HUMAN SERVICES

(a)

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Screening and Screening Outreach Program

Proposed Readoption with Amendments: N.J.A.C. 10:31

Proposed Repeal and New Rule: N.J.A.C. 10:31 Appendix A

Proposed Repeals: N.J.A.C. 10:31-12

Authorized By: Elizabeth Connolly, Acting Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4-27.1 et seq., specifically 30:4-27.5.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2017-183.

Submit written comments by October 20, 2017, to:

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1, Chapter 31, Screening and Screening Outreach Program, was scheduled to expire on July 21, 2017. As the Division of Mental Health and Addiction Services (Division) has filed this notice of readoption with the Office of Administrative Law prior to July 21, 2017, this date is extended 180 days to January 17, 2018. This notice of proposal is excepted from the rulemaking calendar requirements pursuant to N.J.A.C. 1:30-3.3(a)5, because a 60-day public comment period is provided.

The Department of Human Services (the Department), in conjunction with the Division, has reviewed this chapter and has determined it to be necessary, reasonable, and proper for the purpose for which it was originally promulgated to serve, with the amendments and repeals as further described below. Therefore, the Department is proposing to readopt the chapter with amendments and repeals.

Background

The legislation authorizing this chapter was enacted in 1989, and established legally mandated procedures and standards for involuntary commitment. See N.J.S.A. 30:4-27.1 et seq. Specifically relevant to this chapter, that legislation established the policy of encouraging the development of screening services in each county or designated mental health service area as the "entry point in order to provide accessible crisis intervention, evaluation, and referral services to mentally ill persons in the community; to offer mentally ill persons clinically appropriate alternative to inpatient care, if any; and, when necessary, to provide a means for involuntary commitment." See N.J.S.A. 30:4-27.1(d). That legislation vested primary responsibility for designating screening services with the Commissioner of the Department of Human Services. See N.J.S.A. 30:4-27.4.

For over 20 years, screening and screening outreach programs have attempted to meet these statutory mandates by providing, on a daily, round-the-clock basis, emergency psychiatric services and screening at established screening locations within, or independent of, hospitals and, when necessary, in the community through mobile outreach. Trained and credentialed screening staff assess a consumer's psychiatric condition, make any necessary medical referrals and, after examination and consultation with an appropriately licensed psychiatrist, determine whether the consumer is in need of involuntary commitment or whether other, less restrictive forms of treatment are appropriate. The legal process for involuntary commitment can proceed only after a certified screener and a psychiatrist affiliated with a designated screening service have determined that the consumer has a mental illness, is dangerous to him or herself, others, or property as a result of the mental illness, all stabilization options have been considered or exhausted, and the individual refuses treatment. In many instances, it has been shown that use of less restrictive treatment alternatives can be most successful in providing effective crisis stabilization, while simultaneously averting the greater stigma, restrictions, and psychiatric regression often associated with lengthy inpatient hospitalizations. Each consumer must be evaluated individually and a complete assessment made before a course of care is developed. At present, the Division has designated 23 screening services and screening outreach programs to provide these services in geographically appropriate locations throughout the State.

The Division first adopted rules implementing the screening law in 1989. 21 N.J.R. 1562(a). These rules were readopted without change in 1994, 1999, and 2004. 26 N.J.R. 2271(a); 31 N.J.R. 1334(a); 36 N.J.R. 4468(a). In 2007, amendments reflecting screening services' obligations under the Advance Directives for Mental Health Care Act were adopted. 39 N.J.R. 2346(a). In 2010, the Division adopted numerous amendments to these rules to reflect developments in the mental health field, including a robust consumer movement and the Wellness and Recovery Philosophy. 42 N.J.R. 1872(a).

On August 11, 2009, Governor Corzine signed a bill into law that amended the commitment statutes to provide for involuntary commitment to outpatient treatment for individuals in need of such treatment. P.L. 2009, c. 112. By allowing mental health care in the least restrictive environment, this new law attempts to balance the preservation of personal freedom with the State's concerns for individual and public safety. The outpatient commitment law became effective on August 11, 2010, and was implemented Statewide over a three-year period.

Summary of Amendments and Repeals

As further described below in the description of amendments by subchapter, this rulemaking includes amendments reflecting the inclusion of commitment to outpatient treatment in the commitment law and, more specifically, delineates the standards and procedures for determining whether a consumer in need of involuntary commitment to treatment should be assigned to outpatient or inpatient treatment.

In addition to the amendments related to the availability of involuntary commitment to outpatient treatment, this rulemaking also includes substantive amendments to the requirements relating to the use of telepsychiatry in screening services that reflect the growing acceptance of the practice. More specifically, the proposed amendments permit the use of telepsychiatry without the need to obtain a waiver from the Division, as long as the screening service has a Division-approved telepsychiatry plan that meets the requirements set forth in the rules.

Grammatical and technical changes are proposed throughout the rules. In that regard, and as further described under the summary of amendments to specific subchapters below, several provisions are proposed for deletion because they reiterate information from the definition of terms included in N.J.A.C. 10:31-1.3.

The current rules contain several references to outdated names of the Division of Mental Health and Addiction Services. By way of background, the Division of Mental Health and Addiction Service is the result of the merger of the former Division of Mental Health (DMHS) and the former Division of Addiction Services, pursuant to the Fiscal Year 2011 State Appropriations Act. Further, the former Division of Mental Health previously had been known as the "Division of Mental Health and Hospitals" (DMH&H). This rulemaking amends the definition of "Division" to mean "the Division of Mental Health and Addiction Services" and replaces all references to outdated names or acronyms with either "Division of Mental Health and Addiction Services" or "the Division."

In addition, the following amendments appear throughout the chapter: the term "patient" has been replaced with "consumer," which is the currently preferred term of art; and references to the "Department of Health and Senior Services" have been replaced with "Department of Health" to reflect the current name of that Department, pursuant to P.L. 2012, c. 17.

Subchapter 1. General Provisions

N.J.A.C. 10:31-1.2 Purpose

At N.J.A.C. 10:31-1.2(a)1, an amendment is proposed to add that clinical assessment and crisis stabilization services provided by Screening and Screening Outreach Programs are to be provided in a "trauma-informed" manner in addition to the current requirements that such services be culturally competent and recovery-oriented. That is consistent with current developments and trends in the delivery of mental health care services.

At N.J.A.C. 10:31-1.2(a)5, an amendment is proposed to replace "acute care psychiatric resources" with "acute care system" to be consistent with the terminology used in the chapter. In addition, the proposed amendment deletes the list identifying types of services in the acute care system because that information is provided in the definition of that term.

N.J.A.C. 10:31-1.3 Definitions

Definitions for the following terms are added to reflect additions to the statutory definitions at N.J.S.A. 30:4-27.2, as amended by P.L. 2009, c. 112, § 2: "least restrictive environment," "outpatient treatment," "outpatient treatment provider," "plan of outpatient treatment," and "reasonably foreseeable future."

The definition of "acute care" is proposed for amendment to replace "community" with "community-based," "in-patient" with "inpatient," and "out-patient" with outpatient.

The definition of "acute care system" is proposed for amendment to replace "adult acute partial care/hospitalization services" with "adult acute partial hospital services, partial hospital services, partial care services" to be consistent with the terminology used in the rules governing those services. See N.J.A.C. 10:52A and 10:37F.

The definition of "acute partial hospitalization/care" is proposed for deletion and replacement with definitions of "adult acute partial hospital," "partial hospital," and "partial care" to be consistent with terminology used in the rules governing those services. See N.J.A.C. 10:52A and 10:37F.

The definition of "affiliated emergency service" is proposed for amendment to add that an affiliated emergency service is under contract with the Division of Mental Health and Addiction Services and has an affiliation agreement with the designated screening service in its geographic area. Further, proposed for deletion is the description of the specific services provided by an affiliated emergency service because those requirements are addressed in the substantive provisions at N.J.A.C. 10:31-2.2.

The definition of "commitment" is proposed for deletion because it is substantively duplicative of the definition of "in need of involuntary commitment," which is the term of art used in the governing statutes at N.J.S.A. 30:4-27.1 et seq.

The definition of "consensual admission" is proposed for deletion and replacement to include reference to "voluntary admission," which is a term used in the governing statutes at N.J.S.A. 30:4-27.1 and is proposed to be added to the definition section. This does not result in any substantive change to the definition of a "consensual admission," but rather provides a more concise definition that clarifies that a consensual admission is a specific type of voluntary admission, specifically, a voluntary admission to a short-term care facility.

The definition of "consumer protected health information (consumer PHI)," "covered entity," and "psychotherapy notes" are proposed for deletion as these definitions are not otherwise referenced in this chapter as amended.

The definition of "dangerous to self" is proposed for amendment to replace "debilitation" with "harm" and to add the following sentence to the end of the definition: "This determination shall take into account a person's history, recent behavior, and any recent act, threat, or serious psychiatric deterioration." Those changes are proposed to make this definition consistent with the statutory definition at N.J.S.A. 30:4-27.2(h), as amended by P.L. 2009, c. 112, § 2.

The definition of "dangerous to others or property" is proposed for amendment to add "or serious psychiatric deterioration" to the end of the last sentence of the definition to be consistent with the statutory definition at N.J.S.A. 30:4-27.2(i), as amended by P.L. 2009, c. 112, § 2.

The definition of "in need of involuntary commitment" is proposed for deletion and replaced with definition of " 'in need of involuntary commitment' or 'in need of involuntary commitment to treatment' " to be consistent with the definition at N.J.S.A. 30:4-27.2(m), as amended by P.L. 2009, c. 112, § 2, and with no substantive changes.

The definitions of "physician" and "psychiatrist" is proposed for amendment to clarify that for the purposes of this chapter, physicians and psychiatrists must be licensed to practice medicine only in the State of New Jersey.

The definition of "screener" is proposed for amendment to replace "eligibility for involuntary commitment" with "need for involuntary commitment to treatment" to reflect currently used terminology.

