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HEALTH

INTEGRATED HEALTH BRANCH

Patient Supervision at State Psychiatric Hospitals

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

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

Authorized By: Judith M. Persichilli, R.N., B.S.N., M.A., Commissioner, Department of Health.

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.

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

Proposal Number: PRN 2023-034.

Submit written comments by June 30, 2023, electronically to http://www.nj.gov/health/legal/ecomments.shtml, or by regular mail postmarked by June 30, 2023, to:

Joy L. Lindo, Director

Office of Legal and Regulatory Compliance

Office of the Commissioner

New Jersey Department of Health

PO Box 360

Trenton, NJ 08625-0360

The agency proposal follows:

Summary

Reorganization Plan No. 001-2017, A Plan for the Transfer of Mental Health and Addiction Functions From the Department of Human Services to the Department of Health (Governor Christie, filed June 29, 2017, and effective August 28, 2017), at § 1, and Reorganization Plan No. 001-2018, A Plan for the Transfer of Certain Mental Health and Addiction Functions From the Department of Health to the Department of Human Services (Governor Murphy, issued June 21, 2018, effective August 20, 2018), at § 3, transferred the functions, powers, and duties exercised by the Division of Mental Health and Addiction Services (DMHAS) within the Department of Human Services (DHS), with regard to the operation and administration of the State psychiatric hospitals, to the Department of Health (Department). 50 N.J.R. 1517(a).

Pursuant to this authority, the Department of Health (Department) proposes to readopt N.J.A.C. 10:36, Patient Supervision at State Psychiatric Hospitals, and recodify N.J.A.C. 10:36 as new N.J.A.C. 8:135 to reflect the transfer of authority from DHS to the Department. The Department proposes substantive amendments, more fully described below, and non-substantive amendments throughout the chapter to delete references to the DHS and its divisions and add in place thereof, references to the Department, use gender-neutral language, reorganize sections, improve readability, improve grammar, eliminate the passive voice, remove unnecessary capitalization, and update terminology that tends to stigmatize or objectify patients who have psychiatric illnesses. Pursuant to N.J.S.A. 52:14B-5.1.c, N.J.A.C. 10:36 was scheduled to expire on March 29, 2023. Pursuant to N.J.S.A. 52:14B-5.1.c(2), that date was extended 180 days to September

25, 2023, as this notice of proposal was submitted to the Office of Administrative Law prior to the expiration date.

N.J.A.C. 10:36, Patient Supervision at State Psychiatric Hospitals, establishes the requirements for supervision of patients in State psychiatric hospitals, including patients designated as having “special status,” and transferring patients who have been involuntarily committed. DHS originally promulgated N.J.A.C. 10:36 in 1986. 17 N.J.R. 2593(a); 18 N.J.R. 1704(a). DHS readopted N.J.A.C. 10:36 in 1992. 24 N.J.R. 1728(a); 2730(b). In December 1992, DHS readopted N.J.A.C. 10:36 with amendments regarding administrative and treatment procedures at Subchapters 1 and 2. 24 N.J.R. 4232(a); 25 N.J.R. 583(b). DHS readopted N.J.A.C. 10:36 with amendments in 1998 to update the names of agencies and add requirements for treatment teams. 29 N.J.R. 3763(b); 30 N.J.R. 386(a). DHS readopted N.J.A.C. 10:36 with amendments in 2003 to update language and procedures at Subchapter 1, make grammatical changes at Subchapter 2, and update the transfer procedures at Subchapter 3. 34 N.J.R. 4290(a); 35 N.J.R. 2903(a). DHS readopted N.J.A.C. 10:36 without change in 2008 and 2015. 40 N.J.R. 2183(a); 6458(a) and 43 N.J.R. 1203(a), respectively.

Subchapter 1, Levels of Supervision System, describes the system used to make clinical determinations regarding the degree of structure and supervision needed for patients in State psychiatric hospitals.

