirements. Further, to the extent the commenter is seeking to submit comments on the staffing standards set forth by DOH at N.J.A.C. 8:43K, the commenter must submit their comments directly to DOH. The Division will also share these comments about staffing with DOH.

18. COMMENT: One commenter stated that only a nurse, APN, or psychiatrist is "qualified to fully assess for both physical health and/or withdrawal issues" and, therefore, a BH program will need to add medical staff to conduct the screening for physical health and substance withdrawal that is required as part of the admission intake process requirement at N.J.A.C. 10:36-5.1(a)7.

RESPONSE: N.J.A.C. 10:36-5.1(a)7 requires a "[s]creening for physical health and substance withdrawal to identify physical health and/or withdrawal issues that require immediate medical intervention precluding admission to the BH program." Significantly, the requirement involves a "*screening*" and not, as the commenter indicates, a full assessment. As such, the Division disagrees with the commenter that the requirement at N.J.A.C. 10:36-5.1(a)7 requires the addition of medical staffing. The Division believes that non-medical staff can inquire into, and collect information about, a patient's medical status, history, and medication through a screening tool, such as a questionnaire. Upon gathering this information, non-medical staff can facilitate evaluation by an appropriate health care professional and/or any further assessment and evaluation by an appropriate health care professional. At the same time, it is the BH program's responsibility to ensure that only properly qualified staff perform evaluations using screening and assessment tools consistent with N.J.A.C. 10:36-5.2(b).

Moreover, BH programs should already have in place mechanisms to ensure that individuals in need of immediate medical intervention are properly screened and, if appropriate, referred for further medical evaluation and intervention prior to admission. Additionally, screening is necessary because individuals served in BH program settings have higher rates of medical co-morbidity and may have undiagnosed and/or untreated medical problems.

Accordingly, the Division believes it is reasonable and appropriate to screen for physical health and substance withdrawal issues during the admission intake process.

19. COMMENT: With respect to N.J.A.C. 10:36-5.2(a), one commenter requested "[m]ore clarity ... regarding which listed items this applies to as tools to meet this requirement may not exist for all the listed/required screenings."

RESPONSE: According to N.J.A.C. 10:36-5.2(a), BH programs must "use evidence-based, nationally recognized, and peer-reviewed screening and assessment tools." To the extent the commenter is requesting a list of each and every evidence-based, nationally recognized, and peer-reviewed screening and assessment tool for all of the screening and assessment services required pursuant to the rulemaking, the Division declines to provide a list in recognition that screening and assessment tools evolve over time, and because the identification of evidence-based, nationally recognized, and peer-reviewed screening and assessment tools is squarely within the expertise and knowledge of BH programs. To the extent the commenter is asking for clarification of the application of N.J.A.C. 10:36-5.2(a), the requirement at N.J.A.C. 10:36-5.2 for use of evidence-based, nationally recognized, and peer-reviewed screening and assessment tools applies to any and all screening and assessment tools used by the BH program in the provision of BH services.

20. COMMENT: With respect to N.J.A.C. 10:36-5.2(e), one commenter asked, "whether there will be a separate document required/specified for the immediate needs assessment and the current biopsychosocial assessments will be amended or if the immediate needs assessments will continue to be incorporated in the biopsychosocial assessments."

RESPONSE: The intent of the immediate needs assessment (INA) is to identify and address a patient's immediate needs related to food, shelter, and medications, as applicable, before completion of the more comprehensive biopsychosocial assessment. The INA must be completed at the patient's first visit to the BH program, and if any immediate needs are identified, then the BH program must "make appropriate referrals and/or linkages to assist the patient in addressing their immediate needs." See N.J.A.C. 10:36-5.2(e)1. Accordingly, the INA must be a separate document.

21. COMMENT: One commenter recommended deleting N.J.A.C. 10:36-5.3(d) because, they maintain, updating the BH care plan at the time of discharge is redundant when there is a separate discharge plan.

RESPONSE: For the reasons discussed below, the Division declines to delete N.J.A.C. 10:36-5.3(d) and disagrees with the commenter that addressing discharge in the BH care plan is "redundant" to any documentation completed for the patient at discharge.

N.J.A.C. 10:36-5.3(d) requires that, at the time of discharge, the patient's BH care plan address certain minimum items, including the patient's needs post-discharge, safety planning and harm reduction strategies, and referrals and/or linkages to other services and/or resources. Also, discharge planning must be incorporated into the patient's BH care plan, which planning is to be commenced upon admission.

Notably, a BH program is not required to complete a "discharge plan" pursuant to the BH Program Service Standards. Rather, the BH program must provide a patient with the following documentation at discharge: (1) a copy of their BH care plan, see N.J.A.C. 10:36-5.3(b)3; (2) a safety, crisis, and/or relapse prevention plan, as clinically appropriate, see N.J.A.C. 10:36-5.11(e); and (3) discharge instructions, see N.J.A.C. 10:36-5.11(g).

The patient's BH care plan is a comprehensive document that follows and evolves with the patient through their treatment, and, as such, it must be reviewed and updated at the time of discharge to reflect the patient's current needs, their treatment progress, and transition planning at the time of discharge. The discharge instructions are a separate document that focuses, at a minimum, on recommendations and referrals for continued services and medication needs and management. The targeted content of the discharge instructions is aimed at assisting the patient in navigating their post-discharge needs, including any follow-ups to obtain continued services. As such, the Division disagrees that there is any redundancy between the BH care plan and discharge documentation, including discharge instructions. Rather, the documentation required to be provided to a patient at discharge is complementary and intended to best support the patient during and after their discharge.

22. COMMENT: One commenter states that the requirements at N.J.A.C. 10:36-5.6 will require medical staffing, new billing codes, and recommended clarification that: "... medication management continue to be only required of MH PC programs; the prescriber entity is responsible for medication management for OP, IOP, and SU PC patients; the prescribing entity is responsible for medication education and monitoring; medication services be provided according to the prescriber based on clinical indications; and that billing guidance be issued for those services."

RESPONSE: According to N.J.A.C. 10:36-5.6, a BH program must either "provide *or* arrange for the provision of medication services to patients to treat behavioral health conditions." (emphasis added). For those BH programs that do not provide medication services directly, they "must facilitate the provision of medication services to patients." Thus, the rule does not mandate that a BH program provide medication services, nor does it require any substantial increase in staffing. Rather, BH programs have the option of either directly providing medication services or making arrangements for patients to obtain medication services to treat their BH condition with another provider agency or health care professional. Also, if a BH program *chooses* to provide medication services directly, then that BH program must meet the applicable standards at N.J.A.C. 10:36-5.6, and have the appropriate staff employed to provide medication services, including medication education, management, and monitoring, to patients.

To the extent the commenter seeks clarification regarding the provision of medication education, management, and monitoring at N.J.A.C. 10:36-5.6(b), these requirements only apply when the BH program itself is providing medication services directly as part of the treatment services offered to patients. Hence, if a patient is prescribed medication by a health care professional that is not connected to the BH program, then the BH program is not responsible for medication education and management of the patient's medication as prescribed by that professional. However, the BH program should collaborate and coordinate with the professional with respect to medication monitoring as required at N.J.A.C. 10:36-5.6(b)3, including in accordance with any and all applicable Federal and State confidentiality laws, rules, and regulations.

With respect to billing options and guidance, the provision of billing guidance is outside the scope of this rulemaking and the purview of the Division of Mental Health and Addiction Services. The Division, therefore, declines to make any changes at N.J.A.C. 10:36-5.6, as may be recommended by the commenter.

23. COMMENT: One commenter asserts that N.J.A.C. 10:36-5.7(b) is a "new requirement" and requested clarification "on expectations as well as billing codes and guidance ..."

RESPONSE: With respect to the offering of psychoeducation services to family members and other supportive persons identified by the patient, and when appropriate, the Division disagrees that this is a "new" requirement and notes that family counseling and therapy sessions satisfy this requirement, and such sessions are already a basic component of behavioral health treatment services. Further, psychoeducation services for family members and other supportive persons are a recognized best practice and result in positive outcomes for patients. Lastly, the Division declines to provide billing guidance because that is outside the scope of this rulemaking and the Division's purview.

24. COMMENT: One commenter noted that N.J.A.C. 10:36-5.7(c) listed education topics, and that "[n]ormally, specific topics are not documented, however, some inspectors have wanted to see such documentation." The commenter requested clarification on "[t]he expectations for documentation ..."

RESPONSE: N.J.A.C. 10:36-5.7(c) requires that a BH program provide education to patients, including minimally on certain topics listed at N.J.A.C. 10:36-5.7(c)1, 2, 3, and 4. To be clear, it is the Division's expectation that a BH program documents any and all education provided to patients, including the topics covered.

25. COMMENT: One commenter asserts that there is a contradiction between N.J.A.C. 10:36-7.4(b) and 8:43K-6.11(b) and requests guidance on how to reconcile and operationalize these requirements.

RESPONSE: The Division disagrees that N.J.A.C. 10:36-7.4(b) and 8:43K-6.11(b) are contradictory or need reconciliation. Both standards pertain to patient attendance in IOP addictive disorder services and are complementary to one another in supporting the transition of a patient from IOP addictive disorder services to another level of care. Further, N.J.A.C. 10:36-7.4(b) supports clinical determinations with respect to attendance, the continued appropriateness of placement of a patient in IOP addictive disorder services, and the need to transition a patient from IOP addictive disorder services to another level of care. To the extent the commenter is asking for guidance on the operationalization of these

standards, such guidance is outside the scope of this rulemaking. However, the Division will consider whether any guidance regarding operationalization is necessary, and in so doing, may elicit stakeholder input on operationalization.

26. COMMENT: One commenter requested the addition of language at Subchapter 9, Program Standards for Opioid Treatment Program (OTP) Services, to explicitly state the lack of applicability of the "regularly scheduled counseling" requirements in Subchapters 6, 7, and 8 to opioid treatment programs.