The definition of "screening" is proposed for deletion and replacement to replace the description of the standard for commitment in the definition with the phrase "in need of involuntary commitment."

The definition of "screening certificate" is proposed for amendment to delete the reference to "physician's certification" and add the relevant language from the statutory definition of a "clinical certificate." The definition is further proposed for amendment to replace "in need of commitment" with "in need of involuntary commitment to treatment" to reflect current terminology.

The definition of "screening outreach" is proposed for amendment to replace "need involuntary commitment" with "need involuntary commitment to treatment" to use preferred current terminology.

The definition of "screening psychiatrist" is proposed to be added because this is a term used throughout the chapter.

The definition of "screening service" is proposed for amendment to delete the second sentence of the definition because the service described therein is encompassed in the reference to N.J.A.C. 10:31-2.1 in the first sentence of the definition.

The definition of "stabilization options" is proposed for amendment to replace "voluntary admission to local inpatient unit" with "admission on a voluntary basis to a psychiatric unit in a general hospital" to be consistent with terminology used in the commitment statutes at N.J.S.A. 30:4-27.1 et seq.; and to replace "acute partial hospitalization/care" with "adult acute partial hospital," "partial hospital," and "partial care" to be consistent with terminology used in the rules governing those services.

The definition of "voluntary admission" is proposed to be added because this term is used in this chapter. The definition is based on the statutory definition of the term at N.J.S.A. 30:4-27.2ee.

Subchapter 2. Program Requirements

N.J.A.C. 10:31-2.1 Functions of a screening service

Proposed new N.J.A.C. 10:31-2.1(a)1i requires that the screening service use an evidence-based, structured, or standardized tool when performing an evaluation of suicide risk. That requirement is consistent with developments in the healthcare field.

N.J.A.C. 10:31-2.1(a)6 is proposed for amendment to replace "from other AES" with "from an AES." The existing language incorrectly suggests that a screening service is an AES.

N.J.A.C. 10:31-2.1(a)9 is proposed for amendment to use the same language as the corollary provision at N.J.A.C. 10:31-2.2(a)2, which more clearly states that medical services may be provided directly or through arrangement with another entity.

N.J.A.C. 10:31-2.1(a)10 is proposed for amendment to update a cross-reference to the Public Law with the codified cross-reference.

N.J.A.C. 10:31-2.1(a)11 is proposed for amendment to specifically state that the requirement regarding transportation of consumers applies to consumers in need of involuntary commitment to inpatient treatment. That clarification is needed because the proposed amended rules incorporate the statutory requirements regarding involuntary commitment to outpatient treatment. The current rules at N.J.A.C. 10:31 were adopted prior to the amendments adding involuntary outpatient commitment to the statutes. As such, the proposed amendment to this paragraph does not substantively change the requirement.

N.J.A.C. 10:31-2.1(a)13 is proposed for amendment to clarify that it applies to consumers brought to the screening service as the result of the consumer's failure to comply with the terms of a conditional discharge from involuntary commitment to treatment.

N.J.A.C. 10:31-2.1(a)20 is proposed for amendment by deleting the internal reference to the same subsection. The Division believes that the reference is unnecessary and potentially confusing because there is a definition of the acute care system at N.J.A.C. 10:31-1.3 and the requirements of the acute care system review are set forth in greater detail at N.J.A.C. 10:31-5, as referenced in this paragraph.

N.J.A.C. 10:31-2.1(a)21 is proposed for amendment by replacing "acute care mental health services system" with "acute care system," in order to use the terminology as defined in N.J.A.C. 10:31-1.3. This does not result in any substantive change because the definition of acute care system sufficiently identifies these services as mental health services.

N.J.A.C. 10:31-2.1(a)23, which requires the screening service to provide information on the disposition of consumers seen by the screening service for review by the systems review committee to the extent permitted by applicable confidentiality laws, is proposed for deletion. This subsection already includes a requirement that the screening service develop a system for acute care system review in accordance with Subchapter 5 at N.J.A.C. 10:31-2.1(a)20. As such, the Department believes that this specific requirement regarding information for the acute care system review is more properly included in Subchapter 5. Consequently, the rulemaking includes a new provision at N.J.A.C. 10:31-5.1(a) addressing that requirement, discussed below.

N.J.A.C. 10:31-2.2 Functions of an affiliated emergency service (AES)

N.J.A.C. 10:31-2.2(a)4 is proposed for amendment by replacing "emergency" with "crisis" to be consistent with terminology used elsewhere in this chapter.

N.J.A.C. 10:31-2.2(a)4ii is proposed for amendment by deleting the list of examples of services in the acute care system. Examples of services included within the acute care system are provided in the definition of that term.

Proposed new N.J.A.C. 10:31-2.2(a)5 describes an affiliated emergency services role in screening of consumers who might be in need of involuntary commitment to treatment by cross-reference to N.J.A.C. 10:31-2.3(m). This amendment does not substantively change the responsibilities of an AES, but rather serves to clarify the expectations when a consumer in the affiliated emergency service might be in need of involuntary commitment to treatment.

N.J.A.C. 10:31-2.3 Screening process and procedures

N.J.A.C. 10:31-2.3(c)5 is proposed for amendment to replace "acute partial care/hospitalization" with "adult acute partial hospital, partial hospital, and partial care services," to be consistent with terminology used in the rules governing those services. See N.J.A.C. 10:52A and 10:37F. The description of voluntary admissions at existing N.J.A.C. 10:31-2.3(c)10 includes admissions to psychiatric units of general hospitals, which is not consistent with the statutory definition of a voluntary admission in the commitment statute at N.J.S.A. 30:4-27.2ee. To be consistent with the statutory framework, proposed new N.J.A.C. 10:31-2.3(c)10 is added to state that "admission on a voluntary basis to psychiatric units of a general hospital." Recodified N.J.A.C. 10:31-2.3(c)11 is proposed for amendment to not include admissions to psychiatric units of a general hospital, rather, just referring to "voluntary admission."

N.J.A.C. 10:31-2.3(d) is proposed for amendment by replacing "ascertain whether commitment is indicated" with "ascertain whether the consumer is in need of involuntary commitment to treatment" to be consistent with preferred terminology. In addition, N.J.A.C. 10:31-2.3(d)3 is proposed for amendment to reflect that involuntary commitment can be to outpatient treatment pursuant to N.J.S.A. 30:4-27.1 et seq., as amended by P.L. 2009. c. 112.

N.J.A.C. 10:31-2.3(e) is proposed for amendment by replacing "dangerous to self, others or property by reason of mental illness" with "in need of involuntary commitment to treatment" to more accurately reflect when a screening document should be completed. In addition, N.J.A.C. 10:31-2.3(e)1 is proposed for deletion and replacement to that the screening document be completed for consensual admissions, that is, voluntary admission to a short-term care facility, but not other voluntary admissions, rather than require completion of applicable sections of the screening document for all voluntary admissions.

N.J.A.C. 10:31-2.3(f)2 is proposed for amendment by deleting the specific requirements regarding the use of telepsychiatry, which are proposed for relocation and amendment at N.J.A.C. 10:31-2.3(i). More specifically, the language at N.J.A.C. 10:31-2.3(f)2i, specifically referring to the telepsychiatry waiver and plan requirements, is proposed to be deleted and replaced with a reference to N.J.A.C. 10:31-2.3(i). In addition, the changes delete the introductory statement "notwithstanding the above" because it is unnecessary and potentially confusing.

N.J.A.C. 10:31-2.3(f)3 is proposed for amendment by replacing "meets the standards for commitment" with "is in need of involuntary commitment" to be consistent with terminology used in the commitment law. In addition, it is proposed that the requirement that the psychiatrist fully complete all sections of the screening certificate be replaced with the requirement that the psychiatrist complete all applicable sections of the screening certificate, because certain sections of the certificate cannot be completed until the steps set forth at N.J.A.C. 10:31-2.3(f)4 have been completed.

Existing N.J.A.C. 10:31-2.3(f)3ii is proposed for relocation as N.J.A.C. 10:31-2.3(g) with amendments adding designated outpatient treatment providers as entities to which consumers may be involuntarily committed to treatment.

Existing N.J.A.C. 10:31-2.3(f)4 is proposed for deletion as it includes a substantively similar provision to proposed new N.J.A.C. 10:31-2.3(f)3ii. This provision states that if the screening psychiatrist determines that the consumer meets the criteria for a voluntary admission, then the screening certificate should not be completed but the determination must be documented in the consumer's medical record. The provision at existing N.J.A.C. 10:31-2.3(f)4 is potentially ambiguous because the first clause essentially describes all voluntary admissions, but the second clause refers to consensual admissions. The proposed new provision at N.J.A.C. 10:31-2.3(f)3ii clarifies the potential ambiguity by using "voluntary" rather than "consensual."

Proposed new N.J.A.C. 10:31-2.3(f)4 addresses the availability of involuntary commitment to outpatient treatment, which outlines the standards for determining whether a person in need of involuntary commitment should be designated for involuntary commitment to outpatient or inpatient treatment.

Recodified N.J.A.C. 10:31-2.3(h)1 and (h)1i are proposed for amendment by adding that the psychiatrist who completes the screening certificate should not be the consumer's treating psychiatrist at the designated outpatient treatment provider.

As discussed above, existing N.J.A.C. 10:31-2.3(f)2ii and iii are proposed for relocation as new N.J.A.C. 10:31-2.3(i) with the following amendments. There is no change with regard to the requirement that the screening service must have a Division-approved plan before using telepsychiatry that meets specified criteria. The plan criteria listed at N.J.A.C. 10:31-2.3(i)1 are substantively identical to the criteria listed at existing N.J.A.C. 10:31-3.2(f)2iii, except that there is an additional requirement added at subparagraph (i)1xii that the psychiatrist performing telepsychiatry receive training on the New Jersey commitment law and mental health system. However, the Division is proposing to remove the existing requirement that screening services must also have an approved waiver from the Division to use telepsychiatry based on demonstrated need. That change is proposed in response to requests from stakeholders and is consistent with the increasing acceptance of the use of telemedicine in general and telepsychiatry specifically.

