55 NJR 11(1)
November 6, 2023
Filed October 19, 2023

HEALTH

INTEGRATED HEALTH BRANCH

Patient Supervision at State Psychiatric Hospitals

Transfers of Involuntarily Committed Patients Between State Psychiatric Facilities

Readoption with Amendments and Recodification: N.J.A.C. 10:36 as 8:135

Adopted New Rule: N.J.A.C. 8:135-2.5

Proposed: May 1, 2023, at 55 N.J.R. 812(a).

Adopted: September 22, 2023, by Kaitlan Baston, MD, MSc, DFASAM, Acting Commissioner, Department of Health.

Filed: September 22, 2023, as R.2023 d.125, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:1-12, 30:4-24.2, and 30:9A-10; and Reorganization Plan Nos. 001-2017 and 001-2018.

Effective Dates: September 22, 2023, Readoption;

November 6, 2023, Recodification, Amendments, and New Rule.

Expiration Date: September 22, 2030.

Summary of Public Comments and Agency Responses:

The Department of Health (Department) received comments from the following:

1. Louis C. Becker, Psy.D., M.S.W., Ancora, NJ;

2. Mary A Ciccone, Director of Policy, Disability Rights New Jersey, Trenton, NJ;

3. Heather Simms, Deputy Director of Advocacy and Peer Services, Collaborative Support Programs of New Jersey, Freehold, NJ; and

4. Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of New Jersey, Freehold, NJ.

The numbers in parentheses following each comment correspond to the commenters listed above.

General Comments

Support of Rulemaking

1. COMMENT: Commenters state that they support the comments of commenter 2. (3 and 4)

RESPONSE: The Department acknowledges the commenters' support of the comments of commenter 2.

Use of Destigmatizing Language

2. COMMENT: A commenter states that proposed technical amendments "to address language that stigmatizes or objectifies [patients] who have mental health diagnoses do not address all concerns. [The proposed technical amendments] were intended to 'update rule text to use gender-neutral language' and 'remove language that tends to stigmatize or objectify patients who have psychiatric illnesses.' [The commenter applauds the Department's] efforts to make the [rule text] more person-centered and inclusive, [and suggests] additional changes to further that goal."

The commenter states that although the term, "'patient' has been frequently changed to 'resident' throughout, there remain a few instances [in other chapters of Title 8 of the New Jersey Administrative Code], such as [at N.J.A.C.] 8:39-25.3(a) and 8:43E-3.4(a)(22) where the word 'patient' remains …. This term stigmatizes residents of

psychiatric facilities and defines them by their mental health disabilities. Many service providers have moved to the use of 'resident,' 'peer,' 'service recipient,' and other terms [that] remove the hierarchical relationship dynamics seen with doctor and patient." (2)

RESPONSE: The Department acknowledges the commenter's support of proposed technical amendments to make the rule text gender-neutral and remove text that stigmatizes or objectifies patients of the State psychiatric hospitals.

The existing chapter, consistently throughout, uses the term, "patient," to refer to persons who receive health services from State psychiatric hospitals, except at existing N.J.A.C. 10:16-3.4(e)2 and 3, at which the term, "resident," incorrectly appears, which the Department proposed to correct to use the term, "patient." The Department considers persons who receive health services in State psychiatric hospitals to be patients and identifies nothing pejorative in the use of the term. Therefore, the Department will continue to refer to such persons using the term "patient" and will make no change upon adoption in response to this aspect of the comment.

The commenter's request that the Department revise terminology used in other chapters of Title 8 of the New Jersey Administrative Code would exceed the scope of the proposed rulemaking. Therefore, the Department will make no change upon adoption in response to this aspect of the comment.

N.J.A.C. 8:135-1.2 Definitions

<u>Special Status Patient</u>

3. COMMENT: A commenter states that the proposed amendment to the list of crimes that cause a patient to meet the definition of the term "special status patient," at

N.J.A.C. 8:135-1.2, would “improperly broaden the scope of the status” and “would increase the number of hospital residents classified as ‘special status.’ These [patients] are more likely to remain institutionalized and have less autonomy. Historically, … ‘special status’ patients have additional barriers to finding community supports upon discharge. ‘Special status’ is supposed to indicate where the patient’s history or other factors indicate a predisposition for serious violent or other high-risk behavior. [The proposed amendment to the definition of the term, ‘special status patient,’ would] overly broaden the scope of that population.

First, adding ‘attempt’ crimes to the list of crimes that attach ‘special status’ to [a patient] unnecessarily broadens the number of individuals under ‘special status’ subject to the same barriers to discharge and restrictive environments as those who were actually convicted of the completed crimes. [The commenter] recommends removing ‘attempt’ crimes from the definition of ‘special status [patient],’ and reverting to the prior definition of delineated crimes.