N.J.A.C. 10:36-1.2, Definitions, establishes definitions of terms the chapter uses. The Department proposes to amend the definition of the term “special status patient” to add charges for attempted crimes and carjacking to the qualifying offenses and update the process by which the Department would review special status designation. The

Department also proposes to add a definition for the “special status patient review committee.” The proposed amendment to the existing definition of the term “treatment plan” would add a requirement for an assessment of a patient’s risk of violence. The Department proposes to delete the term “ward” and replace it with “unit” and to update usages of the terms throughout the chapter.

Existing N.J.A.C. 10:36-1.3, General provisions, establishes general provisions. The Department proposes to amend this section by removing the requirement for approval prior to any decreases of supervision. Approval would only be needed for discharge decisions, which would be based on risk status. The Department proposes to further amend this section to restate the responsibilities of hospital and division staff in implementing the levels of supervision system.

Subchapter 2, Clinical Review Procedures for Special Status Patients, establishes the procedures for reviewing the treatment and supervision of patients meeting criteria as “special status.” N.J.A.C. 10:36-2.1, Statement, purpose, and scope, establishes the purpose and scope of the subchapter, which is to establish clinical review procedures for special status patients. The Department proposes to exclude levels of supervision from the required circumstances that require a comprehensive review. N.J.A.C. 10:36-2.2, Composition of the special status patient review committee, establishes the composition of the special status patient review committee. The Department proposes to amend this section by removing the requirement that the Director of Nursing and Director of Rehabilitation sit on the committee, and the option to include a designee of the medical director, director of psychology, or director of social services on the committee. New N.J.A.C. 8:135-2.3(l) is proposed pertaining to

supervision and discharge procedure adherence. New N.J.A.C. 8:135-2.4(a)5 is proposed pertaining to the responsibilities of the coordinator to obtain certain records. The Department proposes new N.J.A.C. 8:135-2.5, Treatment team procedures, to specify the procedure by which treatment teams evaluate the risk of violence in special status patients by requiring teams to use of evidence-based risk assessment tools. The findings of this assessment would inform the decision-making process in the treatment of patients and plans for transfer or discharge.

Subchapter 3, Transfers of Involuntarily Committed Patients Between State Psychiatric Facilities, establishes the factors and procedures for transferring patients who have been involuntarily committed to a State psychiatric hospital. The Department proposes to amend the subchapter by updating cross-references throughout. N.J.A.C. 10:36-3.4, General procedures, establishes the general procedures for transferring patients to and from State psychiatric hospitals. The Department proposes to amend this section by deleting the reference to the Division's Assistant Director in the Office of State Hospital Management and adding in place thereof, a reference to the Division Medical Director, to reflect changes resulting from the Reorganization Plans.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

N.J.A.C. 10:36, proposed for readoption and recodification with amendments and a new rule, provides consistency in the supervision and discharge determinations made by the interdisciplinary teams responsible for treatment planning at State-run psychiatric

hospitals. It is based on the concept of individualized decision-making that balances the objectives of effective treatment, personal liberty, and prevention of harm. As it operationalizes the principle of "treatment in the least restrictive conditions necessary to achieve the purposes of treatment," it would continue to benefit patients, staff, and the public. The proposed amendments and new rule provide greater specificity and explanation of the chapter's requirements and, thus, enhance the reader's understanding and advance notice of the chapter's provisions.

By providing uniform policies and procedures regarding patient supervision at State psychiatric hospitals within applicable legal parameters, the rules proposed for readoption with amendments and a new rule would continue to have a positive social impact on the patients at those facilities and other parties interested in the quality of their care, and help to ensure that patients in State psychiatric hospitals receive appropriate treatment in programs that the hospitals customize to patients' care needs, consistent with applicable law and balanced with the need to protect the public from potentially dangerous behavior by some patients.

Economic Impact

No additional costs, either to the public or any State agency, are expected to result from this rulemaking, as it is designed to structure a clinical decision-making process which has been in existence for some time. By providing uniform hospital policies and procedures regarding patient supervision and discharge, the rules proposed for readoption with amendments and a new rule foster cost-effective programs, which is a form of social savings for both patients and the public. The Department does not anticipate a direct economic effect on any specific individuals by

the rules proposed for readoption with amendments and a new rule. No additional administrative costs are required, and no funding sources are affected.