Recodified N.J.A.C. 10:31-2.3(j) is proposed for amendment by replacing "does not meet the commitment standard" with "is not in need of involuntary commitment" to be consistent with preferred terminology. The phrase "shall refer the consumer, for voluntary admission to the appropriate psychiatric unit of a general hospital or a special psychiatric hospital, community mental health or social service agency(s)" is also replaced with "shall refer the consumer to the least restrictive, appropriate treatment or social service agency(s)." That revision reinforces the legislative policy of referring consumers to services in the least restrictive, appropriate environment. See N.J.S.A. 30:4-27.1(c). Finally, the proposed amendments to this subsection delete the last sentence, which states that agencies receiving a referral from a screening service are responsible for procuring needed services because that

requirement applies to entities other than the screening service and, as such, is beyond the scope of the rules.

Recodified N.J.A.C. 10:31-2.3(o) is proposed for amendment to delete the clause "other than the screening service" following the reference to an AES. That clause is unnecessary and potentially confusing because it erroneously suggests that a screening service is a type of AES.

N.J.A.C. 10:31-2.5 Availability of staff

N.J.A.C. 10:31-2.5(a)1 and (b)1 are proposed for amendment by replacing the cross-reference to the provision with the telepsychiatry requirements with the citation as recodified in this rulemaking. In addition, the amendments delete the statement that prior approval is required to use telepsychiatry because under this rulemaking, screening services are no longer required to obtain a waiver prior to using telepsychiatry, as described above.

N.J.A.C. 10:31-2.6 Written policies and procedures

Proposed new N.J.A.C. 10:31-2.6(b)3 requires screening services and AESs to have written policies and procedures describing confidentiality standards and procedures to be followed in the delivery of services that are consistent with all applicable Federal and State confidentiality laws. Although this paragraph is new, it is not a new requirement for screening service and AES providers. The Management and Governing Body Standards at N.J.A.C. 10:37D have long required provider agencies to have policies and procedures on confidentiality that comply with applicable Federal and State laws and Department rules. See N.J.A.C. 10:37D-2.18(a)4. Those standards apply to agencies that provide specific, direct mental health services under contract with, or funded by, the Division, N.J.A.C. 10:37D-1.1 and 1.2 and, as such, are applicable to screening service and AES providers. Consequently, proposed new N.J.A.C. 10:31-2.6 (b)3 merely reinforces that requirement.

Recodified N.J.A.C. 10:31-2.6(b)4 is proposed for amendment by deleting the reference to N.J.A.C. 10:31-12, which is proposed for repeal, and adding the proviso that the contact with the consumer's family members, spouse, or significant others is required to the extent permitted by applicable confidentiality laws.

Subchapter 3. Screening and Screening Outreach Personnel Requirements

N.J.A.C. 10:31-3.3 Screener certification requirement, qualifications, and duties

N.J.A.C. 10:31-3.3(b)1 to 4 are proposed for amendment by replacing "full-time" with "full-time equivalent," which will allow screening services more flexibility in filling the listed positions while still maintaining the high standards.

N.J.A.C. 10:31-3.5 Psychiatrist requirements, qualifications and duties

N.J.A.C. 10:31-3.5(a) is proposed for amendment by removing the language describing the credentials of a psychiatrist, which is duplicative of the information included in the definition of a psychiatrist in this chapter. New subsection (c) is also proposed, which sets forth new requirements regarding training based on a Division-supplied curriculum.

N.J.A.C. 10:31-3.6 Medical director requirement, qualifications, and duties

N.J.A.C. 10:31-3.6(b)4 is proposed for amendment by replacing the requirement that the medical director ensures that telepsychiatrists are familiar with the screening center standards and practices with a requirement that the telepsychiatrist complies with those standards and practices. It also adds a requirement that the medical director ensures that the telepsychiatrists complete all the duties required for clinical management of consumers in the screening service. In addition, a requirement is added that the medical director have periodic face-to-face meetings with telepsychiatrists to review their role in managing patients.

Proposed new N.J.A.C. 10:31-3.6(b)5 is added, which requires the medical director to be responsible for quality improvement activities regarding clinical documentation including, but not limited to, completion of the screening certificate.

Subchapter 4. Affiliated Emergency Service Personnel Requirements

N.J.A.C. 10:31-4.2 AES Coordinator requirements, qualifications, and duties

N.J.A.C. 10:31-4.2(a)4 is proposed for amendment by deleting the requirement that AES coordinators maintain recertification credentials. AES programs do not employ certified screening staff and are, therefore, not involved in the completion of screening documents. This amendment results in a requirement that more closely aligns with the AES program's structure and scope of service.

N.J.A.C. 10:31-4.4 Psychiatrist requirements, qualifications, and duties

N.J.A.C. 10:31-4.4, which addresses the requirements, qualifications, and duties of the AES psychiatrists, is proposed for amendment to mirror the proposed changes in the provisions at N.J.A.C. 10:31-3.5, which provides requirements related to the screening service psychiatrists. More specifically, N.J.A.C. 10:31-4.4(a) is proposed for amendment by removing the language describing the credentials of a psychiatrist, which is duplicative of the information included in the definition of a psychiatrist in this chapter. New subsection (c) is also proposed, which sets forth new requirements regarding training based on a Division-supplied curriculum.

Subchapter 5. Systems Review in the Acute Care System

N.J.A.C. 10:31-5.1 Acute care system review

Proposed new N.J.A.C. 10:31-5.1(a)3 includes the requirement regarding the screening service's responsibility with respect to compiling information for the systems review committee that is located at existing N.J.A.C. 10:31-2.1(a)23.

Subchapter 6. Termination of Services

N.J.A.C. 10:31-6.1 Standards for termination of services

N.J.A.C. 10:31-6.1(a)5 is proposed for amendment by replacing "committed to an STCF, State psychiatric hospital or county psychiatric hospital" with "committed to treatment" to reflect that 2009 amendments to the commitment law providing for commitment to outpatient treatment. In addition, proposed new N.J.A.C. 10:31-6.1(a)6 adds a new discharge requirement to require discharge if the consumer is not in need of involuntary commitment and currently is a patient at a facility that can provide stabilization services or transport the consumer to an appropriate treatment setting.

N.J.A.C. 10:31-6.1(b)1 is proposed for amendment by replacing "linked to the screening service" with "transferred to the screening service" to more accurately reflect that a consumer might physically remain in the AES during the screening process as set forth at recodified N.J.A.C. 10:31-2.3(o).

Subchapter 9. Continued Quality Improvement

N.J.A.C. 10:31-9.1 Continued quality improvement

N.J.A.C. 10:31-9.1(a)2 is proposed for amendment to add that review of telepsychiatry services should be included in the quality improvement plan.

Subchapter 12. Confidentiality of Consumer Records

This subchapter is proposed for repeal. There are multiple confidentiality laws applicable to screening services including, but not limited to, the Privacy Rule implementing the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. Those rules are complex and their applicability to specific circumstances is extremely fact sensitive. Consequently, it is difficult, if not impossible, to provide a concise, but complete, recitation of the rules in this chapter. Moreover, those Federal rules are interpreted and enforced by the Office of Civil Rights in the U.S. Department of Health and Human Services, not the Division. Finally, as covered entities under HIPAA, screening services and AESs have an independent obligation to understand and apply the Federal rules. Accordingly, the Division proposes to delete this subchapter and add a requirement at N.J.A.C. 10:31-2.6(b) that screening services and AESs develop and implement appropriate confidentiality standards and practices based on the applicable laws, as discussed above.

N.J.A.C. 10:31 Appendices

N.J.A.C. 10:31 Appendix A Screening Document for Adults

The proposed amendments revise the screening document, referenced at N.J.A.C. 10:31-2.3(e) and included as N.J.A.C. 10:31 Appendix A, to reflect current commitment law and practice. More specifically, the revised screening document adds fields to collect information on the following items: 1) The use of telepsychiatry (Section II.B and Attachment A); 2) Whether the consumer has a psychiatric advance directive (Section II.G); 3) The recommended disposition for consumers identified as likely in need of involuntary commitment, that is, commitment to inpatient or outpatient treatment (Section IV); and 4) Whether the consumer has a history of substance abuse (Section III.D). It also amends and adds definitions in Section I to be consistent with changes in the commitment law and practice, in particular the availability of outpatient commitment, and the regulatory provisions addressing the use of telepsychiatry and revises the definition of consensual admission to be consistent with the amended definition at N.J.A.C. 10:31-1.2. The changes also delete the quotation from New Jersey Court Rule 4:74-7(b) included as the first paragraph of Section I. Instructions of the current screening document. That provision does not apply to the screening document. In addition, the changes makes non-substantive organizational and formatting changes to the document.

N.J.A.C. 10:31 Appendix B Certification for Return Following Conditional Release; 10:31 Appendix C Order for Temporary Rehospitalization following Conditional Release; and 10:31 Appendix D Screening Outreach

These appendices are proposed for readoption without change.

Social Impact

The goal of the rules proposed for readoption with amendments and repeals and a new rule is to ensure that persons with mental illness receive a higher quality of screening and assessment prior to being considered for involuntary commitment and that all available service options are available to consumers, regardless of the geographic area in which they live.

Screening services are an integral part of a system of acute care services in the community to ensure that whenever possible, a person receives services in their own community. The existence of standards regulating screening services benefit individuals with mental illness because they ensure the effective and efficient delivery of high quality services. In addition, providers benefit from clear, uniform standards that set expectations for their performance.

The two most significant substantive changes proposed in this rulemaking are new provisions implementing the outpatient commitment law; and amendments that permit the use of telepsychiatry without a waiver, as long as the screening service has a Division-approved telepsychiatry plan. The changes implementing outpatient commitment will benefit providers and consumers by setting forth the standards and process for involuntary commitment to outpatient treatment. The amendments with respect to the use of telepsychiatry relieve providers of the burden of having to obtain a waiver for telepsychiatry but continue to protect consumers by retaining the requirement that all provider using telepsychiatry have a telepsychiatry plan that insures the quality of telepsychiatry services and the rights of consumers being assessed for involuntary commitment to treatment. In addition, amendments to the staffing requirements allow providers greater flexibility by permitting the use of full time equivalents.