Second, the proposed amendment [at subparagraph 1v of the definition of the term, ‘special status patient’] makes no distinction between the degrees of robbery, whereas only ‘first degree robbery’ had special status attached in the [existing definition at N.J.A.C. 10:36-1.2]. According to N.J.S.A. 2C:15-1, robbery is only considered ‘a crime of the first degree if in the course of committing the theft the actor attempts to kill anyone, or purposely inflicts or attempts to inflict serious bodily injury, or is armed with, or uses or threatens the immediate use of a deadly weapon.’ [The commenter] recommends that ‘special status’ only apply to first-degree robbery, as [within the existing definition at N.J.A.C. 10:36-1.2]. Including all classes of robberies unfairly

broadens the class of ‘special status [patients]’ … as those accused or convicted of second-degree robbery have not shown the same ‘predisposition for serious violent’ behavior as those accused or convicted of first-degree robbery.

Third, the proposed [amendment of the definition of the term, ‘special status patient’ would add at subparagraph 1x would add] ‘carjacking’ to the list, an addition [that] unnecessarily expands the scope of ‘special status.’

These changes are also not reflected in the [Economic Impact]. The potential to create more special status patients, with arguably higher care needs and longer stays, will potentially raise costs to the taxpayer.” (2)

RESPONSE: The proposed amendment, which would add carjacking to the list of crimes that one could commit and add attempted commission of one of the listed crimes, to the characteristics that result in the identification and treatment of a person as a “special status patient,” would more accurately reflect the behaviors and mental status that warrant the special status designation and the enhanced review associated with a change in such a patient’s level of supervision. The proposed amendment would fill in existing gaps in the definition.

Carjacking is a serious offense and shares many similarities with the offenses of aggravated assault, kidnapping, and robbery. A person who is charged with, and convicted of, any one of these offenses, which may even occur as part of a carjacking, would cause the person to meet the existing definition of a “special status patient.” However, if the person is charged with, and convicted of, the crime of carjacking, the person would not meet the existing definition of a “special status patient,” even though

the conduct in which the person engaged may otherwise cause the person to meet the definition of a “special status patient.”

Similarly, a person who is convicted of attempted murder has demonstrated the necessary intention, and taken actions in furtherance of, the listed crime of murder, but would not meet the definition of a “special status patient,” even though the person’s actions and intention might have warranted conviction for the listed crime of aggravated assault.

A person who demonstrates the necessary intention and performs actions in furtherance of an effort to complete a listed crime, but who fails and is convicted instead of an attempt to commit one of the listed crimes, would not meet the existing definition of a “special status patient.” To exclude a person with this history from designation as a “special status patient” would undermine the purposes for which the “special status patient” supervision classification exists, which is to ensure that the performance of an assessment of required supervisory levels occurs for patients whose past conduct indicates a special risk to themselves or others.

For the foregoing reasons, the Department will make no change upon adoption in response to the comment.

Treatment Plan

4. COMMENT: A commenter notes that the definition of the term “treatment plan” at N.J.A.C. 8:135-1.2 states that the plan is “based upon the patient’s diagnosis and inventory of strengths and weaknesses.” The commenter states that the “use of the term ‘weaknesses’ here is problematic,” and that the use instead of a term, “such as

‘barriers’ would be less stigmatizing and more appropriate, as such terms reflect that peers receiving services may experience setbacks in the discharge process, many of which are out of their control.” (2)

RESPONSE: The use of the term, which the commenter suggests, “barrier” in the context of the definition of the term “treatment plan” might be confusing in practice, because the term “barrier” commonly is used in the context of patient discharge planning to denote issues that are outside of a patient's control, such as issues with funding or immigration. In the context of treatment plan development, use of the term “weaknesses” would avoid this potential for confusion and more aptly reflects the Department’s intended meaning in defining the term “treatment plan.” Therefore, the Department will make no change upon adoption in response to the comment.