Federal Standards Statement

A Federal standards analysis is not required because the Department does not propose to readopt this chapter with amendments and a new rule under the authority of, or to implement, comply with, or participate in, a program established under Federal law or under a State law that incorporates or refers to Federal law, standards, or requirements.

Jobs Impact

There is no foreseeable impact to jobs due to the rules proposed for readoption with amendments and a new rule. There is no stated or planned increase in the number of employees due to the rules proposed for readoption with amendments and a new rule.

Agriculture Industry Impact

The rules proposed for readoption with amendments and a new rule would not have an impact on the agriculture industry.

Regulatory Flexibility Statement

The rules proposed for readoption with amendments and a new rule would establish requirements applicable only to State psychiatric hospitals, none of which is a small business within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required.

Housing Affordability Impact Analysis

The rules proposed for readoption with amendments and a new rule would not have an impact on the affordability of housing or the average costs associated with housing in New Jersey, because the rules proposed for readoption with amendments and a new rule address psychiatric hospitals procedures and have no bearing on housing costs.

Smart Growth Impact Analysis

The rules proposed for readoption with amendments and a new rule would not have an impact on the achievement of smart growth in this State and there is an extreme unlikelihood that the rules proposed for readoption with amendments and a new rule would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan, because the rules proposed for readoption with amendments and a new rule address psychiatric hospital procedures and have no bearing on development in the State.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:36.

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

CHAPTER [36] **135**

PATIENT SUPERVISION AT STATE PSYCHIATRIC HOSPITALS

SUBCHAPTER 1. LEVEL**S** OF SUPERVISION SYSTEM

[10:36]**8:135**-1.1 Introduction and purpose

(a) The [Levels] **levels** of [Supervision System] **supervision system (system)** is designed to provide a timely, uniform process which affords each patient the structure and intensity of supervision appropriate to [his or her] **the patient's** condition during the course of hospitalization.

1. The structure provided through the [levels] system takes the form of an individualized set of clinical interventions, schedule of activities, and conditions under which patients exercise their personal autonomy and liberty.

2. Level determination is based primarily upon the **patient's** clinical condition [of the patient] and related behaviors.

3. The [Levels of Supervision System] **system** is not a treatment modality or a [system of earned] **mechanism to earn** privileges[. It]**; rather, it** is a [mechanism] **tool** to be [utilized in making] **used to make** a clinical determination as to the degree of structure and supervision necessary for each patient to successfully participate in treatment and rehabilitation programs, while maintaining a safe and secure therapeutic [milieu] **environment** for patients and staff alike.

4. Appropriate structure and supervision [will also facilitate] **facilitates** each patient's successful participation in treatment and rehabilitation programs, which are designed to improve functioning [and]**,** promote positive social adjustment while hospitalized, **reduce risk of violence to self or others,** and [after discharge in the community] **move patients to the least restrictive setting as quickly as possible**.

5. The [Level of Supervision System] **system** is separate from and in addition to the clinical interventions of special precautions (for example, choking, suicide, arson**,** and escape precautions) and special levels of observations (two-to-one supervision, one-to-one supervision, constant visual observation, periodic visual observation, face checks, and head counts).

(b) The [Levels of Supervision System] **system** shall be interpreted and implemented in a manner that facilitates the effective treatment of each patient while maintaining the least restrictive setting necessary to accomplish individual goals identified in the treatment plan.

1. Under no circumstances shall this policy be interpreted and implemented in any manner that abridges liberties specified in the "Patients' Bill of Rights" (N.J.S.A. 30:4-24.2 et seq.).

(c) The [Treatment Team] **treatment team** shall determine the appropriate level for each patient upon admission [with] **and** review [of] the assigned level at any time during the course of **a patient's** hospitalization, but, minimally, at the patient's scheduled treatment planning review.