Economic Impact

Overall, the Department believes that the rules proposed for readoption with amendments and repeals and a new rule will not have any economic impact on agencies providing screening and outreach services because those agencies are funded to provide the services as required through contracts with the Division of Mental Health and Addiction Services. The Department further believes that the general public, persons with mental illness and their families, will experience both social and personal savings by the anticipated increase in diversions from more costly inpatient hospitalizations to less costly community-based services that screening services will provide.

Federal Standards Statement

The rules proposed for readoption with amendments and repeals and a new rule do not contain any standards that exceed those established by Federal law and, therefore, a Federal standards analysis is not required.

Jobs Impact

The rules proposed for readoption with amendments and repeals and a new rule would neither generate nor cause the loss of any jobs.

Agricultural Industry Impact

The rules proposed for readoption with amendments and repeals and a new rule would have no impact on agriculture in the State.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., small businesses are defined as those that employ fewer than 100 full-time employees, are independently owned and operated, and are not dominant in their field. The rules proposed for readoption with amendments and repeals apply to agencies providing screening and screening outreach services and affiliated emergency services, some of which may qualify as small businesses. The rules proposed for readoption with amendments include recordkeeping, reporting, and other compliance requirements as described in this Summary above, and outlined below:

● Affiliation agreements: Screening services are required to develop and maintain affiliation agreements with community-based agencies, N.J.A.C. 10:31-2.1(a)12ii and designated short-term care facilities serving the screening service's geographic area, N.J.A.C. 10:31-2.1(a)16. Affiliated emergency services are required to have an affiliation agreement with the screening service in their geographic areas.

● Written plans: Screening services are required to have written plans for training and providing technical assistance to police and other community referral sources, N.J.A.C. 10:31-2.1(a)17; for providing transportation to consumers in crisis, N.J.A.C. 10:31-2.1(a)18; for prioritizing response to screening outreach calls, N.J.A.C. 10:31-2.1(d); for use of telepsychiatry, if telepsychiatry is be used, N.J.A.C. 10:31-2.3(i)1; and protocols addressing staff availability and chain of command, N.J.A.C. 10:31-2.5(a)1ii, 2i, and 4i and ii.

● Recordkeeping: Screening services and affiliated emergency services are required to record specified information in the consumer's medical record, N.J.A.C. 10:31-2.3(b)3 and (h)1ii; to complete and retain copies of the screening document and clinical certificates as required to initiate the involuntary commitment process, N.J.A.C. 10:31-2.3(e) and (f)3 and 4; to complete the "Certification of Return Following Conditional Release" when the screening assessment indicates that a consumer who violated conditions of their discharge from involuntary commitment is in need of involuntary commitment, N.J.A.C. 10:31-2.4(e); and to complete the "Authorization of Police Transport" form when requesting law enforcement transport of a consumer evaluated during a screening outreach visit, N.J.A.C. 10:31-7.1(a).

● Reporting: Screening services are required to track treatment openings in the acute care system, N.J.A.C. 10:31-2.1(a)21, and compile information on the disposition of consumers seen by the screening service, N.J.A.C. 10:31-5.1(a)3.

● Policies and procedures: Screening services are required to have policies and procedures that ensure compliance with applicable Federal and State laws, rules, and regulations governing services for persons with mental illness and that are designed to ensure consumer access to appropriate services in the least restrictive environment possible, N.J.A.C. 10:31-2.6, and that delineate circumstances for requesting police response to a mental health crisis and requests for law enforcement to remain at the screening service, N.J.A.C. 10:31-7.1 and 7.3(b).

● Quality assurance activities: Screening services are required to develop and coordinate an acute care system review mechanism, N.J.A.C. 10:31-2.1(a)21, 5.1, 5.2, and 5.3; provide training to screening service and affiliated emergency service psychiatrists, including those providing services via telepsychiatry, on New Jersey commitment law and practice and the local mental health system of care, N.J.A.C. 10:31-2.3(i)1xii, 3.5(c), and 4.4(c); have medical director oversight of

telepsychiatrist(s) and quality assurance review of screening certification and other clinical documentation, N.J.A.C. 10:31-3.6(b)4 and 5; and develop and implement a continued quality improvement plan, N.J.A.C. 10:31-9.1.

It is not expected that any small business subject to these rules will have to employ professional services to comply with the recordkeeping, reporting, or compliance requirements in the rules proposed for readoption with amendments. Rather, agencies should be able to comply with those requirements by using existing staff. Further, it should be noted that the cost of those activities generally are covered under the agency's contract with the Division of Mental Health and Addiction Services.

The reporting, recordkeeping, and compliance requirements in the rules proposed for readoption with amendments apply to all screening and outreach services and affiliated emergency services, regardless of size. A primary purpose of this chapter is to ensure that individuals with mental illness receiving these services throughout the State do so in accordance with the basic minimum standards of quality, objectivity, and timeliness. These standards are important because the individuals being screened are typically in psychiatric crisis at the time and subject to involuntary commitment. Therefore, no differing compliance requirements for small businesses are provided for in the rules proposed for readoption with amendments.

Housing Affordability Impact Analysis

The rules proposed for readoption with amendments and repeals and a new rule will have an insignificant impact on the affordability of housing in New Jersey and there is an extreme unlikelihood that the rules would evoke a change in the average costs associated with housing because the rules pertain to screening and outreach programs from the Division.

Smart Growth Development Impact Analysis

The rules proposed for readoption with amendments and repeals and a new rule will have an insignificant impact on smart growth and there is an extreme unlikelihood that the rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules pertain to screening and outreach programs from the Division.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:31.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:31-12 and 10:31 Appendix A.

Full text of the proposed amendments and new rule follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

10:31-1.2 Purpose

(a) The purposes of the Screening and Screening Outreach Program are as follows:

1. To provide clinical assessment and crisis stabilization in the least restrictive, clinically appropriate setting, as close to the individual's home as possible, in a manner that is culturally competent, **trauma-informed,** and recovery-oriented and assists the consumer in achieving a self-directed transition to wellness;

2.-3. (No change.)

4. To assure referral and linkage, which is voluntary in nature, to appropriate community mental health and social services;

5. To coordinate access, where appropriate, to the publicly affiliated acute care [psychiatric resources] **system** serving a designated geographic area[, that is, acute partial hospitalization/care, crisis housing or voluntary inpatient services];

6.-10. (No change.)

10:31-1.3 Definitions

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

"Acute care" means [community out-patient and in-patient] **community-based outpatient and inpatient** psychiatric services designed to provide stabilization during the acute phase of psychiatric illness.

"Acute care system" means those services either contracted for or identified by the Division of Mental Health **and Addiction** Services, in consultation with the appropriate county mental health board, as part of a geographic area's acute care services. They may include, but are not limited to, the screening service, affiliated emergency services, short-term care [facility] **facilities**, inpatient psychiatric services, **adult** acute partial [care/hospitalization] **hospital services**, **partial hospital services, partial care services,** crisis housing, integrated case management services (ICMS), programs of assertive community treatment (PACT), and peer support, self-help, and acute family support services.

["Acute partial hospitalization/care" means a day treatment program whose purpose is to promote stabilization and acute symptom reduction through structured individual and group activities and interventions, which are provided throughout the day and early evening.]

"Adult acute partial hospital" means an intensive and time-limited acute psychiatric service for beneficiaries 18 years of age or older who are experiencing, or are at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization.

"Affiliated emergency service (AES)" means a mental health provider **that is under contract with the Division of Mental Health and Addiction Services and has an affiliation agreement with the designated screening service in its geographic area and is** responsible for the provision of services to people in psychiatric crisis. [AES includes mental health and social service provision or procurement and advocacy. Affiliated emergency services offer immediate crisis intervention services and service procurement to relieve the consumer's distress and to help maintain or recover his or her healthful functional level. Such services include, where indicated, the initiation of involuntary commitment proceedings or the referral of a consumer to a screening service for that purpose.] Emphasis is on stabilization, so that the consumer can actively participate in needs assessment and service planning.

. . .

["Commitment" means the procedure for authorizing admission to a treatment facility of an adult who is mentally ill, whose mental illness causes the person to be dangerous to self or dangerous to others or property, and who is unwilling to be admitted to a facility voluntarily for care, and who needs care at a short-term care facility, psychiatric facility or special psychiatric hospital because other services are not appropriate to meet the person's mental health care needs.]

. . .

["Consensual admission" means the type of admission applicable to a person who has received an assessment from a screener and screening psychiatrist in a screening service, who is determined to be dangerous to self, others or property by reason of mental illness, and who understands and agrees to be admitted to a short-term care facility for stabilization and treatment.]

"Consensual admission" means a voluntary admission specifically to a short-term care facility from a screening service.

. . .

["Consumer protected health information (consumer PHI)" means all information, certificates, applications, records and reports that directly or indirectly identify a consumer currently or formerly receiving services, or for whom services were sought.]

. . .

["Covered entity" means the professional staff of a community agency under contract with the Division of Mental Health Services, or of a screening service, short-term care or psychiatric facility as those facilities are defined in N.J.S.A. 30:4-27.2.]

. . .

"Dangerous to others or property" means that, by reason of mental illness, there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This

determination takes into account a person's history, recent behavior and any recent act, threat, or serious psychiatric deterioration.

"Dangerous to self" means that, by reason of mental illness, the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his or her need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical [debilitation] **harm** or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his or her need for nourishment, essential medical care, or shelter if he or she is able to satisfy such needs with the supervision and assistance of others who are willing and available. **This determination shall take into account a person's history, recent behavior and any recent act, threat, or serious psychiatric deterioration.**

["Dangerous to others or property" means that, by reason of mental illness, there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination takes into account a person's history, recent behavior and any recent act or threat.]