RESPONSE: Pursuant to N.J.A.C. 10:36-9.1(a), only Subchapters 1, 2, 3, and 4 apply in full to OTPs, and only N.J.A.C. 10:36-5.8, 5.9, and 5.10 at Subchapter 5 apply to OTPs. Further, Subchapters 6, 7, and 8 only apply to those BH programs that are providing the level of care identified by the subchapter; that is, Subchapter 6 applies to outpatient addictive disorder and/or mental health services; Subchapter 7 applies to intensive outpatient addictive disorder services; and, Subchapter 8 applies to partial care mental health and/or partial care addictive disorder services. The Division believes that the language at N.J.A.C. 10:36-9.1(a), specifically stating what subchapters, or specific standards within a subchapter, apply to OTPs, is sufficiently clear to express the standards applicable to OTPs pursuant to this rulemaking. However, to the extent that an OTP elects to be licensed to provide another level of care, the OTP will need to adhere to standards applicable to that distinct level of care in providing services to patients.

27. COMMENT: One commenter requested language to ensure that references to the ASAM and DSM are to the "most current" editions of each source, including, in part, to address that The ASAM Criteria may be released in different "population-specific" versions.

RESPONSE: The Division believes the definitions of "ASAM criteria" and "DSM" at N.J.A.C. 10:36-2.1 are sufficiently clear in that they are inclusive of subsequent editions. Specifically, the definitions already include language indicating that The ASAM Criteria and DSM are incorporated "as amended and supplemented." As a further point of clarification, the incorporation of The ASAM Criteria is limited to adults, consistent with the application of this rulemaking to BH services provided to adults.

28. COMMENT: One commenter recommended that the Division "further enhance low-barrier, patient-centered treatment within OTPs" by "strengthening and expanding access to take-home methadone; clarifying authorization for methadone guest dosing; explicitly authorizing interim treatment in alignment with Federal regulations; and establishing a patient advisory structure."

RESPONSE: The Division believes that program standards for OTPs at N.J.A.C. 10:36 are client-centered. Further, to the extent that the commenter is suggesting that the Division adopt Federal reforms with respect to OTPs, this rulemaking represents a substantial departure from standards applicable to OTPs pursuant to N.J.A.C. 10:161B (proposed for repeal by DOH) and, rather, aligns with and defers to Federal standards for OTPs, including 42 CFR 8.12i ("take home" medication doses) and 8.12j (interim treatment).

29. COMMENT: One commenter expressed concern that the language at N.J.A.C. 10:36-5.10(b) with respect to "relapse" may be "susceptible to a narrow interpretation" applying only to a patient's return to use after a period of abstinence, exclusive of a patient's continued use. The commenter also expressed concern that the term "relapse" is potentially stigmatizing and should be avoided in the rulemaking.

RESPONSE: The Division will review whether there is a need to make any changes to language to address the commenter's concerns regarding the use of "relapse" at N.J.A.C. 10:36-5.10(b), but declines to make any changes in response to this comment because the term "relapse" as used at N.J.A.C. 10:36-5.10(b), and elsewhere in the rulemaking, functions appropriately in the context of the standards articulated.

30. COMMENT: One commenter recommended changing N.J.A.C. 10:36-5.8 to "[e]stablish guardrails on the use of administrative discharge for patient unavailability" and specifically requested amendments "to impose a minimum period (for example, no less than 30 days) before a BH program may administratively discharge a patient for unavailability, require a BH program to make reasonable attempts to reestablish contact with a patient deemed unavailable, and require BH programs to document such attempts to reestablish communication in a patient's record."

RESPONSE: The Division believes the current standards set out at N.J.A.C. 10:36-5.8, Administrative discharge from the BH program, allow for clinical discretion with respect to discharge of patients who become unavailable, and further prescription of standards is unnecessary at this time. Additionally, the standards require that the BH program make reasonable efforts to issue discharge instructions and ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons. See N.J.A.C. 10:36-5.8(c). Thus, in making reasonable efforts pursuant to N.J.A.C. 10:36-5.8(c), the BH program would need to attempt to contact the patient regarding their discharge instructions and ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons. Further, it is expected that the BH program will document its reasonable efforts as a matter of good practice in the patient's treatment record. Accordingly, the Division declines to change N.J.A.C. 10:36-5.8.

31. COMMENT: One commenter requested clarification regarding the "intent of provisions on voluntary discharge" and questioned "why the proposed rule must specify the circumstances in which voluntary discharge is permissible — outside of legally mandated treatment, a patient remains free to exit treatment for any reason or no reason." The commenter recommended an amendment to "specify that the patient must be involved in the process of determining and consent to any final determination that they have met the conditions specific in subsections (a)(1) or (a)(2)."

RESPONSE: The Division includes "voluntary discharge" to address circumstances outside of an administrative discharge or involuntary discharge where patients may elect to discontinue receiving services by their own choice, or when a BH program determines discharge is appropriate because a patient has reached maximum benefit in their level of care and/or met all of their treatment goals, or a patient has reached maximum benefit in their level of care and is transitioning to another level of care. It is the Division's expectation that the voluntary discharge process be one in which the BH program and patient are engaged in shared decision making about the patient's discharge. The Division also believes the voluntary discharge standards sufficiently recognize that patients are "free to exit treatment for any reason or no reason."

Regarding patients' involvement in the process of voluntary discharge pursuant to N.J.A.C. 10:36-5.9(a)1 and 2, the Division believes that the standards sufficiently contemplate patients will be involved in the discharge process through the issuance of their discharge instructions and in the course of ascertaining whether patients want their discharge instructions shared with family members or other supportive persons. See N.J.A.C. 10:36-5.9(c). Therefore, the Division declines to change N.J.A.C. 10:36-5.9.

32. COMMENT: One commenter recommended that N.J.A.C. 10:36-9.2(b)2 be made applicable and extended to all BH programs with respect to medically managed withdrawal from opioid agonist medication. In addition, this commenter recommended that N.J.A.C. 10:36-9.2(c) be made applicable to all BH programs with respect to continued medication access during the pendency of an appeal.

RESPONSE: N.J.A.C. 10:36-9.2(b)2 requires that prior to a patient's involuntary discharge, the OTP must facilitate a patient's medically managed withdrawal from their opioid agonist medication, when appropriate. N.J.A.C. 10:36-9.2(c) requires that when a patient elects to appeal their involuntary discharge, an OTP must maintain the patient's access to medication pending the outcome of the BH program's internal appeals process.

Both of these OTP-specific standards reflect the specialized nature of medication services provided to patients by an OTP — particularly, that methadone, a highly regulated medication, may only be accessed as an opioid agonist medication through an OTP. Thus, the standards at N.J.A.C. 10:36-9.2(b)2 and (c) address the need to facilitate medically managed withdrawal in an OTP setting from methadone, as well as the need for continued contact by the patient with the OTP for access to methadone during the pendency of their appeal.

Regarding non-OTP settings and continued medication access during the pendency of an appeal of an involuntary discharge, the Division believes that the standards at N.J.A.C. 10:36-5.10(c) are sufficient to address continuity of care for medication services in non-OTP settings. Pursuant to N.J.A.C. 10:5-10(c), a BH program must issue discharge

instructions, which must address recommendations and referrals for medication needs and management and, if the patient consents, assist the patient with linkages to services, which may include medication services.

To the extent the commenter is also recommending that patient consent to medically managed withdrawal be addressed at N.J.A.C. 10:36-9.2(b)2, the Division believes that patient consent and cooperation is inherently necessary to implement medically managed withdrawal, and further, that obtaining patient consent is best practice.

Therefore, the Division declines to make the standards at N.J.A.C. 10:36-9.2(b)2 and (c) applicable to all BH programs.

33. COMMENT: One commenter recommended that the Division "include language explicitly prohibiting punitive reductions in medication dosages or reductions in medication take-home privileges" and that the Division "reinforce the NJ DOH Proposed Rule's protections against administrative or involuntary discharge based on drug screening, toxicology, or other laboratory results."

RESPONSE: The Division declines to make the specific changes at N.J.A.C. 10:36 recommended by the commenter. Although the Division declines to make such changes, it is the Division's expectation that BH programs will not engage in punitive actions with regard to medication dosages or medication take-home privileges because a patient may be uncooperative with counseling or other services available at the BH program. If a patient is uncooperative or unwilling to engage in the full continuum of treatment services, including counseling, the BH program should meet with the patient to inquire whether the patient wants to continue receiving services — inclusive of all essential components of their BH care plan — or whether the patient's needs may be better met through another BH program provider or health care professional. The Division notes that medication, along with counseling and other treatment services, are best practices, and this full spectrum of services is typically provided by a BH program. The Division further notes that patients must be "willing to participate" in treatment services (see admission eligibility criteria at N.J.A.C. 8:43K-6.10, 6.11, and 6.12).

Notably, N.J.A.C. 8:43K applies to all BH programs licensed by DOH to provide BH services to adults in an outpatient setting. As such, BH programs governed by N.J.A.C. 10:36 must comply with all standards established by DOH at N.J.A.C. 8:43K, and it is unnecessary to "reinforce" or duplicate DOH's standards in this rule.

To the extent that the commenter is requesting that the Division address these recommendations in standards related to policies and procedures, or patient rights, both of those areas are within the jurisdiction of DOH and addressed at N.J.A.C. 8:43K, including methadone withdrawal and dosage in OTPs at N.J.A.C. 8:43K-8.1(a)5. Accordingly, they fall outside the scope of this rulemaking. Additionally, the Division defers to Federal standards for OTPs, including 42 CFR 8.12i ("take home" medication doses).