1. Level determinations shall be made in accordance with the parameters set forth herein.

2. Treatment teams shall [utilize] **use** these parameters to [promote] **motivate patients to exercise** increased responsibility, accountability**,** and independence [on the part of the patient] while **correspondingly** decreasing **the** structure and intensity of **staff** supervision [provided by the staff]. [Incremental]

i. These incremental steps [taken towards this goal shall be viewed as] **are** part of a continuum [that] **by which a patient** progresses through the system toward the goal of discharge with appropriate community support[s].

3. The [medical] **treatment team shall document in a patient's clinical** record [shall contain the documentation] **its justification for the level** that [justifies the level determined] **the treatment team determines to be** necessary [by the treatment team].

(d) The purpose of the system is:

1.-2. (No change.)

3. To establish a system that maximizes continuity of care for patients whenever transfer from [ward] **unit** to [ward] **unit**, or hospital section to hospital section becomes appropriate and necessary.

4. (No change.)

[10:36]**8:135**-1.2 Definitions

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

"CEO" means the [Chief Executive Officer] **chief executive officer** of a State [Psychiatric Hospital] **psychiatric hospital**.

"Division" means the Division of [Mental] **Behavioral** Health [and Addiction] Services, within the Department of [Human Services] **Health**.

"Department" means the Department of [Human Services] **Health**.

"Special status patient" means a patient who:

1. Is charged [with], **or** awaiting to be charged with**,** or convicted of**, or attempt to commit,** one of the following offenses:

i.-iv. (No change.)

v. [First degree robbery] **Robbery**;

vi.-vii. (No change.)

viii. Weapons offense; [or]

ix. Kidnapping[.]**; or**

x. Carjacking;

2. Has been hospitalized because [he or she] **the patient** has been adjudicated "Not Guilty by Reason of Insanity" (NGRI) or "Incompetent to Stand Trial" (IST) for one of the enumerated crimes [in] **at paragraph** 1 above [under] **pursuant to** N.J.S.A. 2C:4-1 et seq.**;**

i. If a patient's criminal charges have been dismissed or NGRI or IST status removed, [his or her] **the special status patient review committee must review the** special status designation [shall] **and send the designation to the Division for review to determine whether the SSPRC designation may safely** be removed**,** unless [he or she] **the patient** meets the standard [in] **at paragraph** 3 below; or

3. Has been determined by the treatment team to be clinically appropriate for consideration [by] **under** the [Special Status Patient] **special status patient** review process because [of his or her] **the patient's** history or other factors [indicating] **indicate** a predisposition for serious violent or other [high risk] **high-risk** behavior.

"Special status patient review committee" or "SSPRC" means a committee within a State psychiatric hospital that reviews recommendations and determinations for special status patients.

"Treatment plan" means the plan of care that defines and delineates the comprehensive course of therapeutic and rehabilitative activities proposed for an individual patient, based upon the patient's diagnosis and inventory of strengths and weaknesses.

1. The treatment plan shall [establish]**:**

i. Establish short-term and [long-range] **long-term** goals, the specific treatment modalities to be utilized, and the responsibilities of each member of the treatment team[.]**; and**

ii. Include an assessment of the patient's risk of violence using an evidence-based risk assessment tool approved by the Division Medical Director.

"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.

1. Members of the team meet to share their expertise with one another; [to] develop and implement treatment plans; [to] monitor patient progress; [to] reassess and [make adjustments in] **adjust** treatment plans, as needed; and [to] plan [discharge/aftercare] **discharge and aftercare**.

2. A patient is expected**,** and shall be permitted**,** to participate in the development of the treatment plan to the extent that [his or her] **the patient's** clinical condition permits.

3. Family members and significant others are encouraged**,** and shall be permitted**,** to [be part of] **participate in** the treatment planning process.

4. Treatment team members shall include, at a minimum, a psychiatrist, a registered nurse, and a social worker.

5. The treatment team shall request the participation of whatever other unit or community liaison staff is necessary for the treatment and responsible discharge of the patient.