"Division" means the Division of Mental Health **and Addiction** Services, Department of Human Services.

. . .

["In need of involuntary commitment" means that an adult who is mentally ill, whose mental illness causes the person to be dangerous to self, others, or property and who is unwilling or unable to be admitted to a facility voluntarily for care, and who needs care at a short-term care facility, psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs.]

"In need of involuntary commitment" or "in need of involuntary commitment to treatment" means that an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment, or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs.

. . .

"Least restrictive environment" means the available setting and form of treatment that appropriately addresses a person's need for care and the need to respond to dangers to the person, others, or property and respects, to the greatest extent practicable, the person's interests in freedom of movement and self-direction.

. . .

"Natural support system" means the [patient's] **consumer's** family, friends, neighbors, or significant others who are willing and able to provide emotional, financial, or other help.

"Outpatient treatment" means clinically appropriate care, based on proven or promising treatments directed to wellness and recovery, provided by a member of the patient's treatment team to a person not in need of inpatient treatment. Outpatient treatment may include, but shall not be limited to, day treatment services, case management, residential services, outpatient counseling and psychotherapy, and medication treatment.

"Outpatient treatment provider" means a community-based provider, designated as an outpatient treatment provider pursuant to N.J.S.A. 30:4-27.8, that provides or coordinates the provision of outpatient treatment to persons in need of involuntary commitment to treatment.

"Partial care" means an individualized, outcome-oriented mental health service, which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program in a community setting to assist consumers who have serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives. Partial care services are offered to an individual age 18 or older with a primary psychiatric disorder that is accompanied by an impaired ability to perform living, learning, working, or social roles. Partial care services support consumer stabilization and community integration and are alternatives to more intensive acute interventions. Partial care services provide active treatment and psychiatric rehabilitation for consumers who do not require inpatient hospitalization, but require support and structured programming.

"Partial hospital" means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

. . .

"Physician" means a person who is licensed to practice medicine in [any one of the United States or its commonwealths or territories or the District of Columbia] **the State of New Jersey** [and who has complied with all relevant New Jersey professional licensing laws, including, but not limited to, the requirements of the New Jersey State Board of Medical Examiners].

"Plan of outpatient treatment" means a plan for recovery from mental illness approved by a court pursuant to N.J.S.A. 30:4-27.15.a that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting.

. . .

"Psychiatrist" means a physician **licensed to practice medicine in the State of New Jersey** who has completed the training requirements of the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry [and who has complied with all relevant New Jersey professional licensing laws and the requirements of the New Jersey State Board of Medical Examiners].

. . .

["Psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date (45 CFR 164.501).]

"Reasonably foreseeable future" means a time frame that may be beyond the immediate or imminent, but not longer than a time frame as to which reasonably certain judgments about a person's likely behavior can be reached.

"Referral" means services, which are voluntary in nature, [and which] **that** direct, guide, and link a consumer with appropriate services, which promote the achievement of the goals of wellness and recovery and which include diversion from hospitalization, as clinically appropriate.

"Screener" means an individual who has fulfilled the requirements set forth in N.J.A.C. 10:31-3.3 and has been certified by the Division to assess a consumer's [eligibility] **need** for involuntary commitment **to treatment**.

["Screening" means the process by which it is ascertained that the individual being considered for commitment meets the standards for both mental illness and dangerousness as defined in P.L. 1987, c.116 (N.J.S.A. 30.4-27.1 et seq.), and that all stabilization options have been explored or exhausted.]

"Screening" means the process for determining whether an individual is in need of involuntary commitment to treatment.

. . .

"Screening certificate" means a [physician's certification on a] form developed by the Division and approved by the Administrative Office of the Courts [stating] **that is executed by a psychiatrist or other physician affiliated with a screening service who has examined the consumer and which states** that the [person] **consumer** designated therein is in need of **involuntary** commitment **to treatment**. The form shall also state the specific facts upon which the examining physician

has based his or her conclusion and shall be certified in accordance with the Rules of Court. The certificate may not be executed by a person who is a relative, by blood or marriage, of the person who is being screened.

. . .

"Screening outreach" means an evaluation provided by a certified screener, wherever the person to be screened may be located, when clinically relevant information indicates the person may need involuntary commitment **to treatment** and is unable or unwilling to come to a screening service.

"Screening psychiatrist" means a psychiatrist employed by a screening service or a psychiatrist affiliated through a written agreement with a screening service. The written agreement shall minimally outline a supervisory procedure consistent with N.J.A.C. 10:31-3.6.

"Screening service" means a public or private ambulatory care service with mobile capacity designated by the Commissioner, which provides mental health services, as specified in N.J.A.C. 10:31-2.1. [In addition to affiliated emergency services, a screening service is the program in the public mental health care treatment system wherein a person believed to be in need of commitment to a short-term care facility, psychiatric facility or special psychiatric hospital undergoes an assessment to determine what mental health services are appropriate for the person and where those services may be most appropriately provided.]

. . .

"Special psychiatric hospital" means a public or private hospital licensed by the Department of Health [and Senior Services] to provide voluntary and involuntary mental health services, including assessment, care, supervision, treatment, and rehabilitation services to persons with mental illness.

"Stabilization options" means treatment modalities or means of support used to remediate a crisis. They may include, but are not limited[,] to, early intervention programs, crisis intervention counseling, acute partial [care/hospitalization] **hospital services, adult partial hospital services, partial care services**, crisis housing, acute in-home services, extended crisis evaluation bed with medication monitoring, or emergency stabilization regimes, **admission on a voluntary basis to a psychiatric unit in a general hospital,** [voluntary admission to local inpatient unit,] referral to other 24-hour treatment facilities, referral and linkage to other community resources, and use of natural support system.

. . .

"Voluntary admission" means that an adult with mental illness, whose mental illness causes the person to be dangerous to self or dangerous to others or property and is willing to be admitted to a facility voluntarily for care, needs care at a short-term care or psychiatric facility because other facilities or services are not appropriate or available to meet the person's mental health needs. A person may also be voluntarily admitted to a psychiatric facility if his or her mental illness presents a substantial likelihood of rapid deterioration in functioning in the near future, there are no appropriate community alternatives available, and the psychiatric facility can admit the person and remain within its rated capacity.

SUBCHAPTER 2. PROGRAM REQUIREMENTS

10:31-2.1 Functions of a screening service

(a) A screening service shall perform the following functions:

1. Assessment of the crisis situation and identification of stabilization, diversion, and support services needed and/or screening for commitment. This shall take place throughout the geographic area served by the service, including such sites as other emergency services, jails, and nursing homes[;].

i. When evaluation of suicide risk is indicated, the assessment shall include an evidence-based, structured, or standardized tool designed to assess suicide risk;

2.-5. (No change.)

6. Operation of a 24-hour hotline, which shall be answered at all times directly by a certified screener, crisis intervention specialist, or other clinical personnel under the supervision of the screener or crisis intervention specialist and which shall receive calls that have been forwarded from [other] **an** AES during off hours;

7.-8. (No change.)

9. [Direct or indirect provision of] **Provision of, or arrangement for,** appropriate medical services for consumers who are receiving screening services;

10. Provision of medication monitoring, which shall include medication for the purpose of crisis stabilization. Medication shall be administered in accordance with [P.L. 1991, c. 233] **N.J.S.A. 30:4-27.11e.a(1)** and shall not be given to consumers in non-emergency situations without their consent;

11. Arranging transportation of consumers in need of **involuntary** commitment **to inpatient treatment** to the receiving facility;

12. (No change.)

13. In accordance with the procedures set forth at N.J.A.C. 10:31-2.4, [assessment of the commitability of] **determine if a** consumer[s who are returned for] **brought to the** screening service[s when they fail to meet] **pursuant to a court order issued as the result of the consumer's failure to comply with** the terms of their conditional [release orders] **discharge from involuntary commitment to treatment is in need of involuntary commitment to treatment**;

14.-19. (No change.)

20. Develop and coordinate a mechanism for acute care system review [for all acute care services listed in N.J.A.C.10:31-2.1(a) and] in accordance with N.J.A.C. 10:31-5;

21. Maintain a system for tracking currently available treatment openings in the acute care [mental health services] system for which the screening service is granted access either directly, by subcontract or by affiliation; **and**

22. Ensure that screening services are made known to the community at large through, among other modalities, publication of services in the local telephone directory[; and].

[23. Comply with N.J.A.C. 10:37-6.79 regarding records of all persons seen by the screening service and compile information regarding disposition of such persons for review by the systems review committee (N.J.A.C. 10:31-5).]

(b)-(d) (No change.)

10:31-2.2 Functions of an affiliated emergency service (AES)

(a) In addition to the screening service, a geographic area may include one or more affiliated emergency services (AESs). All AESs shall be affiliated by written agreement with the geographic area's screening service. All AESs shall operate in accordance with contractual agreements with the Division and affiliation agreements with the designated screening service. Each AES shall provide all of the following services:

1. (No change.)

2. Provision of or arrangement for appropriate medical services for consumers receiving care at the AES; [and]

3. (No change.)

4. Assessment, referral, linkage, and follow-up, which shall include maintenance of contact with all consumers until they are engaged in another service or the [emergency] **crisis** has been resolved. The AES shall also:

i. (No change.)

ii. Facilitate linkage to **services in the** acute care [services, such as crisis housing, acute partial and acute mental health in-home services] **system**; and

iii. Provide linkage to, and necessary follow-up regarding, other mental health and non-mental health services; [and]

5. When an AES believes that a consumer might be in need of involuntary commitment, arrange for screening of the consumer as set forth at N.J.A.C. 10:31-2.3(m); and

[5.] **6.** (No change in text.)

(b) (No change)

10:31-2.3 Screening process and procedures

(a) (No change.)

(b) The screening service or affiliated emergency service shall provide a thorough assessment of the consumer and his or her current situation to determine the meaning and implication of the presenting

problem(s) and the nature and extent of efforts that have already been made.

1. (No change.)