34. COMMENT: One commenter noted that "[t]he proposed rule requires BH programs seeking to involuntarily discharge a patient to provide the patient with written notice of '*internal* appeal procedures'" (emphasis in original). The commenter recommended expanding "procedural protections to adverse actions other than involuntary discharge, including by requiring BH programs to provide patients with notice and an opportunity to appeal any adverse action." Further, the commenter recommended establishing "requirements and guardrails" in BH program policies and procedures regarding patient appeals. Lastly, the commenter requested clarification of any process by which "a patient may file an appeal with the State to challenge a facility's determination in a patient's appeal."

RESPONSE: The Division declines to expand the written notice requirements at N.J.A.C. 10:36-5.10(b) to administrative discharges or adverse actions, or prescribe specific requirements for internal appeal procedures for BH programs with respect to "adverse actions." N.J.A.C. 10:36-5.10(b) requires that prior to an involuntary discharge, BH programs must provide a patient with written notice of the involuntary discharge, which shall include the reasons for the involuntary discharge and internal appeal procedures. Although the Division believes it is necessary to establish this written notice requirement for involuntary discharges, the Division does not believe that a comparable notice requirement is necessary for administrative discharges due to a patient's unavailability or for other "adverse actions" that may be addressed through internal procedures established by a BH program.

To the extent that the commenter is requesting that the Division address patient appeals in standards related to policies and procedures, this area is within the jurisdiction of DOH and addressed at N.J.A.C. 8:43K. It is, therefore, outside the scope of this rulemaking. In addition, if a patient has a complaint about their discharge from treatment services, the patient may submit a complaint to DOH, Certificate of Need and Licensing (https://www.nj.gov/health/healthfacilities/).

35. COMMENT: One commenter requested that DMHAS "[a]ddress inconsistencies and/or direct conflicts with the NJ DOH Proposed Rule" regarding:

(1) "if a patient receives medication treatment from a non-OTP outpatient BH program and declines the mandatory regularly scheduled counseling, therapy, and/or psychoeducation sessions: the Division's proposed rule would expressly authorize involuntary discharge based on the patient's refusal to participate in those treatment services while the NJ DOH Proposed Rule would explicitly prohibit involuntary discharge on such grounds"; and

(2) with respect to discharge, "an inconsistency between the two proposed rules as the Division's proposed rule requires neither patient consent nor confirmation of availability and the patient's acceptance into the alternative level of care." More specifically, the commenter points to the DOH rule as requiring patient consent and acceptance into an alternative level of care for discharge, whereas the Division's rule allows a BH program to involuntarily discharge a patient "refusing to participate in treatment so long as the BH program 'facilitates the patient's referral to another clinically appropriate level of care.'"

RESPONSE: The Division believes the two rules referenced by the commenter are consistent with each other because the definition of "regularly scheduled" at N.J.A.C. 10:36-2.1 allows flexibility for those patients who may not be engaging with counseling services. It is within the clinician's purview to determine whether counseling services are clinically indicated and the frequency of the same. However, it is the Division's expectation that BH programs engage with clients who are resistant to counseling and other ancillary services that are clinically indicated. If a patient is uncooperative with all clinically indicated and offered services (except for medication), a BH program may need to re-evaluate the patient's continued eligibility for services, including a determination of whether the patient is actively "willing to participate" in program services, see, for example, N.J.A.C. 8:43K-6.10(a)3, 6.11(a)4, and 6.12(f)1iii and 2iii.

With respect to concerns about inconsistencies between the two rules regarding discharge, the Division does not believe that there is any inconsistency between the two rules. The DOH rule requires that policies and procedures address that a "facility does not discharge a patient to a higher, lower, or an alternative level of care without patient consent and enrollment confirmation, *to the extent possible* ..." N.J.A.C. 8:43K-5.1(a)20iv (emphasis added). The DOH rule further requires that a BH services facility must establish policies and procedures addressing discharge, including "criteria for voluntary, administrative, and involuntary discharge, subject to" certain conditions, including that "[a] facility may discharge a patient to an alternative level of care only with the patient's consent, and upon confirmation of availability of, and the patient's acceptance into, the alternative level of care ..." N.J.A.C. 8:43K-6.7(a)5i(2). The Division requires that when a BH program involuntarily discharges a patient for refusing to participate in their treatment, the BH program must facilitate the patient's referral to another clinically appropriate level of care. N.J.A.C. 10:36-5.10(a)2 and 9.2(b)1.

The Division believes that the commenter has more narrowly construed DOH's requirements than what DOH intends by the plain language at N.J.A.C. 8:43K-5.1(a)20iv. Specifically, DOH included the phrase, "to the extent possible"; this phrase contemplates that sometimes a patient may be unwilling to engage in a referral to another clinically appropriate level of care and that a discharge may occur without a patient's consent and enrollment confirmation. Further, the Division believes that DOH intends for this acknowledgment of the lack of patient consent and enrollment confirmation to be equally applicable at N.J.A.C. 8:43K-6.7, to avoid any confusion.

Moreover, with respect to patient consent, if a BH program is facilitating a referral to another clinically appropriate level of care for a patient, then the patient must be agreeable to the referral, and any referral must be done in accordance with applicable Federal and State confidentiality requirements. If a patient is not agreeable to a referral, in other words, does not consent to a referral, the BH program will not be able to assist and facilitate the patient's referral to another clinically appropriate level of care. Thus, patient consent is already integral to the referral process and must be consistent with applicable State and Federal confidentiality laws and regulations.

Accordingly, the Division believes the two rules can be read together and does not believe there are any inconsistencies between them. Should any issues or concerns arise during implementation of the two rules, the Division and DOH will engage collaboratively to address same.

36. COMMENT: One commenter recommended that the Division modify the proposed rule to align with DOH's proposed rule N.J.A.C. 8:43K to expand requirements related to medication access and harm reduction services and supports and that N.J.A.C. 10:36-5.6(a) be amended to "explicitly state that the requirement for BH programs to provide or facilitate access to medication services to patients to treat behavioral health conditions includes patient access to clinically appropriate agonist and partial agonist medications for opioid use disorder (i.e., methadone and buprenorphine)."

RESPONSE: Pursuant to N.J.A.C. 10:36-5.6(a), a BH program must provide or arrange for the provision of medication services to patients to treat BH conditions. Also, pursuant to N.J.A.C. 10:36-5.7(c)2 and 3, a BH program must provide education on harm reduction for addictive disorders and overdose prevention and information about how to access opioid overdose reversal medication.

The Division disagrees with the commenter in that it needs to "explicitly state" types of medications that may be used to treat BH conditions. The type of medication that is used to treat a BH condition is squarely within the discretion of the prescribing health care professional and may encompass more than medications used to treat opioid use disorder, including medications to treat alcohol use disorder and mental health conditions.

With respect to making changes to align with N.J.A.C. 8:43K, N.J.A.C. 8:43K applies to all BH programs licensed by DOH to provide BH services to adults in an outpatient setting. As such, BH programs governed by N.J.A.C. 10:36 must comply with all standards established by DOH at N.J.A.C. 8:43K, and it is unnecessary to align with DOH's standards in this rule.

Therefore, the Division declines to make any changes to the rulemaking.

37. COMMENT: One commenter proposed that N.J.A.C. 10:36-9.1 be modified to require that "BH programs operating OTP services to educate *all* patients on harm reduction, overdose prevention, and opioid overdose reversal medications rather than only requiring such education prior to a patient's involuntary discharge."

RESPONSE: The Division declines to change the rule to add a requirement at N.J.A.C. 10:36-9.1 for a BH program providing OTP services to provide education on harm reduction, overdose prevention, and opioid overdose reversal medications other than prior to a patient's involuntary discharge. With respect to educational requirements, the Division defers to the Federal standards at 42 CFR Part 8, which includes harm reduction and recovery-oriented counseling at 42 CFR 8.12(f)5, and believes the education and information requirements prior to a patient's involuntary discharge at N.J.A.C. 10:36-9.2(a)3 and 4 are sufficient. Therefore, the Division declines to change N.J.A.C. 10:36-9.1 to include any additional educational requirements.

38. COMMENT: One commenter requested modification at N.J.A.C. 10:36-5.3(c)7 and 9.1 to require that all BH programs, OTPs, and non-OTPs, "provide referral and/or linkages to harm reduction services for patients who use substances" to align with the DOH's proposed rule, N.J.A.C. 8:43K.

RESPONSE: This rulemaking sets forth the minimum standards for BH programs and does not preclude referral and/or linkages to harm reduction services for patients when such a referral is clinically appropriate. Indeed, referral and/or linkages should be based on the patient's particular clinical and non-clinical needs. Further, DOH has addressed referral for harm reduction services, see, for example, N.J.A.C. 8:43K-5.2(c). Also, for OTPs, the Division defers to the Federal standards regarding harm reduction and referral at 42 CFR 8.12(f)5 and believes this standard is sufficient. Accordingly, the Division declines to amend the rulemaking to mandate referral and/or linkages for harm reduction services.

39. COMMENT: One commenter commended the Division for recognizing the importance of naloxone access and noted that the rulemaking includes provisions requiring BH programs to provide information about opioid overdose reversal medication. The commenter recommended that the Division require BH programs to "offer a naloxone kit" to all patients with a history of opioid use or at risk for overdose. The commenter further recommended that the Division "require that naloxone kits include only formulations containing no more than four mg of naloxone per dose unless a patient specifically requests a higher dose product ..."

RESPONSE: The Division declines to require that BH programs offer or provide naloxone kits to patients or set standards regarding the specific dosage of naloxone. The Division believes that the provisions in the rulemaking regarding information on access to opioid overdose reversal medication are sufficient. In addition, the Division notes that there are two DHS initiatives that offer naloxone access to New Jersey residents: (1) DHS Naloxone Direct is a naloxone distribution initiative that allows local government agencies, first responders, and other eligible entities, including DOH-licensed SUD provider agencies, to make requests for naloxone through an online portal; and (2) DHS Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community through which individuals can simply walk into a participating pharmacy and ask the pharmacist for naloxone and receive a carton of naloxone 4mg nasal spray (two doses per carton) for free.