5. COMMENT: A commenter states that the rules proposed for readoption with amendments and recodification refer “to the use of evidence-based risk assessment tools. Risk assessment tools can be influenced by subjective judgments and biases, which can affect the accuracy of the results ... This can be problematic if these biases are not recognized or acknowledged by the organization using the tool, and, instead, repeatedly used as though they provide an accurate depiction. Currently, the three prominent risk assessment tools being used are HCR-20, VRAG, and SORAG. These risk assessment tools have different sources finding them to be limited in their effectiveness.” The commenter requests that the Department “provide additional supporting documentation that the risk assessment tools used [at the State psychiatric hospitals] are evidence-based and non-discriminatory and that [the Department]

reevaluate the risk assessment tools used periodically to ensure that they remain supportable by evidence." (2)

RESPONSE: The Department acknowledges that available risk assessment tools have the potential for inherent bias; however, the commenter overemphasizes the Department's reliance on the use of these tools in determining a patient's level of supervision. The rules proposed for readoption with amendments, recodification, and a new rule would continue to require the use of structured professional judgment on the part of the patient's treatment team in determining the level of supervision that is appropriate for each patient. The use of structured professional judgment provides the treatment team a more wholistic view of each individual patient, thereby minimizing potential bias that might be inherent to the use of risk assessment tools alone. It can also capture progress in treatment, whereas actuarial tools, such as risk assessment tools, cannot. While risk assessment tools might still be used, the chapter clearly calls for the use of structured professional judgment when making determinations on the level of supervision appropriate for a patient. See, for example, N.J.A.C. 8:135-1.3(e)2, as proposed for amendment, which would require the treatment team to adjust the time a patient is on a level of supervision when clinical progress indicates an adjustment is appropriate based on a structured professional judgment of risk. Based on the foregoing, the Department will make no change upon adoption in response to the comment.

Treatment Team

6. COMMENT: A commenter states that the treatment planning process as proposed for amendment is "not person-centered" and that the Department should revise the process "to increase the degree in which the [patients] of psychiatric hospitals have input into their care and their freedom." The commenter states that "42 CFR 482.60 (referring to 42 CFR 482.13) … requires that patients in psychiatric hospitals have the [right] to participate in the development and implementation of their treatment [plans]." With respect to the definition of the term "treatment team" as proposed for amendment at N.J.A.C. 8:135-1.2, the commenter states that paragraph 2 "suggests that [patients] should be participants in their treatment." The commenter "strongly agrees with this sentiment," but is "concerned" because of "the lack of inclusion of the [patient] in the" first sentence of the definition of the term "treatment team" which states that the treatment team "means the organized group of clinical staff who are responsible for the treatment of a specific patient who has been admitted to an adult psychiatric hospital." The commenter states that "including the [patient] as part of the treatment team would help increase the [patient's] participation in the development and implementation of [the patient's] treatment plan, and increase [the patient's] investment in [the patient's] own treatment."

The commenter states that, in the definition of the term "treatment team" at paragraph 2, the statement that a patient "shall be permitted" to participate in the development of the treatment plan "gives the impression of a hierarchy, of which patients are at the bottom … does not point to the importance of the [patient's]

participation in [the patient’s] own treatment plan[, and] suggests that [patients] being included in their own treatment planning is a permissive exception.”

The commenter states that the phrase, “to the extent that the patient’s clinical condition permits,” in the definition of the term, “treatment team,” at paragraph 2, would establish a standard that “is too subjective; a patient should be ‘permitted’ to participate in nearly every circumstance, barring a complete inability to engage in the process. A [patient’s] involvement in [the patient’s] treatment team planning is of the utmost importance, and any potential barriers put in place of that involvement are unacceptable.” (2)

RESPONSE: The treatment team consists of the individuals who provide treatment to the patient. The patient is not a treatment provider. Nonetheless, the definition of the term “treatment plan” at paragraph 2, as proposed for amendment, would state that a “patient is expected, and shall be permitted, to participate in the development of the treatment plan to the extent that the patient's clinical condition permits.” This requires the treatment team to ensure that a patient has the opportunity to elect to participate in the development of the patient’s treatment plan unless some aspect of the patient’s clinical condition would impede the patient’s participation. This emphasizes the importance of the patient’s participation in treatment planning. Based on the foregoing, the Department will make no change upon adoption in response to the comment.

7. COMMENT: A commenter requests that the Department revise paragraph 4 of the definition of the term “treatment team,” as proposed for amendment at N.J.A.C. 8:135-1.2, to provide that treatment “team members shall include, at a minimum,” a

psychologist, in addition to the other listed members. The commenter states that psychologists "are the responsible discipline to assess the patient's risk of violence using evidence-based risk assessment tools that [address] the violence risk of patients under the SSPRC review. They are a critical part of the team as their unique expertise/training is utilized when assessing risk of violence. [It is] necessary to list the psychologist as an essential treatment team member, especially as it relates to potentially high-risk individuals who fall under the [special status] designation." (1)

RESPONSE: Paragraph 4 of the definition of the term "treatment team" is not proposed for amendment. N.J.A.C. 8:135-2.2, as proposed for amendment, at subsection (c), would continue to require the Director of Psychology to be a member of the SSPRC.