2. The screening service or affiliated emergency service staff shall consult with each adult consumer, significant others as permitted by law, and the [DMHS] **Division** Registry established pursuant to N.J.A.C. 10:32-2.1, to determine whether the consumer has executed an advance directive for mental health care, has a guardian, or has executed a durable power of attorney, and shall take no action that conflicts with those documents, insofar as they exist and compliance is required by law.

3. (No change.)

(c) All stabilization options shall be fully explored before involuntary commitment is considered. Such options shall include, but shall not be limited to:

1.-4. (No change.)

[5. Acute partial care/hospitalization;]

5. Adult acute partial hospital, partial hospital, or partial care services;

6.-8. (No change.)

9. Referral to other 24-hour treatment facility; [and]

10. Admission on a voluntary basis to a psychiatric unit of a general hospital; and

[10.] **11.** Voluntary admission [to a State psychiatric hospital or the psychiatric unit of a general hospital or special psychiatric hospital].

(d) After exploring the appropriateness of, and exhausting all options listed in (c) above, the screener shall ascertain whether **the consumer is in need of involuntary** commitment [is indicated] **to treatment**. In making this determination, the screener shall consider whether the individual:

1.-2. (No change.)

3. Understands the nature of the recommended treatment and is unwilling to **voluntarily** accept appropriate, available [inpatient] **outpatient** treatment **or inpatient care** at an STCF, psychiatric facility, or special psychiatric hospital **after it has been offered**.

(e) If the screener determines that the individual is [dangerous to self, others or property by reason of mental illness] **in need of involuntary commitment to treatment** under the standard referenced [above] **in this section**, the screener shall fully complete, within 24 hours of the individual's presentation for screening services, all sections of the screening document found at N.J.A.C. 10:31 Appendix A, incorporated herein by reference, after exhausting all reasonable efforts to stabilize the individual or divert him or her to less restrictive care. Through the screening document, the screener shall certify that the individual is in need of commitment.

[1. If the screener determines that the individual is dangerous by reason of mental illness under the standards referenced in (d)1 and 2 above and is willing to accept appropriate inpatient treatment at an STCF, psychiatric facility or special psychiatric hospital, the screener shall complete all relevant sections of the screening document, indicating that the individual has agreed to voluntary admission.]

1. The screener shall also complete the relevant sections of the screening document if the screener determines that the individual meets the criteria for a consensual admission.

(f) After fully completing the screening document, the screener shall contact the screening service psychiatrist for further assessment of the individual.

1. (No change.)

2. The screening psychiatrist shall conduct and document a thorough psychiatric evaluation of the consumer.

i. [Notwithstanding the above, the] **The** psychiatric evaluation may be accomplished through technologically assisted means, also known as "telepsychiatry," [provided that the screening service is granted a waiver for this purpose, in accordance with the provisions set forth at N.J.A.C. 10:31-11, and has a Division-approved plan delineating a procedure for evaluation via telepsychiatry] **when the conditions set forth at (i) below are met**.

[ii. Prior to seeking approval of the plan for telepsychiatric assessment, the screening service shall make and fully document all reasonable efforts to have psychiatrists available on-site during the hours to be covered by the telepsychiatry program.

iii. A screening service's plan to utilize telepsychiatry shall contain and document to the Division the following conditions and provisions:

(1) The consumer shall be afforded, in all instances, the opportunity to have a face-to-face assessment with a psychiatrist, rather than a telepsychiatric assessment, unless clinical circumstances require a more timely assessment;

(2) Telepsychiatry shall not be used where it is clinically contraindicated;

(3) Screening staff shall obtain and document the consumer's valid consent to being assessed through the means of telepsychiatry;

(4) A screener or registered nurse shall be with or available to the consumer at all times during the telepsychiatric assessment;

(5) Pursuant to State and Federal laws, confidentiality shall be preserved by both electronic safeguards and through the training of on-site and off-site staff;

(6) The psychiatrists involved in telepsychiatry may be employed as staff of the screening service or may be under contract with the screening service. A screening service that contracts for telepsychiatry pursuant to an approved Division waiver shall still be required to hire and credential psychiatrists to perform any other duties or services required by this chapter;

(7) The psychiatrist performing the telepsychiatric assessment shall hold a full, unrestricted medical license in New Jersey;

(8) The psychiatrist performing the telepsychiatric assessment shall be capable of performing all the duties that an on-site psychiatrist can perform, including prescribing medication, monitoring restraints and other related interventions that require a physician's orders or oversight;

(9) As appropriate, the screening service shall ensure that the telepsychiatrist performing the assessment maintains privileges with the general hospital affiliated with the screening service, and is actively and routinely involved in the quality improvement process of the screening service;

(10) The psychiatrist performing the telepsychiatric assessment shall be considered an active part of the treatment team and shall be available for discussion of the case with facility staff, or for interviewing family members and others, as the case may require; and

(11) The technology used in the telepsychiatric assessment shall be consistent with the current technological state of the art acknowledged in the profession.]

3. If the psychiatrist determines that the consumer [meets the standards for] **is in need of involuntary** commitment, the psychiatrist shall [fully] complete all **applicable** sections of the screening certificate (on the form approved by the Administrative Office of the Courts, designated a "screening/clinical certificate," and also known as the "physician's certificate").

i. (No change.)

ii. Where the consumer is dangerous by reason of a mental illness, but is willing and able to consent to treatment, the screening certificate should not be completed. Instead, the psychiatrist shall document those findings in the consumer's medical record and recommend that the consumer be admitted voluntarily to treatment. That documentation will become part of the referral packet for admission to the short-term care facility.

4. Upon the psychiatrist's determination that the consumer is in need of involuntary commitment to treatment and completion of the applicable sections of the screening certificate, screening service staff, in consultation with the psychiatrist or another physician, as appropriate, shall determine the least restrictive environment for the appropriate treatment to which the person shall be assigned or admitted, taking into account the person's prior history of hospitalization and treatment and the person's current mental health condition. Screening service staff shall designate:

i. Inpatient treatment, if the consumer is immediately or imminently dangerous or if outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others, or property within the reasonably foreseeable future; or

ii. Outpatient treatment, when outpatient treatment is deemed sufficient to render the consumer unlikely to be dangerous to self, others, or property within the reasonably foreseeable future.

5. Upon determination of the designation in (f)4 above, the remainder of the screening certificate shall be completed.

[ii.] **(g)** In accordance with N.J.S.A. 30:4-[27.9(c)]**27.9.c**, within 72 hours of the psychiatrist's completion of the screening certificate, the following events must occur:

[(1)] **1.** The consumer must be admitted to **a designated outpatient treatment provider,** a short-term care facility, psychiatric facility, or special psychiatric hospital;

[(2)] **2.** A psychiatrist on staff at **the designated outpatient treatment provider or** the admitting facility must complete the clinical certificate; and

[(3)] **3.** Staff at **the designated outpatient treatment provider or** the admitting facility must commence court proceedings for involuntary commitment by filing with the court both the screening certificate (completed by the screening psychiatrist) and the clinical certificate (completed by the treating psychiatrist on staff at the admitting facility).

[4. Where the consumer is dangerous by reason of a mental illness, but is willing and able to consent to treatment, the psychiatrist shall document these findings in the consumer's medical record and recommend that the consumer be admitted consensually. There is no need to complete a screening certificate in the case of a consensual admission; however, the documentation will become part of the referral packet for admission to the short-term care facility.]

[(g)] **(h)** The screening psychiatrist completing the assessment delineated in (f) above shall not be the consumer's treating psychiatrist.

1. The screening service's policies and procedures shall specify that the psychiatrist who assesses the consumer in the screening service and who completes the screening certificate shall not be the psychiatrist who treats the consumer in the STCF, psychiatric facility, [or] special psychiatric hospital**, or designated outpatient treatment provider** and who completes the clinical certificate, unless, and only after, reasonable but unsuccessful attempts were made to have another psychiatrist conduct the assessment and execute the certificate.

i. The screening service policies and procedures shall stipulate that the "reasonable attempts" referred to in [(g)1] **(h)1** above shall include, but not be limited to, reassignment, scheduling changes, or any other mechanism that may result in another psychiatrist treating the patient in the STCF, psychiatric facility, [or] special psychiatric hospital**, or designated outpatient treatment provider**.

ii. (No change.)

(i) The psychiatric assessment may be completed through use of telepsychiatry, provided that the screening service has a Division-approved plan setting forth its policies and procedures for providing a psychiatric assessment via telepsychiatry that meets the following criteria:

1. The consumer shall be afforded, in all instances, the opportunity to have a face-to-face assessment with a psychiatrist rather than a telepsychiatric assessment, unless clinical circumstances require a more timely assessment;

2. Telepsychiatry shall not be used where it is clinically contraindicated;

3. Screening staff shall obtain and document the consumer's valid consent to being assessed through the means of telepsychiatry;

4. A screener or registered nurse shall be with or available to the consumer at all times during the telepsychiatric assessment;

5. Pursuant to State and Federal laws, confidentiality shall be preserved by both electronic safeguards and through the training of on-site and off-site staff;

6. The psychiatrists involved in telepsychiatry may be employed as staff of the screening service or may be under contract with the screening service. A screening service that contracts for telepsychiatry shall still be required to hire and credential psychiatrists to perform any other duties or services required by this chapter;

7. The psychiatrist performing the telepsychiatric assessment shall hold a full, unrestricted medical license in New Jersey;

8. The psychiatrist performing the telepsychiatric assessment shall be capable of performing all the duties that an on-site psychiatrist can perform, including prescribing medication, monitoring restraints, and other related interventions that require a physician's orders or oversight;

9. As appropriate, the screening service shall ensure that the telepsychiatrist performing the assessment maintains privileges with the general hospital affiliated with the screening service, and is actively and routinely involved in the quality improvement process of the screening service;

10. The psychiatrist performing the telepsychiatric assessment shall be considered an active part of the treatment team and shall be available for discussion of the case with facility staff, or for interviewing family members and others, as the case may require;

11. The technology used in the telepsychiatric assessment shall be consistent with the current technological state of the art acknowledged in the profession; and

12. The psychiatrist performing the telepsychiatric assessment shall receive training based on a Division-supplied curriculum that will address the New Jersey commitment standards and the local mental health system of care including, but not limited to, information about all least restrictive community treatment settings.