40. COMMENT: One commenter recommended that DMHAS replace "21 U.S.C. § 823(h)(1)" with "21 U.S.C. § 823(h)" at N.J.A.C. 10:36-9.1(f).

RESPONSE: The Division declines to change the definition of OTP at N.J.A.C. 10:36-9.1(f) because that definition is consistent with the definition of OTP at 42 CFR 8.2, which defines an OTP as follows: "Opioid Treatment Program or OTP means a program engaged in OUD treatment of individuals with MOUD registered pursuant to 21 U.S.C. 823(h)(1)."

41. COMMENT: One commenter requested amending N.J.A.C. 10:36-5.4, Safety plan, to clarify the contents of a safety plan, or alternatively, provide guidance on how BH programs may satisfy the requirement.

RESPONSE: N.J.A.C. 10:36-5.4 requires a BH program to ensure that an evidence-informed safety plan is developed collaboratively with any patient experiencing suicidal ideation, otherwise at risk for suicide, or at risk of overdose. The Division believes that BH programs have the familiarity and expertise to develop safety plans and declines to prescribe the specific contents of a safety plan in the rule.

However, the Division may evaluate whether there is any need to propose changes with respect to safety plans, including defining the contents of a safety plan, in future rulemakings or issue guidance on safety plans to BH programs.

42. COMMENT: One commenter requested that the Division "[m]odify or eliminate the requirement in proposed N.J. Admin. Code § 10:36-5.6(d) for BH programs to 'ensure that medications are administered in accordance with their approved product labeling.'"

RESPONSE: The Division declines to modify or eliminate the provision at N.J.A.C. 10:36-5.6(d) requiring that BH programs "maintain current procedures to ensure that medications are administered in accordance with their approved product labeling" because this standard ensures that medication is safe and effective for patient use in the administration of medication.

43. COMMENT: One commenter requested clarification at N.J.A.C. 10:36-5.1(a)5 because it "suggests differential application depending on whether a patient has an SUD." The commenter further stated that "[o]ur best reading of the proposed language is that urine drug screens during admission intake are always considered clinically indicated for patients with an SUD while a BH program must specifically identify a clinical need before conducting a urine drug screen during intake for patients without an SUD." The commenter further requested clarification between

"the interaction" between N.J.A.C. 10:36-5.1(a)5 and 5.2(c)5 with respect to urine drug screens.

RESPONSE: According to N.J.A.C. 10:36-5.1(a)5, a BH program must implement an admission intake process that includes "[l]aboratory testing, for example, urine drug screens, as *may* be clinically indicated, and for patients with an SUD, the intake process *may* include a urine drug screen *and* other applicable and clinically indicated laboratory testing ..." (emphasis added.)

To the extent that the commenter believes that urine drug screens are "differentially applied" or mandated for patients with a substance use disorder diagnosis, the Division disagrees. The language at N.J.A.C. 10:36-5.1(a)5 indicates that a urine drug screen is based on clinical discretion, regardless of whether the patient has a SUD or other diagnosis. However, the intake process for a patient with a SUD "*may* include a urine drug screen *and other* applicable and clinically indicated laboratory testing." (emphasis added.) Thus, the only distinction for patients with a SUD is that the admission intake process may include "other applicable and clinically indicated laboratory testing." Further, the Division does not believe it is necessary to clarify "the interaction" between N.J.A.C. 10:36-5.1(a)5 and 5.2(c)5 with respect to urine drug screens because the standards are consistent with respect to clinical appropriateness for urine drug screens.

44. COMMENT: One commenter encouraged the Division to "[a]ddress reimbursement for [medications for opioid use disorder] in the Division's SUD Fee for Service Initiative," but also recognized "this issue is beyond the scope of the present rulemaking."

RESPONSE: The Division appreciates the comment, but as the commenter recognized, reimbursement for MOUD is outside the scope of this rulemaking.

Summary of Agency-Initiated Changes:

1. At N.J.A.C. 10:36-2.1, the Division is correcting a typographical error in the citation to The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

2. At N.J.A.C. 10:36-2.1, the Division is clarifying the definition of a BH care plan by removing the clause specifying that care plans must meet the requirements at N.J.A.C. 10:36-5.3. The definition now indicates that a BH care plan must meet the requirements of this chapter, which more clearly captures all standards applicable to a care plan, including, but not limited to, N.J.A.C. 10:36-5.3.

3. At N.J.A.C. 10:36-2.1, the Division is clarifying the definition of psychiatric advance directive for consistency with the definition of psychiatric advance directive at N.J.A.C. 10:32, Advance Directives for Mental Health Care, see specifically, N.J.A.C. 10:32-1.3, by updating the statutory cross-reference.

4. At N.J.A.C. 10:36-8.4, the Division is changing the following: (1) correcting the internal cross-reference to properly refer to N.J.A.C. 10:36-8.4(b), and not 5.2(b); and (2) removing the reference to N.J.A.C. 10:36-5.2(e) as being excepted for partial care services because an INA must be completed for partial care services consistent with N.J.A.C. 10:36-5.1(a)4 and 8.2.

Federal Standards Statement

OTPs are subject to, and must comply with, Federal regulations that govern their operation and services, including regulations promulgated by SAMHSA, which is within the U.S. Department of Health and Human Services. Most particularly, SAMHSA sets forth regulations related to OTP accreditation, certification, and standards for the treatment of opioid use disorder (OUD) with medications for OUD at 42 CFR Part 8, Medications for the Treatment of OUD.

In accordance with N.J.S.A. 52:14B-22 and E.O. No. 63 (2019), the Division reviewed the Federal regulations promulgated by SAMHSA for OTPs, and recognizes that the Federal standards provide adequate and acceptable minimum program standards for operation of, and services at, OTPs in New Jersey, and as such, the Federal standards "sufficiently protect the health, safety and welfare of New Jersey citizens." N.J.S.A. 52:14B-22.

Therefore, the program standards applicable to OTPs in the Division's rules demonstrate a substantial departure from current program standards applicable to OTPs and are proposed for repeal by DOH at N.J.A.C. 10:161B, including at Subchapter 11, Opioid Treatment Services. The Division has taken substantial steps to reduce regulatory burdens for OTPs by aligning with and deferring to the Federal standards for OTPs in this new chapter. Notably, any Division rules applicable to OTPs are minimal, and related primarily to areas outside the subject matter covered by the Federal regulations for which there is a particular State interest in setting standards to ensure the health, safety, and welfare of New Jersey citizens, including those regulations described below.

1. OTPs must adhere to the "General BH Program Operational Requirements" set forth at Subchapter 3; these operational requirements are general standards related to legal compliance, confidentiality, data submission, and regulatory waivers.

2. OTPs must comply with standards related to administrative discharge, voluntary discharge, and involuntary discharge set forth at Subchapter 5 (BH Program Core Service Standards). Specifically, N.J.A.C. 10:36-5.8, Administrative discharge from the BH program, 5.9, Voluntary discharge from the BH program, and 5.10, Involuntary discharge from the BH program, set forth minimum standards defining discharge criteria and addressing discharge processes.

3. OTPs must comply with service-level-specific standards delineated at Subchapter 9, Program Standards for OTP Services. N.J.A.C. 10:36-9.1 addresses general requirements, including the need for compliance with applicable Federal laws and regulations. N.J.A.C. 10:36-9.2, OTP services involuntary discharge, sets forth additional minimum standards addressing involuntary discharge from an OTP, including standards related to management of medication for patients.

Significantly, the operational requirements at Subchapter 3, and the core standards related to discharge at N.J.A.C. 10:36-5.8, 5.9, and 5.10, apply to all BH programs because they set forth foundational, operational, and core standards that assist in ensuring the health, safety, and welfare of New Jersey residents. Further, any additional or supplemental standards applicable to OTPs at Subchapter 9 reflect standards that enhance and promote the safe and effective delivery of services to patients in OTPs operating in New Jersey.

In all, the standards applicable to OTPs in these new rules do not represent any material conflict or inconsistency with the Federal rules that apply to OTPs. And, although the Division believes the Federal standards are sufficient for purposes of regulation of OTPs, the Division also believes the standards as described above and applicable to OTPs in this new chapter are justified and necessary to promote safe and effective services in OTPs, and ensure patients in OTPs operating in New Jersey are afforded the same quality of services and protections as patients receiving services in non-OTP BH programs.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 36
BEHAVIORAL HEALTH PROGRAM SERVICE STANDARDS

SUBCHAPTER 1. PURPOSE AND SCOPE

10:36-1.1 Purpose

The purpose of this chapter is to protect the health and safety of patients by establishing minimum rules and standards of care that govern the provision of behavioral health treatment programs and services to patients in New Jersey.

10:36-1.2 Scope and applicability

(a) This chapter applies to all facilities licensed by the New Jersey Department of Health pursuant to N.J.A.C. 8:43K, to provide behavioral health services to adults in an outpatient setting. Behavioral health consists of the following programs, services, and levels of care: outpatient addictive disorder and/or mental health, intensive outpatient addictive disorder, partial care mental health, partial care addictive disorder, and opioid treatment programs. Behavioral health services pursuant to this chapter are provided in an outpatient setting to patients who present and depart on the same day.

(b) The rules in this chapter constitute the basis for the monitoring of behavioral health care programs and services by the New Jersey Department of Human Services, Division of Mental Health and Addiction Services.

SUBCHAPTER 2. DEFINITIONS

10:36-2.1 Definitions

The following words and terms, as used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Addictive disorder" means a clinical presentation that demonstrates signs and symptoms that substantiate diagnosis of an addictive disorder as defined in the DSM, such as a gambling disorder and/or substance use disorder.

"Admission" or "admitted" means accepted for treatment at the BH program.