N.J.A.C. 8:135-1 Levels of Supervision System

8. COMMENT: A commenter has "concerns about the [term 'levels of supervision'] as it implies a paternalistic degree of control over [patients]." The commenter suggests that the Department change the term to "levels of service." (2)

RESPONSE: The Department acknowledges the commenter's concerns. The term "levels of supervision" more accurately reflects the reality of the oversight that a patient in a State psychiatric hospital must receive as a therapeutic and risk management element of the patient's care and treatment. The phrase that the commenter suggests, "level of service," is imprecise as it might cause confusion with the term "treatment plan," which establishes "the plan of care that defines and delineates the comprehensive course of therapeutic and rehabilitative activities proposed for an individual patient"; in other words, the services that a State psychiatric hospital is to

provide a patient. Based on the foregoing, the Department will make no change upon adoption in response to the comment.

N.J.A.C. 8:135-1.4 Procedures

9. COMMENT: A commenter states that there is ambiguity in the "determination of levels of supervision" and states that the rules proposed for readoption with amendments, recodification, and a new rule, "are supposed to streamline and restate the responsibilities of hospital and [Division] staff in implementing the supervision levels system. This objective cannot be reached because the [rules] lack adequate detail as to what determines a [patient's] level of supervision. Without standardized protocols defining what level of supervision each [patient] is to receive, supervision levels are subject to subjective decision-making and the potential for coercive or punitive actions by staff. To ensure consistency across the [State] psychiatric hospitals," the commenter "urges more guidance on the frequency of patient risk assessments that are required for the various levels of supervision" and suggests that the Department "develop a protocol that provides clear reasons for why a [patient] is considered one level over the other. In addition, this protocol should be transparent to the [patients]." Transparency will keep [patients] informed on why they are considered one level, and what is needed for them to advance to another level." (2)

RESPONSE: N.J.A.C. 8:135-1.4(b), as proposed for amendment, establishes a standard as to the frequency of assessments to determine a patient's appropriate level of supervision, requires adherence to the reassessment standards of the facility's accrediting body, and provides the opportunity for patients themselves and their

representatives to request reassessment. Likewise, N.J.A.C. 8:135-2.5(a)1, as proposed for amendment, would continue to require a violence risk assessment for special status patients to occur upon admission, at least annually, on the request of patients or their representatives, as part of discharge planning, and when a patient's change in behavior warrants review of the patient's violence risk assessment. Therefore, the Department disagrees with the commenter's statement that the chapter does not provide specific guidance as to the frequency with which level of supervision and violence risk assessments are to occur. Based on the foregoing, the Department will make no change on adoption in response to the comment.

N.J.A.C. 8:135-2.2 Composition of Special Status Patient Review Committee

10. COMMENT: A commenter notes that, as proposed for amendment, N.J.A.C. 8:135-2.2, Composition of special status patient review committee (SSPRC), at subsection (c), would no longer require the directors of, respectively, nursing and rehabilitation of a State psychiatric hospital "to sit on the SSPRC" and that this "will result in less transparency in the SSPRC process and may, possibly, result in more arbitrary decisions by the Committee. The SSPRC must be familiar with the [patient's] entire circumstances to make an equitable ruling on their special status. Words written in a chart should not be determinative of a [patient's] status, and [the commenter is] concerned that removing the professionals will result in the SSPRC just reviewing a [patient's] chart while … making [its] decisions." The commenter recommends that the Department reconsider "the decision to remove the requirement that [these directors] sit on the SSPRC."

The commenter states that N.J.A.C. 8:135-2.2, as proposed for amendment, would permit “hospitals to appoint” designees of the SSPRC’s required members. The commenter “has grave concerns about the lack of clarity in the appointment and qualifications of the designee” and states that the rule would “provide … no protocol for the appointment of the designee, and there is no way to ensure that the designee of [a director] is competent to make a determination of the [patient’s] special status.” The commenter recommends that the Department require the medical director of a State psychiatric hospital, rather than a designee, to “sit on the SSPRC,” insert “clarification as to the qualification of a designee, or [place] safeguards on the designee’s authority, such as requiring later signoff from the director who appointed the designee, to protect the rights of [patients]. (2)

RESPONSE: The commenter is incorrect in stating that N.J.A.C. 8:135-2.2(c), as proposed for amendment, would allow “hospitals” to appoint SSPRC members’ designees and would establish “no protocol for the appointment of the designee.” N.J.A.C. 8:135-2.2(c)1 would maintain the provision in the existing rule text that at least one member of an SSPRC must be a psychiatrist. Likewise, N.J.A.C. 8:135-2.2(c)2 would maintain the provision in the existing rule text that SSPRC members themselves, that is, not State psychiatric hospitals, “may appoint designees … who are of sufficient experience to appropriately review” matters coming before an SSPRC, and would continue to prohibit an SSPRC member’s designee from endorsing a recommendation in the making of which the designee participated or that the designee made in the capacity of being a member of a special status patient’s treatment team. Thus, contrary to the commenter’s assertion, N.J.A.C. 8:135-2.2 would not permit “hospitals” to appoint

designees, would establish a minimum standard for the maintenance of a psychiatrist on the SSPRC and the qualifications pursuant to which members are to appoint designees, and would require designees to be of sufficient experience to appropriately review SSPRC matters.