[(h)] **(j)** If the assessment reveals that a consumer [does not meet the commitment standard] **is not in need of involuntary commitment**, the screening service shall refer the consumer[, for voluntary admission to the appropriate psychiatric unit of a general hospital or a special psychiatric hospital, community mental health] **to the least restrictive, appropriate treatment** or social service agency(s). [It shall be the responsibility of such agencies to procure needed services.]

Recodify existing (i)-(l) as **(k)-(n)** (No change in text.)

[(m)] **(o)** The screening of consumers seen in an AES [(other than the screening service)] may be accomplished in any of the following ways, in accordance with affiliation agreements developed between the screening service and the AES, based upon the best interest of the consumer, and with the goal of avoiding the transportation of the consumer, except where necessary for treatment purposes:

1.-4. (No change.)

10:31-2.5 Availability of staff

(a) A screening service shall have, at a minimum, the following personnel:

1. A psychiatrist, who shall be available 24 hours per day, 365 days per year, to provide telephone consultation, medication orders, and face-to-face evaluation as needed. Psychiatrist availability may be accomplished through telepsychiatry[, upon prior approval from the Division and consistent with the terms of] **when the conditions set forth at** N.J.A.C. 10:31-2.3[(f)2]**(i)2 are met**.

i.-ii. (No change.)

2.-6. (No change.)

(b) An affiliated emergency service shall have, at a minimum, the following personnel:

1. A psychiatrist, who shall be available 24 hours per day, 365 days per year, to provide telephone consultation, medication orders, and face-to-face evaluation, as needed. Psychiatrist availability may be accomplished through telepsychiatry[, upon prior approval from the Division and consistent with the terms of] **when the conditions set forth at** N.J.A.C. 10:31-2.3[(f)2]**(i)2 are met**;

2.-3. (No change.)

10:31-2.6 Written policies and procedures

(a) (No change.)

(b) Each policy and/or procedure shall be designed to ensure accessibility to services and to ensure that consumers receive treatment in the least restrictive, clinically appropriate setting, as close to their own community as possible, with the achievement of wellness and recovery as its goal. Service provision shall balance the value of liberty with the need for safety or treatment.

1.-2. (No change.)

3. The policy and procedure manual shall include policies and procedures setting forth confidentiality standards and procedures that are to be followed in all aspects of the screening services or

AES's provision of services to consumers that are consistent with all applicable Federal and State law, including, but not limited to, the Privacy Rule implementing the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, N.J.S.A. 30:4-24.3, and N.J.A.C. 10:37-6.79.

[3.] **4.** The policies [of the screening service/emergency service, consistent with confidentiality provisions at N.J.A.C. 10:31-12,] shall require**, to the extent permitted under applicable confidentiality laws,** contact with the consumer's family, spouse, civil union partner, or significant other and current or previous service providers to determine what the clinical needs of the consumer and what services would best meet those needs in the best interest of the consumer. Agency policy shall require that the extent of these efforts be documented in the consumer's record.

Recodify existing 4.-5. as **5.-6.** (No change in text.)

[6.] **7.** Written policies and procedures regarding the provision of extended crisis evaluation services shall include, but not be limited to, the following: admission criteria, intensive observation and continuous monitoring of consumers, use of physical restraints, administration and monitoring of medication, and documentation of all treatment interventions provided to consumers while in extended crisis evaluation beds.

i. Policies and procedures for the use of physical restraints and the administration and monitoring of medication shall be consistent with Division and Department of Health [and Senior Services] requirements, and any other applicable Federal and State laws.

ii. (No change.)

Recodify existing 7.-11. as **8.-12.** (No change in text.)

SUBCHAPTER 3. SCREENING AND SCREENING-OUTREACH PERSONNEL REQUIREMENTS

10:31-3.3 Screener certification requirement, qualifications, and duties

(a) (No change.)

(b) Individuals who apply for status as a certified screener after August 16, 2010, shall possess at least one of the following educational credentials, which shall serve as prerequisites to admission to the Division's screener certification course and to subsequent status as a temporary or fully certified screener:

1. A master's degree in a mental-health-related field from an accredited institution, plus one year of postmaster's, full-time **equivalent**, professional experience in a psychiatric setting;

2. A bachelor's degree in a mental-health-related field from an accredited institution, plus three years post-bachelor's, full-time **equivalent**, professional experience in the mental health field, one of which is in a crisis setting;

3. A bachelor's degree in a mental-health-related field from an accredited institution, plus two years post-bachelor's, full-time **equivalent**, professional experience in the mental health field, one of which is in a crisis setting and currently enrolled in a master's program; or

4. A licensed registered nurse with three years full-time **equivalent**, post-RN, professional experience in the mental health field, one of which is in a crisis setting.

(c)-(g) (No change.)

10:31-3.5 Psychiatrist requirements, qualifications, and duties

(a) Each screening service shall employ one or more psychiatrists. [The psychiatrist shall be a physician, who has completed the training requirements of the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, and who has complied with all relevant New Jersey professional licensing laws and the requirements of the New Jersey State Board of Medical Examiners.]

(b) (No change.)

(c) The psychiatrist(s) shall receive training based on a Division-supplied curriculum that will address the New Jersey commitment standards and the local mental health system of care including, but not limited to, information about all least restrictive community treatment settings.

10:31-3.6 Medical director requirement, qualifications, and duties

(a) (No change.)

(b) The duties of a medical director shall include, but not be limited to, the following:

1.-2. (No change.)

3. The assurance of available psychiatric services; [and]

4. Assuming a leadership, supervisory role over all clinical operations and quality improvement activities of the screening service, including, but not limited to, supervision of any telepsychiatric services to ensure that the telepsychiatrist [is familiar with] **adheres to** the quality standards and clinical practices of the screening service[.] **and completes all duties required for the clinical management of consumers in the screening service, as described at N.J.A.C. 10:31-3.5(b). To insure compliance, supervision of telepsychiatrists shall include periodic face-to-face meetings to review the telepsychiatrist's role in managing patients; and**

5. The medical director shall assume responsibility for quality improvement activities in regard to documentation, which shall include review of screening certificates and other clinical documentation to insure compliance with content-based criteria issued by the Division.

SUBCHAPTER 4. AFFILIATED EMERGENCY SERVICE PERSONNEL REQUIREMENTS

10:31-4.2 AES coordinator requirements, qualifications, and duties

(a) Each AES shall have a coordinator. The coordinator shall possess the following minimum requirements:

1.-3. (No change.)

4. Successful completion of the Division-sponsored screener certification course[,] **and** passage of proficiency exam within six months of the date of hire[, and maintenance of recertification credentials].

(b) (No change.)

10:31-4.4 Psychiatrist requirements, qualifications, and duties

(a) Each affiliated emergency service shall employ one or more psychiatrists. [The psychiatrist shall be a physician, who has completed the training requirements of the American Board of Psychiatry and Neurology or the American Board of Osteopathic Neurology and Psychiatry and who has complied with all relevant New Jersey professional licensing laws and the requirements of the New Jersey State Board of Medical Examiners.]

(b) (No change.)

(c) The AES psychiatrist(s) shall receive training based on a Division-supplied curriculum that will address the New Jersey commitment standards and the local mental health system of care including, but not limited to, information about all least restrictive community treatment settings.

SUBCHAPTER 5. SYSTEMS REVIEW IN THE ACUTE CARE SYSTEM

10:31-5.1 Acute care system review

(a) The screening service in each geographic area, in consultation with the Division, shall monitor the provision of acute care services.

1.-2. (No change.)

3. The screening service shall compile information regarding the disposition of persons seen in the screening service for review by the systems review committee to the extent permitted by any applicable confidentiality laws.

[3.] **4.** (No change in text.)

SUBCHAPTER 6. TERMINATION OF SERVICES

10:31-6.1 Standards for termination of services

(a) Consumers will be terminated from the screening service for any of the following reasons:

1.-3. (No change.)

4. The consumer has been voluntarily admitted to a hospital or other treatment facility; [or]

5. The consumer has been involuntarily committed to [an STCF, State psychiatric hospital or county psychiatric hospital.] **treatment; or**

6. The consumer does not meet the standard for involuntary commitment and is a current patient of a facility that can stabilize or treat the consumer or can arrange for transport of the individual to an appropriate treatment setting.

(b) Consumers will be terminated from the affiliated emergency service for any of the following reasons:

1. The consumer has been [linked] **transferred** to the screening service for further evaluation or commitment;

2.-5. (No change.)

SUBCHAPTER 9. CONTINUED QUALITY IMPROVEMENT

10:31-9.1 Continued quality improvement

(a) The quality and appropriateness of care and services provided by the screening service/affiliated emergency service are monitored and evaluated in accordance with the agency's continued quality improvement plan and Division standards for continued quality improvement as defined at N.J.A.C. 10:37-9.

1. (No change.)

2. Information analyzed shall include, but not be limited to, access to screening, appropriateness of commitment, use and frequency of mobile outreach, including police involvement, **quality of telepsychiatry services, if applicable, provision of telepsychiatry services in adherence to requirements enumerated in N.J.A.C. 10:31-2.3(i)1,** and systems review data.

SUBCHAPTER 12. (RESERVED)

APPENDIX A
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

SCREENING DOCUMENT FOR ADULTS
(Pursuant to N.J.S.A. 30:4-27.1 et seq)

I. DEFINITIONS

A. "Certified screener" means an individual who has fulfilled the requirements set forth in N.J.A.C. 10:31-3.3 and has been certified by the Division as qualified to assess eligibility for involuntary commitment to treatment. (N.J.S.A. 30:4-27.2p)

B. "Consensual admission" means a voluntary admission specifically to a short-term care facility from a screening service.