"American Society of Addiction Medicine criteria" or "ASAM criteria" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer/discharge of individuals with addictive disorder. These ASAM criteria are set forth in *[the]* ***The*** ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Volume 1: Adults, 4th ed., Hazelden Publishing (2023), incorporated herein by reference, as amended and supplemented.

"Behavioral health," also referred to as "BH," means the treatment of mental illness and/or addictive disorders. It includes the support of individuals with a mental illness or an addictive disorder, or individuals with a co-occurring disorder, who are experiencing and/or in recovery from these conditions.

"BH care plan" means a plan of care developed collaboratively between the patient and patient's inter-disciplinary team that meets the requirements of this chapter*[, specifically, at N.J.A.C. 10:36-5.3]*.

"BH program" means behavioral health program services provided in or through a community outpatient setting to patients with a diagnosis of a mental illness and/or an addictive disorder. A BH program integrates a trauma-informed, culturally and linguistically appropriate approach in all aspects of service delivery and the patient care experience. A BH program provides services in one or more of the following service categories: (1) outpatient addictive disorder and/or mental health; (2) intensive outpatient addictive disorder; (3) partial care mental health; (4) partial care addictive disorder; and/or (5) opioid treatment program services.

"Biopsychosocial assessment" means a multi-dimensional evaluation of the patient's biological, psychological and social history, and status, as applicable and as identified by the patient, and collateral sources, as appropriate, to inform the BH care plan.

"DEA" means the U.S. Drug Enforcement Administration.

"Department" or "DHS" means the New Jersey Department of Human Services in this chapter, unless otherwise specified.

"Department of Health" or "DOH" means the New Jersey Department of Health.

"Division" or "DMHAS" means the New Jersey Division of Mental Health and Addiction Services within DHS. The Division is the Single State Authority for Substance Abuse and the State Mental Health Authority.

"Document," "documented," or "documentation" means an electronic or written record.

"Dosage" means the quantity of a medication to be taken or applied all at one time or in fractional amounts within a given time.

"DSM" or "DSM-5-TR" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, incorporated herein by reference, as amended and supplemented, the standard classification of mental disorders in the United States, published by and available from the American Psychiatric Association.

"Evidence-based practices" means a treatment and/or intervention for specific problems that has demonstrated effectiveness through repeated empirical research.

"Family members and/or other supportive persons" means immediate kindred, domestic partner, legal guardian, legally authorized representative, or an individual granted a power of attorney. The term may also include those persons having a commitment and/or personal significance to the patient.

"FDA" means the U.S. Food and Drug Administration.

"Immediate needs assessment" means an assessment used to identify a patient's immediate needs related to food, shelter, and medications, as applicable.

"Inter-disciplinary team" or "IDT" means those BH program staff who work together to provide treatment planning and care to a patient.

"Medication" means a substance as defined by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39-1.2.

"Mental illness" means a mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (for example, serious mental illness).

"Opioid use disorder" or "OUD" means a cluster of cognitive, behavioral, and functional symptoms associated with a problematic pattern of opioid use that continues despite clinically significant impairment or distress within a 12-month period.

"Patient" means an adult individual, age 18 years or older, who is receiving behavioral health care services from a facility licensed by DOH pursuant to N.J.A.C. 8:43K and subject to this chapter. "Patient" may also mean a client or other terminology used by a licensed facility to refer to the individuals to whom it provides treatment.

"Progress note" means a written or electronic summary of the treatment and/or services, and the patient's response.

"Psychiatric advance directive" means a writing executed in accordance with the requirements of the New Jersey Advance Directives for Mental Health Care Act, N.J.S.A. 26:2H-*[102 et seq]* ***107***.

"Psychoeducation services" means a mutual exchange of information and education between qualified staff, and the patient, or the qualified staff and family members and/or other supportive persons, designed to increase the likelihood of family, supportive persons, and community support to the patient and to reduce the probability of patient decompensation. Information may address etiology and symptoms characteristic of the patient's mental illness and/or addictive disorder, effects of medication, coping skills, daily living skills, community resources and supports, and similar mental health or addiction service-related matters.

"Regularly scheduled" means services and/or activities that are offered as clinically indicated, such as weekly, monthly, quarterly, or as otherwise set, and subject to patient availability and willingness to participate.

"Rehabilitative support services" means any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within their scope of practice to promote the maximum reduction of physical or mental disability and restoration of a patient to their best possible functional level.

"SAMHSA" means the Substance Abuse and Mental Health Administration within the U.S. Department of Health and Human Services.

"Serious mental illness" means a diagnosable behavioral, mental, or emotional condition as defined in the DSM-5, and the condition substantially interferes with, or limits, on a persistent basis one or more major life activities, such as basic daily living (for example, eating or dressing); instrumental living (for example, taking prescribed medications or getting around the community); or participating in a family, school, or workplace.

"Treatment record" means a medical record and/or clinical treatment record, as applicable to a BH program pursuant to N.J.A.C. 8:43K.

SUBCHAPTER 3. GENERAL BH PROGRAM OPERATIONAL REQUIREMENTS

10:36-3.1 Compliance with laws and rules

(a) In order to provide behavioral health services, a BH program shall:

1. Have a contract or affiliation agreement with the DMHAS; and

2. Be licensed by DOH, as applicable, including pursuant to N.J.A.C. 8:43K.

(b) A BH program shall comply with all applicable Federal, State, and local laws, rules, and regulations, and with any applicable accrediting organizations.

(c) A BH program shall comply with any and all rules established by DOH for licensing purposes, including at N.J.A.C. 8:43K.

(d) The DMHAS may refer any findings related to a BH program's non-compliance with the standards set forth in this chapter, or any other regulatory compliance concerns, including those related to patient services or the quality of patient care provided by a BH program, to DOH for review and, if appropriate, licensing action, including licensure suspension/revocation and/or penalties.

10:36-3.2 Patient confidentiality

A BH program shall comply with all applicable Federal and State confidentiality laws, rules, and regulations, including 42 CFR Part 2, Federal Confidentiality of Alcohol and Drug Abuse Patient Records, 45 CFR Parts 160 and 164, HIPAA Privacy and Security Rules, and N.J.S.A. 30:4-24.3.

10:36-3.3 Submission of documents and data to the DHS and/or DMHAS

(a) A BH program shall timely report and submit any and all data and information as required by, and into, a DHS-designated and/or DMHAS-designated electronic database(s) and/or management system(s), including, but not limited to, the Division's New Jersey Substance Abuse Monitoring System and any other applicable capacity and referral system.

1. A BH program shall attend and participate in any mandatory DHS and/or DMHAS orientation and/or trainings for any DHS-designated and/or DMHAS-designated electronic database(s) and/or management system(s), or the like, as are applicable to the services provided by a BH program.

(b) A BH program shall cooperate with any and all DHS and/or DMHAS monitoring activities (for example, audits, complaint reviews, investigations), and provide any and all data and information requested by DHS and/or DMHAS as part of those monitoring activities.

(c) Any failure to report or provide data and information and/or cooperate with DHS and/or DMHAS monitoring activities by a BH program shall be considered non-compliance and may result in a referral to DOH for review and, if appropriate, licensing action, including licensure suspension/revocation and/or penalties.

10:36-3.4 Waiver

(a) A BH program may seek a waiver of one or more standards in this chapter; provided that the following conditions are satisfied:

1. The BH program shall submit the request for waiver(s), in writing, to the Assistant Commissioner of DMHAS, or their designee, at the following address: DMHAS, PO Box 362, Trenton, NJ, 08625-0362 or DMHAS.RuleWaiver@dhs.nj.gov; and, with a copy sent to: DOH, Office of Certificate of Need and Licensing, PO Box 358, Trenton, NJ, 08625-0358;

2. The BH program shall identify the specific rule(s) for which a waiver(s) is requested; and

3. The BH program shall provide an explanation justifying issuance of a waiver(s), including:

i. The specific reason(s) supporting issuance of a waiver(s), including, but not limited to, the type and degree of hardship that would result to the BH program if waiver(s) were not granted, and clear clinical and/or programmatic rationale for such waiver;

ii. An alternate proposal to ensure the safety of patients, staff, patient families, and the public, as appropriate, and to ensure program integrity and treatment services; and

iii. Specific documentation supporting the waiver request.

(b) A BH program shall provide such other additional explanation, information, and documentation, as requested by DMHAS for purposes of evaluating the waiver request.

(c) All waiver requests must be reviewed and approved by the Assistant Commissioner, or their designee.

(d) The granting of any waiver(s) shall be:

1. At the discretion of the Assistant Commissioner, or their designee, and in consultation with DOH, so long as the waiver(s) does not adversely affect the health, safety, welfare, or rights of patients, staff, patient families, or the public, does not adversely impact program integrity and treatment services, and is consistent with public policy;

2. For a time period as determined appropriate and specified by the Assistant Commissioner, or their designee, but subject to renewal upon BH program request; and

3. Communicated, in writing, to the requesting BH program, and indicating which specific rule(s) and standard(s) are waived, any applicable expiration date of the waiver(s), and any conditions or limitations placed on the waiver(s).

(e) The Assistant Commissioner, or their designee, may suspend or revoke the waiver(s) at any time for reasons including, but not limited to, the following:

1. That the waiver(s) is no longer consistent with the purpose and intent of this chapter or public policy;

2. That program integrity and treatment services are adversely affected as a result of the waiver(s); and/or

3. The health, safety, welfare, or rights of patients, staff, patient families, or the public are endangered.

SUBCHAPTER 4. BH PROGRAM STAFFING REQUIREMENTS

10:36-4.1 General staffing requirements

A BH program shall comply with any and all applicable staffing requirements set forth in DOH's facility licensing standards, including at N.J.A.C. 8:43K, and Federal standards, including at 42 CFR Part 8 (describing staffing requirements for OTPs).