Summary of Agency-Initiated Changes:

The Department is making the following changes upon adoption:

1. The Department is changing the chapter heading to indicate that the chapter addresses “transfers of involuntarily committed patients between State psychiatric facilities,” in addition to addressing patient supervision.

2. The Department is changing the section heading of N.J.A.C. 8:135-1.4 from “Procedures” to the more descriptive heading “Supervision level assignment procedure.”

3. The Department is changing N.J.A.C. 8:135-1.3(c)2 and 3 and 2.3(i) upon adoption to retain Division administrative review of determinations to decrease a patient’s levels of supervision (as was codified in the exiting rule text). The Division is retaining the language regarding the oversight of a decrease in level changes. The deletion of existing paragraph (c)1 and oversight of increase in level changes will remain deleted.

To maintain continuity with the change to the general provisions section at N.J.A.C. 8:135-1.3(c)2 and 3, changes are also being made upon adoption at N.J.A.C. 8:135-2.3(i). The portion of subsection (i) that maintains that the SSPRC have oversight of the granting of a patient’s decrease to Level III or IV will remain unchanged from the existing language.

4. The Department is not adopting the proposed addition of the term, “agency” at N.J.A.C. 8:135-2.3(i)1, to prevent confusion as to the forum to which reviews of such decisions are presented. Commitment determinations are reviewed upon presentation to the civil commitment court pursuant to N.J.S.A. 30:4-24 through 30:4-27.38, and not to the Office of Administrative Law.

Federal Standards Statement

42 CFR 482.13(b)(1) is Federal standard that applies to health care facilities that receive funding from the Centers for Medicare and Medicaid Services, which include the State psychiatric hospitals. This provision establishes a patient’s right to participate in the planning and implementation of the patient’s plan of care. The rules readopted with amendments and new rule meet but do not exceed this standard.

Except as stated above, the rules readopted with amendments and new rule are not adopted pursuant to the authority of, or in order to implement, comply with, or participate in, a program established pursuant to Federal law or a State statute that incorporates or refers to any Federal law, standard, or requirements. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 8:135.

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

CHAPTER 135

PATIENT SUPERVISION AT STATE PSYCHIATRIC HOSPITALS ***AND TRANSFERS OF INVOLUNTARILY COMMITTED PATIENTS BETWEEN STATE PSYCHIATRIC FACILITIES***

8:135-1.3 General provisions

(a)-(b) (No change from proposal.)

(c) With regard to special status patients, the following procedures apply:

1. Prior to implementation, any ***decrease in supervision or*** discharge decision shall be approved through hospital administrative review procedures, as delineated at N.J.A.C. 8:135-2.3.

***2. A decision to decrease to levels III or IV shall be approved through both hospital and Division administrative review.**

3. A decision to discharge or transfer a special status patient to a less restrictive setting within the hospital (for example, a cottage) requires approval through both hospital and Division administrative review.*

[2.] ***4.*** (No change in text from proposal.)

(d)-(g) (No change from proposal.)

8:135-1.4 *[Procedures]* ***Supervision level assignment procedure***

(a)-(d) (No change from proposal.)

8: 135-2.3 Procedures for review of recommendations and determinations; final *[agency]* decision

(a)-(h) (No change from proposal.)

(i) If a special status patient’s treatment team and the SSPRC both recommend the ***granting of a supervision decrease to Level III or Level IV or the*** patient’s discharge, then, within two days of the SSPRC finalizing its recommendation, the SSPRC shall forward to the Division Medical Director the information that the treatment team submitted to the SSPRC, the material that the SSPRC submitted to the clinical or medical director, and the recommendations of the treatment team and the SSPRC.

1. Following review of the material transmitted pursuant to this subsection, the Division Medical Director shall issue a determination as to the special status patient's discharge, which will be a final *[agency]* action, and notify hospital staff of the determination by no later than five working days after the Division Medical Director’s receipt of the material transmitted pursuant to this subsection.

(j)-(l) (No change from proposal.)