C. "Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration. (N.J.S.A. 30:4-27.2i)

D. "Dangerous to self" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical harm or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration. (N.J.S.A. 30:4-27.2h)

E. "In need of involuntary commitment" or "in need of involuntary commitment to treatment" means that an adult with mental illness, whose mental illness causes the person to be dangerous to self, or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered, needs outpatient treatment or inpatient care at a short-term care or psychiatric facility or special psychiatric hospital because other services are not appropriate or available to meet the person's mental health care needs. (N.J.S.A. 30:4-27.2m).

F. "Least restrictive environment" means the available setting and forms of treatment that appropriate address a person's need for care and the need to respond to dangers to the person,

others or property and respect, to the greatest extent practicable, the person's interests in freedom of movement and self-direction. (N.J.S.A. 30: 4-27.2gg)

G. "Mental Illness" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability un less it results in the severity of impairment described herein. The term mental illness is not limited to "psychosis" or "active psychosis," but shall include all conditions that result in the severity of impairment described herein. (N.J.S.A. 30:4-27.2r)

H. "Outpatient treatment" means clinically appropriate care based on proven or promising treatments directed to wellness and recovery, provided by a member of the patient's treatment team to a person not in need of inpatient treatment. Outpatient treatment may include, but shall not be limited to, day treatment services, case management, residential service, outpatient counseling and psychotherapy, and medication treatment. (N.J.S.A. 30:4-27.2hh)

I. "Outpatient treatment provider" means a community-based provider designated as an outpatient treatment provider pursuant to Title 30 of the New Jersey statutes P.L. 1987, c. 116 (c.30:4-27.8), that provides or coordinates that provision of outpatient treatment to persons in need of involuntary commitment to treatment. (N.J.S.A. 30: 4-27.2ii)

J. "Plan of outpatient treatment" means a plan for recovery from mental illness approved by a court pursuant to N.J.S.A. 30:4-27.15b prepared by an outpatient treatment provider for a patient who has a history of responding to treatment. The plan may include medication as a component of the plan; however, medication shall not be involuntarily administered in an outpatient setting. (N.J.S.A. 30:4-27.2jj)

K. "Screening service" means a public or private ambulatory care service designated by the commissioner, which provides mental health services including assessment, emergency and referral services to persons with mental illness in a specified geographic area (N.J.S.A.30:4-27.2z). Screening is the process by which an individual being considered by commitment meets the standards for mental illness and dangerousness as defined herein.

L. "Stabilization options" means treatment modalities or means of support used to remediate a crisis and avoid hospitalization. They may include but are not limited to crisis intervention counseling, acute partial care, crisis housing, voluntary admission to a local inpatient unit, referral to other 24 hour treatment facilities, referral and linkage to other community resources, and use of natural support systems.

M. "Telepsychiatry option" – means a psychiatric evaluation which is accomplished through technologically assisted means that fully comports with the requirements of N.J.A.C 10:31-2.3(i)

This document is to be used only by a certified screener to document a person's need for involuntary commitment to treatment or for a consensual admission to a Short Term Care Facility.

II. SCREENING INFORMATION

A. This document is being prepared as a:

( ) Screening document recommending inpatient treatment (Pursuant to N.J.S.A. 30: 4-27-1 et seq.)
( ) Screening document recommending outpatient treatment (Pursuant to N.J.S.A. 30: 4-27-1 et seq.)
( ) Consensual admission document (Pursuant to N.J.A.C 10:31-2.3(e)1.)

B. Name of consumer: _____

C. Date of Birth_____

D. Sex: _____M _____F

E. English language abilities:

Speaks English as primary language: _____Yes _____No
Speaks English but it is not primary language:

_____Few Words _____Conversationally _____Fluent

If not English, what is the person's primary language? _____
Primary Language Abilities
_____Speaks _____Reads _____Writes

Did you interview this person in his or her primary language? ____Yes ____No

If no, was an interpreter present? ____Yes ____No

If an interpreter was present, please give the interpreter's name and title:

_____ _____

F. Psychiatric Advance Directive

( ) The patient does not have a psychiatric advance directive (PAD)
( ) I was unable, after reasonable inquiry, to determine at this time whether the patient has a PAD
( ) The patient has a PAD which is appended hereto.
( ) The PAD names _____to act as a Mental Health Care Representative
( ) The PAD does not name a Mental Health Care Representative.
( ) The patient claims to have a Psychiatric Advance Directive but it has not, after a reasonable search, been found.

III. FINDINGS

A. Reasons for screening. Describe circumstances that led to the consumer being brought to the screening service. Describe symptoms and behaviors._____

_____

_____

_____

_____

Attach extra sheets or relevant documents marked "III A." if more room is required for explanation. You may also attach copies of progress notes, records and other relevant documentation if it would be more efficient.

B. Describe the person's mental illness (refer to the definition above and include person's psychiatric diagnoses and mental health history, including his/her recent and past treatment history:_____

_____

_____

Attach extra sheets or relevant documents marked "III B." if more room is necessary for explanation. You may also attach copies of progress notes, records and other relevant documentation if it would be more efficient.

C. Is it likely that this disturbance is a result of simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability?

No____ Yes____

If yes, state cause and test results or symptoms supporting this conclusion: _____

_____

_____

D . Does the patient have a history of substance abuse?

No____ Yes_____

If yes, provide detail:

_____

_____

_____

E. Patient's dangerousness due to mental illness. Check and describe only appropriate items:

( )Dangerous to self/suicidal
Describe the danger: Include history of recent and past attempts, whether there are current suicidal threats, plans or intent (quote statements made), availability and lethality of means, or recent actions and behaviors indicating serious psychiatric deterioration, that make it more likely than not that serious harm or death will result from this person's actions within the reasonably foreseeable future.

_____

_____

_____

( ) Dangerous to self/not suicidal
Describe the danger. Include history, self-injury threats, plans or intent (quote statements made), or recent actions and behaviors, that would make it more likely than not that substantial bodily injury, serious physical debilitation, death or serious psychiatric deterioration will result within the reasonably foreseeable future. If indicated, also describe how person has behaved so as to indicate that he/she is unable to satisfy his need for nourishment, essential medical care or shelter.

_____

_____

_____

( ) Dangerous to others
Describe the danger: Include history, threats, plans or intent (quote statements made) to hurt others, availability and lethality of means, or recent actions, behaviors or serious psychiatric deterioration indicating a substantial likelihood that this individual will inflict serious bodily harm on another person within the reasonably foreseeable future. If known, identify intended victim(s).

_____

_____

_____

( ) Dangerous to property
Describe the danger: Include history, threats, plans or intent (quote statements made), availability of means, person's recent actions or behavior, or serious psychiatric deterioration indicating a substantial likelihood that this individual will cause serious property damage within the reasonably foreseeable future.

_____

_____

_____

F. Documentation of diversion attempts. Identify interventions or services which have been attempted to stabilize the person and avert the need for involuntary or consensual admission. Check at least one column for each alternative.

Type of intervention	Appropriate	Not appropriate	Available	Not available
1. Existing natural support System				
2. Referral & Linkage to Community Services				
3. Crisis Intervention Counseling				
4. Outpatient Services for Medication Monitoring				
5. Adult acute partial hospital, partial hospital or partial care services				
6. Acute in home services (e.g., PACT)				
7.Extended Crisis Evaluation Bed with Medication Monitoring				
8.Crisis Housing				
9. Referral to other non-mental health 24 hour facility				
10.Admission on a voluntary basis to a psychiatric unit of a general hospital				
Other (describe) _____ _____ _____ _____ _____				

IV. DISPOSITION

A. Recommendation for involuntary commitment to treatment (if consensual go to section V)

( ) involuntarily commitment to inpatient facility because (check all that apply)
- ( ) the danger presented by this patient is imminent, or
- ( ) involuntary outpatient treatment is unavailable, or
- ( ) involuntary outpatient treatment is not sufficient to render the patient unlikely to be dangerous in the reasonably foreseeable future.

( ) commitment to involuntary outpatient treatment because the danger that is presented by the patient's condition, while reasonably foreseeable, is not at this time imminent, and outpatient treatment is sufficient to render the patient unlikely to be a danger in the reasonably foreseeable future. Patient __has been or __will be referred for admission to a functioning outpatient program in this county which has availability provided by:

_____
(provider)

Detail patient's past history of responding to treatment. What treatment modalities were successfully utilized in stabilization and managing safe behavior in the community?

_____

_____

_____

Attach notes or extra sheets marked "IOC recommendation" if needed for full explanation.

( ) I have spoken to _____ at the designated outpatient provider to discuss referral and development of a treatment plan.

Outpatient commitment treatment plan
I recommend the following as essential elements of any treatment plan implemented for this patient by an outpatient treatment provider:

( ) Medication monitoring @_____
( ) Group therapies _____
( ) Individual therapy@_____
( ) Case management_____
( ) Residential supervision_____
(describe intensity of supervision required)_____
( ) other services and programs required to maintain or lessen current level of dangerousness
( ) PACT_____

B. Least restrictive available setting rationale.
If involuntary commitment to an inpatient facility is recommended, briefly explain why no less restrictive intervention/service was appropriate and available and describe why the individual's current mental health condition renders him or her imminently dangerous or why commitment to outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future.

_____

_____

_____

_____

V. Signature of Screener Completing this Document

I am a NJ Certified Mental Health Screener and an employee of _____. On the date identified below my signature, I completed a screening assessment of _____ pursuant to N.J.A.C. 10:31-2.3(b)-(e). I assure that the information in this document is a true and accurate record of the information obtained during that assessment and that the findings and recommendations therein accurately reflect my professional opinion based on that information.

(Fill out only one side below)

.....

SCREENING DOCUMENT	:	CONSENSUAL ADMISSION DOCUMENT
_____	:	_____
Signature of Screener	:	Signature of Screener
_____	:	_____
Screener Number	:	Screener Number
_____	:	_____
Date	:	Date
_____	:	_____
Time	:	Time