SUBCHAPTER 5. BH PROGRAM CORE SERVICE STANDARDS

10:36-5.1 Admission intake process

(a) A BH program shall implement an admission intake process that includes, at a minimum, the following:

1. A DSM diagnosis;

2. An assessment for addictive disorder and/or mental illness, as follows:

i. For patients being evaluated for treatment of an addictive disorder, a Level of Care assessment. A BH program shall use an evidence-based and nationally recognized addiction assessment tool, such as the ASAM criteria; or

ii. For patients being evaluated for treatment of a mental illness, a clinical assessment. A description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment shall be documented in the patient's biopsychosocial assessment;

3. A biopsychosocial assessment.

i. For patients with a mental illness, the biopsychosocial assessment shall include a description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment;

4. An immediate needs assessment;

5. Laboratory testing, for example, urine drug screens, as may be clinically indicated, and for patients with an SUD, the intake process may include a urine drug screen and other applicable and clinically indicated laboratory testing;

6. Screening for addictive disorders and mental illness for patients who screen as at risk for one or more behavioral health disorders;

7. Screening for physical health and substance withdrawal to identify physical health and/or withdrawal issues that require immediate medical intervention precluding admission to the BH program;

8. Screening for suicide risk; and

9. Screening for emotional and psychological trauma.

10:36-5.2 Screening and assessment services and tools

(a) A BH program shall use evidence-based, nationally recognized, and peer-reviewed screening and assessment tools.

(b) A BH program shall ensure that only staff possessing the appropriate clinical background, education, credentials, and qualifications shall perform evaluations using screening and assessment tools.

1. Subject to appropriate clinical supervision and consistent with their scope of practice, interns may perform evaluations using screening and assessment tools that do not require a clinical degree or license.

(c) A BH program shall implement, at a minimum, the following screening and assessment services:

1. Screening for addictive disorder and mental illness;

2. Assessment for addictive disorders and/or mental illness, as applicable, and as follows:

i. For patients being evaluated for treatment of an addictive disorder, a Level of Care assessment. A BH program shall use an evidence-based and nationally recognized addiction assessment tool, such as the ASAM criteria; or

ii. For patients being evaluated for treatment of a mental illness, a clinical assessment. A description of the clinical assessment, findings, and determination regarding the patient's clinical appropriateness for treatment shall be documented in the patient's biopsychosocial assessment;

3. A biopsychosocial assessment;

4. An immediate needs assessment;

5. Drug screening, as clinically appropriate and/or based on patient use drug patterns, as established by the BH program's policy;

6. Screening to identify physical health issues;

7. Screening for substance withdrawal;

8. Screening for suicide risk; and

9. Screening for emotional and psychological trauma.

(d) A BH program shall ensure that a biopsychosocial assessment is conducted:

1. At the time of the patient's admission to the BH program; and

2. At a minimum, reviewed and updated:

i. On a quarterly basis during the patient's first year of admission to the BH program; and

ii. Subsequently, on an annual basis, or earlier if clinically indicated.

(e) A BH program shall conduct and complete an immediate needs assessment at the patient's first visit to the BH program.

1. If a patient has any immediate needs, a BH program shall make appropriate referrals and/or linkages to assist the patient in addressing their immediate needs.

2. The immediate needs assessment and any related referrals, including the outcome and results of referrals and follow-up, shall be documented in the patient's treatment record.

(f) A BH program shall ensure that screening for suicide risk occurs, at a minimum, upon admission and subsequently, on an annual basis, or more frequently, if clinically indicated, such as for patients with a history of suicide attempts or other risk factors.

10:36-5.3 BH care plan and planning

(a) A BH program shall implement a BH care plan and planning process that requires, at a minimum, the following:

1. The BH care plan shall be developed in a collaborative manner between the patient and the patient's IDT;

2. The BH care plan shall be developed with the participation of each member of the patient's IDT who is directly involved in the patient's treatment, and their participation shall be documented in the patient's treatment record;

3. The BH care plan shall be signed by an appropriately credentialed and/or licensed IDT member, and as permitted, within their scope of practice, who is directly involved in the patient's treatment and the patient.

i. If the patient is unavailable or unable to sign their BH care plan, then the BH program shall document the reason for the patient's unavailability or inability to sign their BH care plan in the patient's treatment record;

4. When beneficial to the patient, and unless clinically contraindicated, the BH program shall include family members and/or other supportive persons identified by the patient in BH care planning, so long as such inclusion is in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3; and

5. The patient's BH care plan shall be updated based on additional patient information and patient progress and participation in treatment.

(b) A BH program shall ensure that a copy of the BH care plan shall be:

1. Maintained in the patient's treatment record;

2. Provided to the patient upon their request; and

3. Provided to the patient at the time of discharge.

(c) The BH care plan shall address, at a minimum, the following:

1. The patient's needs and strengths and stated goals;

2. The goals and objectives for the patient's treatment with timeframes;

3. A description of applicable evidence-based treatment services and interventions, for the patient to address their symptoms and improve treatment outcomes;

4. A description of applicable non-clinical peer support services for the patient;

5. A medication history and list of current medications, including dosage, frequency, and side effects;

6. Identification of community resources being used by the patient;

7. Referral and/or linkages for the patient to other services and/or resources. This shall include, but not be limited to, any referrals or linkages to:

i. Medical and nursing services for patients with physical health needs, if such services are not provided directly by the BH program; and/or

ii. Vocational, educational, social, and/or other support services, if such services are not provided directly by the BH program;

8. Patient discharge planning and criteria;

9. Patient transition planning and criteria;

10. Be informed by any and all applicable assessments conducted for the patient (for example, INA, biopsychosocial assessment, psychiatric assessment); and

11. Documentation of any other service(s) in which the patient participates and, if applicable, in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(d) At the time of discharge, the BH program shall ensure that the patient's BH care plan addresses, at a minimum, the following:

1. The patient's needs post-discharge, including transition and medication needs, as applicable, including:

i. A list of the patient's current prescribed medication(s), along with the following information: dosage, quantity, date of any injections, and side effects; and

ii. Any referrals made for medication management;

2. Safety planning and harm reduction strategies (for example, drug use, safe sex); and

3. Referrals and/or linkages to other services and/or resources, including self-help groups, and peer wellness and recovery supports.

10:36-5.4 Safety plan

A BH program shall ensure that an evidence-informed safety plan is developed collaboratively with any patient experiencing suicidal ideation, any patient who is otherwise at risk for suicide, or any patient at risk of overdose to identify warning signs or triggers, and support their individualized coping strategies. The safety plan shall be distinct from a BH care plan, but shall be incorporated within the patient's BH care plan.

10:36-5.5 Counseling and/or therapy services

(a) The BH program shall be responsible for the provision of counseling and/or therapy services to patients, as applicable.

(b) The BH program shall ensure that counseling and/or therapy services are based upon and incorporate evidence-based practices (for example, cognitive behavioral therapy, illness management and recovery, motivational interviewing, recovery-oriented cognitive therapy).

(c) Counseling and/or therapy services shall only be provided by staff possessing the appropriate clinical background, education, credentials, and/or qualifications.

(d) Counseling and/or therapy services may consist of individual, group, and family counseling and therapy sessions and psychoeducation sessions.

(e) Counseling and/or therapy services and the frequency and type of counseling, therapy, and/or psychoeducation sessions shall be:

1. Tailored to each patient's clinical severity, functioning, and response to treatment; and

2. Be directed by the patient's IDT.

(f) Any group counseling and/or therapy sessions must contain no more than 12 patients.

10:36-5.6 Medication services

(a) A BH program shall provide or arrange for the provision of medication services to patients to treat behavioral health conditions.

1. A BH program that provides medication services directly must adhere to any licensing requirements and standards related to the

administration, prescribing, and storage of medications as required by DOH.

2. A BH program that does not provide medication services directly must facilitate the provision of medication services to patients.

(b) A BH program shall ensure that patients prescribed medication as part of their treatment services receive medication education, management, and monitoring. A BH program shall provide:

1. Medication education consisting of information about the patient's prescribed medications, including benefits, side effects, and risks and especially medication-related risks, such as cardio-metabolic risks, metabolic syndrome with anti-psychotics, and methadone-induced cardiac arrhythmia, as may be applicable;

2. Medication management, including routine monitoring of patients for treatment response and treatment-related side effects; and

3. Medication monitoring, including monitoring of patient health indicators (for example, weight, blood pressure, blood glucose levels, lipids). As part of medication monitoring, a BH program shall collaborate and coordinate with the patient's healthcare provider, subject to and consistent with any and all applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(c) The BH program shall ensure medication used for the treatment of addiction disorders and/or mental illness is administered, dispensed, ordered, and/or prescribed in accordance with applicable State and Federal law, rules, regulations, and standards.

(d) The BH program shall maintain current procedures to ensure that medications are administered in accordance with their approved product labeling.

10:36-5.7 Psychoeducational and patient education services

(a) A BH program shall provide psychoeducation services to patients.

(b) A BH program shall offer psychoeducation services to family members and other supportive persons identified by the patient and when appropriate, unless the patient objects, psychoeducation services are clinically contraindicated, and/or the family/supportive persons are unwilling to participate in offered psychoeducation services.

(c) A BH program shall provide education to patients, including on the following topics:

1. The patient's diagnosis, and if the patient has:

i. An addictive disorder, then education about their addictive disorder;

ii. A mental illness, then education about their mental illness; and

iii. A co-occurring addictive disorder and mental illness, then education about both their addictive disorder and their mental illness;

2. Harm reduction for addictive disorders;

3. Overdose prevention and information about how to access opioid overdose reversal medication; and

4. Self-care and illness self-management.

10:36-5.8 Administrative discharge from the BH program

(a) A BH program may administratively discharge a patient from the BH program for unavailability. Unavailability means the patient is incarcerated, hospitalized, or lost to contact.

(b) A BH program shall administratively discharge a patient by no later than 90 days from when the patient is unavailable to continue to receive services.

(c) Prior to any administrative discharge, a BH program shall make reasonable efforts to:

1. Issue discharge instructions; and

2. Ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members, or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2, and N.J.S.A. 30:4-24.3.

10:36-5.9 Voluntary discharge from the BH program

(a) A BH program may voluntarily discharge a patient when the patient has:

1. Received the maximum benefit of their level of care and/or met all their treatment goals;

2. Received the maximum benefit of their level of care and is transitioning to another level of care; or

3. Elected to discontinue receiving services from the BH program.

(b) Prior to any voluntary discharge, a BH program shall:

1. Issue discharge instructions; and

2. Ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA and 42 CFR Part 2.

10:36-5.10 Involuntary discharge from the BH program

(a) A BH program may only involuntarily discharge a patient for one or more of the reasons listed in this subsection.

1. The patient is exhibiting serious episodes of assaultive, disruptive, and/or threatening behaviors towards staff or other patients;

2. The patient is refusing to participate in their treatment, and the BH program facilitates the patient's referral to another clinically appropriate level of care; or

3. The patient is unable to pay for services, and the BH program has made reasonable attempts to work with the patient and resolve their inability to pay.

(b) A BH program shall not involuntarily discharge a patient who is experiencing, or has experienced, a relapse related to an addictive disorder.

(c) Prior to any involuntary discharge, a BH program shall:

1. Attempt to address the patient's behavior, refusal to participate in services, and/or inability to pay for services.

i. For patients who are unable to pay for services, the BH program shall explore treatment funding sources, including those available at the local or State level, and consider alternate payment options, such as a payment plan, with the patient;

2. Have the BH program clinical supervisor conduct a review of the proposed involuntary discharge.

i. The BH program clinical supervisor shall document their approval of any proposed involuntary discharge in the patient's treatment record; and

ii. A patient shall not be involuntarily discharged without the prior written approval of the BH program clinical supervisor;

3. Provide written notice to the patient of the involuntary discharge, which shall include the reason(s) for the involuntary discharge and internal appeal procedures;

4. Issue discharge instructions;

5. Make reasonable efforts to ascertain whether the patient wants their discharge instructions shared with family members or other supportive persons identified by the patient and, if so, the patient's discharge instructions shall be shared with family members or other supportive persons identified by the patient, consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA and 42 CFR Part 2; and

6. If the patient consents, then assist the patient with any linkages to services consistent with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3. If the patient does not consent to assistance with linkages pursuant to this paragraph, then such refusal shall be documented in the patient's treatment record.

(d) The BH program shall maintain documentation relating to a patient's involuntary discharge in the patient's treatment record. At minimum, this documentation shall include:

1. Progress notes or other written documentation describing attempts to address the reasons for the patient's involuntary discharge, including the patient's behavior;

2. The BH program clinical supervisor's written approval of the patient's involuntary discharge;

3. A copy of the written notice to the patient of the involuntary discharge;

4. Copies of any written appeals filed by the patient; and

5. Copies of any documentation issued by the BH program in response to any appeal.

10:36-5.11 Discharge documentation and planning

(a) A BH program shall commence discharge planning upon admission of the patient to the BH program.

(b) A BH program shall incorporate discharge planning into the BH care plan.

(c) When beneficial to the patient, and unless clinically contraindicated, a BH program shall include family members and/or other supportive persons identified by the patient in discharge planning, so long as such inclusion is in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

(d) A BH program shall assist the patient with making appointments, when clinically appropriate, for recommended continued behavioral health services, including medication management services, and in accordance with applicable Federal and State confidentiality laws, rules, and regulations, including HIPAA, 42 CFR Part 2 and N.J.S.A. 30:4-24.3.

1. The BH program shall document efforts regarding appointment assistance in the patient's treatment record.

2. If a patient declines assistance with making appointments, then the BH program shall document this in the patient's treatment record.

(e) A BH program shall provide a safety, crisis, and/or relapse prevention plan, as clinically appropriate, to the patient prior to their discharge.

(f) A BH program shall provide education on, and facilitate assistance with, execution of psychiatric advance directives to the patient prior to their discharge.

(g) A BH program shall provide all patients discharged from the BH program with discharge instructions prior to their discharge, irrespective of whether the discharge is administrative, voluntary, or involuntary.

1. At a minimum, the discharge instructions shall include the following:

i. Recommendations and referrals for continued services;

ii. Recommendations and referrals for medication needs and management; and

iii. Information regarding the patient's current prescribed medications and instructions to ensure continuity of medication.

2. The discharge instructions shall be:

i. Reviewed and signed by an appropriately licensed and credentialed clinical member of the patient's inter-disciplinary team; and

ii. Reviewed with and signed by the patient. If the patient is unavailable or unable to sign their discharge instructions, then the BH program shall document the reason for the patient's unavailability or inability to sign their discharge instructions in the patient's treatment record.

(h) A BH program shall ensure that:

1. A discharge summary is completed for each patient discharged from the BH program, irrespective of whether the discharge is administrative, voluntary, or involuntary;

2. The discharge summary is completed within 60 days of a patient's discharge and is filed in the patient's treatment record;

3. The discharge summary is reviewed and signed by an appropriately licensed and credentialed clinical member of the patient's inter-disciplinary team; and

4. At a minimum, the discharge summary includes the following:

i. The patient's date of admission and date of last service;

ii. A summary of the patient's course of, and response to, treatment;

iii. The primary presenting problem;

iv. Any significant findings and the reason(s) for discharge;

v. The clinical condition at the time of discharge;

vi. Recommendations, arrangements, and referrals, if applicable, consistent with any Federal and State confidentiality laws, rules, and regulations, for further treatment and any referrals made, including for medication management;

vii. Information regarding prescribed medications, including dosage, quantity, and date of any injections;

viii. Any known medical conditions; and

ix. The patient's final DSM diagnoses.

(i) Following a patient's discharge from the BH program, the BH program shall make reasonable attempts to follow up with the patient in order to determine whether the patient is engaged in treatment with another BH program or healthcare provider or to provide referrals for services.

SUBCHAPTER 6. PROGRAM STANDARDS FOR OUTPATIENT ADDICTIVE DISORDER AND/OR MENTAL HEALTH SERVICES

10:36-6.1 Outpatient services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of outpatient services, including, as may be modified within this subchapter, by a BH program. In addition, a BH program providing outpatient services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) Outpatient services are organized services delivering regularly scheduled appointments, including for counseling, therapy, and medication management to, or on behalf of, patients based on their individualized clinical needs and severity.

10:36-6.2 Outpatient services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes the requirements set forth at N.J.A.C. 10:36-5.1.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-6.3 Outpatient BH care plan development and review timeframes

(a) A BH program shall implement a BH care plan and planning process that includes the requirements set forth at N.J.A.C. 10:36-5.3.

(b) The BH program shall develop a patient's BH care plan within 45 days of their admission intake interview.

(c) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-6.4 Outpatient services counseling and/or therapy services and hours

(a) A BH program shall implement counseling and/or therapy services that include the requirements set forth at N.J.A.C. 10:36-5.5.

(b) The BH program shall provide each patient with regularly scheduled counseling, therapy, and/or psychoeducation sessions.

SUBCHAPTER 7. PROGRAM STANDARDS FOR INTENSIVE OUTPATIENT (IOP) ADDICTIVE DISORDER SERVICES

10:36-7.1 IOP addictive disorders services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of IOP addictive disorder services, including as may be modified through this subchapter, by a BH program. In addition, a BH program providing IOP addictive disorders services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) IOP services are services that provide a range of treatment sessions in a structured environment, and include clinical intensive substance use counseling and psycho-educational (didactic) sessions.

10:36-7.2 IOP addictive disorders services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes the requirements set forth at N.J.A.C. 10:36-5.1.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-7.3 IOP addictive disorders services BH care plan development and review timeframes

(a) A BH program shall implement a BH care plan and planning process that includes the requirements set forth at N.J.A.C. 10:36-5.3.

(b) A BH program shall develop a patient's BH care plan within three visits, but not more than 30 days, of the patient's admission intake interview.

(c) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-7.4 IOP addictive disorders services description of services and hours

(a) In addition to the standards for counseling and therapy services set forth at N.J.A.C. 10:36-5.5, a BH program shall:

1. Provide each patient with IOP services of a minimum of nine contact hours or more a week; and

2. Provide each IOP patient with the following services as clinically indicated: individual counseling/therapy sessions, group therapy sessions, family sessions, psycho-education sessions, and medication services.

i. If a patient does not participate in any one or more services described in this section, then the BH program shall document attempts to engage the patient, outreach to the patient, and the patient's reasons for non-participation in the service(s).

(b) If a patient's attendance is frequently or consistently unreliable or sporadic without reasonable cause or excuse (for example, the patient does not attend their nine hours of IOP services for two consecutive weeks during a four-week period, pursuant to (a) above, then the BH program shall confer with the patient to review the patient's course of treatment and level of care that supports the patient's needs and continued engagement with treatment services.

SUBCHAPTER 8. PROGRAM STANDARDS FOR PARTIAL CARE (PC) MENTAL HEALTH OR ADDICTIVE DISORDER SERVICES

10:36-8.1 PC services general requirements and standards

(a) N.J.A.C. 10:36-1 through 5 shall apply to the provision of PC mental health and/or addictive disorder services, including, as may be modified through this subchapter, by a BH program. In addition, a BH program providing PC mental health and/or addictive disorder services shall adhere to any supplemental program standards set forth in this subchapter. If there is any inconsistency between the program standards set forth in this subchapter and at N.J.A.C. 10:36-1 through 5, as applicable, the program standards in this subchapter shall apply.

(b) PC services are a broad range of licensed, individualized, rehabilitative, and structured treatment services and supports provided in a community setting, which promote patient stabilization and community integration.

10:36-8.2 PC services admission intake process and timeframe

(a) A BH program shall implement an admission intake process that includes, at a minimum, the requirements set forth at N.J.A.C. 10:36-5.1 and the following:

1. For PC mental health services, a psychiatric assessment; or

2. For PC addictive disorder services, if the screening for mental illness required at N.J.A.C. 10:36-5.1(a)2 is positive for serious mental illness, then a psychiatric assessment must be conducted.

(b) A BH program shall complete the admission intake process for each patient within 14 days of the first visit or at the second visit, whichever is later.

10:36-8.3 PC mental health services provisional services during admission intake

Completion of the formal admission intake process shall not preclude an otherwise eligible patient from participating in PC mental health services program activities or receiving services on a provisional basis during a seven-day trial period.

10:36-8.4 PC services screening and assessment services and tools

(a) A BH program providing PC mental health or addictive disorder services shall adhere to the screening and assessment requirements set forth at N.J.A.C. 10:36-5.2, except as to *[subsections (d) and (e), which are replaced at N.J.A.C. 10:36-5.2(b) and (c), respectively]* ***subsection (d) which is replaced at (b) below***.

(b) The BH program shall ensure that a biopsychosocial assessment is conducted:

1. Within 14 days of the first visit or at the second visit, whichever is later;

2. Reviewed and updated at least every six months, or earlier, if clinically indicated during the patient's first year of admission to the BH program; and

3. Subsequently, on an annual basis, or earlier, if clinically indicated.

(c) A BH program providing PC mental health services shall implement the following additional screening and assessment services:

1. A psychiatric assessment. The initial psychiatric assessment shall be conducted within 14 days of the first visit or at the second visit to the BH program, whichever is later; and, then reviewed and updated at least every six months, or earlier if clinically indicated.

(d) A BH program providing PC addictive disorder services shall implement the following additional screening and assessment services:

1. A psychiatric assessment as part of the admission intake process if the screening for mental illness required at N.J.A.C. 10:36-5.1(a)2 indicates risks or symptoms of serious mental illness; and, then reviewed and updated every six months, or earlier, if clinically indicated.

10:36-8.5 PC services BH care plan development and review timeframes

(a) A BH program shall develop a patient's care plan within 45 days of the patient's admission intake interview.

(b) The patient's BH care plan shall be reviewed as clinically necessary, but no less than every three months during the first year of admission to the BH program, and revised, as necessary, and thereafter, it shall be reviewed every six months, and revised, as necessary.

10:36-8.6 PC services counseling and/or therapy services

In addition to the standards for counseling and therapy services set forth at N.J.A.C. 10:36-5.5, a BH program shall be equipped to provide regularly scheduled counseling, therapy, psychoeducation, and/or rehabilitative sessions, as clinically indicated for patients.

10:36-8.7 PC services off-site activities and/or interventions

(a) A BH program may provide off-site activities and/or interventions, so long as:

1. The activity or intervention is based upon and consistent with the patient's BH care plan;

2. The activity or intervention is a subordinate component of the patient's BH care plan; and

3. The clinical justification is documented in the patient's treatment record.

(b) Off-site activities and/or interventions that are solely recreational or diversional in nature shall not be considered a partial care activity or intervention.

10:36-8.8 PC services rehabilitative support services

(a) A BH program providing PC mental health or addictive disorder services shall provide rehabilitative support services directly to patients and comply fully with the standards set forth in this section for the provision of rehabilitative support services.

(b) A BH program shall ensure that rehabilitative support services are:

1. Based upon and incorporate evidence-based practices (for example, illness management and recovery);

2. Provided individually and/or in a group setting; and

3. Tailored to each patient's clinical needs.

(c) Rehabilitative support services may include:

i. Activities and/or interventions involving teaching the patient various physical, cognitive/intellectual, and behavioral skills related to identified goals in order to increase competency; and

ii. Skill teaching involving discussions with the patient about the skill, past experience in using the skill, what the skill entails, when to use the skill, benefits of learning the skill, breaking the skill down into its

component parts, showing examples of how the skill is correctly used or performed, arranging opportunities to practice the skill in community settings, and providing education and feedback on skill performance.

(d) A BH program shall be equipped to provide rehabilitative support services including, but not limited to, skills related to:

1. Crisis intervention and response;
2. Daily living;
3. Development of a psychiatric advance directive;
4. Financial literacy;
5. General education;
6. Health and medical care;
7. Housing transition and tenancy sustenance;
8. Pre-vocation and vocational (for example, job interview preparation);
9. Recreational needs and opportunities;
10. Spiritual and cultural linkages and connections;
11. Relapse prevention;
12. Self-advocacy, including as related to legal needs;
13. Social networks and interactions; and
14. Transportation access and education.

SUBCHAPTER 9. PROGRAM STANDARDS FOR OPIOID TREATMENT PROGRAM (OTP) SERVICES

10:36-9.1 OTP services general requirements and standards

(a) N.J.A.C. 10:36-1, 2, 3, and 4 shall apply to the provision of OTP services. N.J.A.C. 10:36-5 shall not apply to the provision of OTP services, except that the standards at N.J.A.C. 10:36-5.8, 5.9, and 5.10 shall apply to the provision of OTP services.

(b) A BH program providing OTP services shall adhere to any supplemental program standards set forth in this subchapter.

(c) If there is any inconsistency between the program standards set forth in this subchapter and/or the standards set forth at N.J.A.C. 10:36-1, 2, 3, and 5, as applicable, then the program standards in this subchapter shall apply.

(d) A BH program shall comply with all Federal regulations and standards established by SAMHSA, including 42 CFR Part 8, and all Federal regulations and standards enforced by the DEA.

(e) If a conflict occurs between the standards set forth in this chapter and any Federal regulations and standards applicable to OTP services, including the Federal standards set forth at 42 CFR Part 8, then the more restrictive standards shall govern over the less restrictive standards.

(f) "Opioid treatment program" or "OTP" means a program engaged in OUD treatment of individuals with medications for OUD registered pursuant to 21 U.S.C. § 823(h)(1).

10:36-9.2 OTP services involuntary discharge

(a) In addition to the requirements for involuntary discharge set forth at N.J.A.C. 10:36-5.10, the BH program shall adhere to the supplemental standards governing involuntary discharge set forth in this section.

(b) Prior to a patient's involuntary discharge, a BH program shall:

1. Make reasonable efforts to facilitate the patient's admission at an alternate OTP, so long as the patient is agreeable and consistent with applicable Federal and State confidentiality laws, rules, and regulations;
2. Facilitate the patient's medically managed withdrawal from their opioid agonist medication, when appropriate;
3. Provide education on overdose and relapse prevention; and
4. Provide information about how to access opioid overdose reversal medication.

i. If the patient is not agreeable to or cooperative with any of the activities described in this subsection, then the BH program shall document the same in the patient's treatment record.

(c) If the patient elects to appeal their involuntary discharge through a BH program's internal appeal process, then the BH program shall maintain the patient's access to medication, pending the outcome of the BH program's internal appeals process.

1. If the patient is uncooperative with the BH program's attempts to maintain their access to medication, then the BH program shall document same in the patient's treatment record.

(d) To the extent that any standards at N.J.A.C. 10:36-5.10 require actions by a BH program clinical supervisor, including approvals, the OTP medical director, in lieu of a BH program clinical supervisor, may perform such actions consistent with the requirements set forth at N.J.A.C. 10:36-5.10 for BH program clinical supervisors.

LAW AND PUBLIC SAFETY

(a)

YOUTH JUSTICE COMMISSION

Juvenile Funds and Gifts to the Commission

Readoption with Amendments: N.J.A.C. 13:90A

Proposed: October 20, 2025, at 57 N.J.R. 2392(a).
Adopted: March 5, 2026, by the Executive Board of the Youth Justice Commission, by the Honorable Jennifer Davenport, Attorney General and Chair, through Nicholas Kormann, Attorney General Designee.
Filed: March 11, 2026, as R.2026 d.050, **without change**.

Authority: N.J.S.A. 2C:43-3.3, 2C:46-4, 30:4-15.1, 30:4-16.4, 52:17B-170, 52:17B-171, and 52:17B-176.

Effective Dates: March 11, 2026, Readoption;
Apil 6, 2026, Amendments.
Expiration Date: March 11, 2033.

Summary of Public Comment and Agency Response:

The Youth Justice Commission (Commission) received one public comment in response to the notice of proposal from Barbara Sachau.

1. COMMENT: Ms. Sachau states that youth are in juvenile facilities because they committed criminal acts, they should be punished and they should not receive awards of any type while in a juvenile detention facility.

RESPONSE: The Commission thanks Ms. Sachau for her comments. The commenter has not made specific suggestions to the proposed rules; rather, she has offered general commentary. The comments are not within the scope of N.J.A.C. 13:90A, which is specific to proper handling of juvenile funds and property and gifts to the Commission, and the Commission declines to make any revisions to the chapter.

Federal Standards Statement

A Federal standards analysis is not required because the rules readopted with amendments are not adopted pursuant to the authority of, or in order to implement, comply with, or participate in any program established pursuant to Federal law or pursuant to a State statute that incorporates or refers to Federal law, standards, or requirements.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 13:90A.

Full text of the adopted amendments follows:

SUBCHAPTER 1. GENERAL PROVISIONS

13:90A-1.1 Purpose

(a) The purpose of this chapter is to establish policies and procedures for:

1.-3. (No change.)
4. Processing juvenile claims for lost, damaged, or destroyed personal property;
5.-6. (No change.)

13:90A-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

. . .

"Chief Administrative Officer" means the Commission staff member, by whatever name or title, in charge of the Commission's Office of Administration.

"Chief Investigator" means the Chief Investigator of the Commission's Office of Investigations, charged with oversight and management