["Ward"] **"Unit"** means [that] **an** area [where] **at which** a hospitalized patient sleeps, receives [services that are] medically and therapeutically necessary **services**, and is accounted for in the hospital census.

[10:36]**8:135**-1.3 General provisions

(a) The [Levels of Supervision System] **system** applies to all adult [regional] State [Psychiatric Hospitals] **psychiatric hospitals**.

(b) A description of the [Levels of Supervision System] **system** shall be posted on all [wards] **units** and communicated to patients.

(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 [in] **at** N.J.A.C. [10:36]**8:135**-2.3.

[2. An increase to levels 3 or 4 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.]

[4.] **2.** [In addition to the required reviews in (c)1 through 3 above, any] **Any** decrease in supervision **level** or discharge decision pertaining to a patient who is hospitalized because [he or she] **the patient** was found "Not Guilty by Reason of Insanity," or "Incompetent to Stand Trial" must be approved by order of the committing court prior to implementation.

(d) A patient may be discharged from the hospital while on any level, when documented as clinically appropriate **as indicated based upon risk status** and, [where] **if** applicable, when approved by court order.

I A patient is not required to go through each level in sequence.

1. The treatment team may increase or decrease the patient's assigned level of supervision as warranted in consideration of a significant change in the patient's clinical condition.

2. The treatment team shall [determine]**:**

i. Determine the amount of time [each] **that a** patient shall spend at a specific supervision level based upon the patient's clinical needs and treatment goals[,]**;** and [shall adjust]

ii. Adjust the time when clinical progress indicates that an adjustment is appropriate **based on a structured professional judgment of risk**.

(f) [Patients] **A patient** who disagree**s** with the treatment team regarding [their] **the patient's** assigned level of supervision may appeal through hospital grievance procedures or to the Division's [Representative] **patient service representative who is** assigned to each institution.

1. The [Client Service Representative] **patient service representative** will involve hospital administration and/or clinical staff**,** as indicated in the resolution of the disagreement.

(g) The [Levels of Supervision System shall be monitored by the] department in charge of continued quality improvement, or other designee of the Chief Executive Officer at each hospital**, shall monitor the system** to ensure that any staffing, programmatic, clinical**,** or other problems are identified and addressed.

[10:36]**8:135**-1.4 Procedures

(a) Upon admission, **a** patient[s] shall be [placed on] **assigned to supervision** Level I [of the Levels of Supervision System].

1. Within 72 hours, the treatment team shall assign the **patient to the supervision** level that is most appropriate**,** [to] **based on** the **patient's** clinical condition and treatment needs [of the patient].

(b) [Each] **The treatment team shall evaluate each** patient's **supervision** level [shall be evaluated] at least as frequently as [is called for in] the treatment plan review schedule **specifies**, [or] **and** more frequently if **reevaluation of a patient's supervision level is** clinically indicated or [requested by] the patient **requests reevaluation**.

1. The treatment plan review schedule shall comply, at a minimum, with the standards set by the applicable accrediting body for the hospital. [The]

2. A patient may review [his or her] **the patient's** treatment plan at any time.

3. A patient's family members, significant others, lawyers, guardians, and custodians are permitted to review a patient's treatment plan upon their request and **with the patient's** prior consent [of the patient].

(c) When a sudden change in [the] **a** patient's behavior or clinical condition constitutes a crisis or emergency to the extent that the [current] level [determination] **to which the patient is then assigned** is no longer appropriate, **clinical staff in charge may authorize** temporary limitations on **the patient's** activities [may be authorized by clinical staff in charge] to maintain a safe and secure environment[. The] **and shall document the** rationale for temporary limitations [shall be documented] in the patient's clinical record [and the]**.**

1. The treatment team shall [review]**:**

i. Review the rationale by the next working day [and document their findings in the clinical record. The treatment team shall either]**;**

ii. Either rescind the limitations when clinically appropriate or continue them for a clinically justified period of time[.]**; and**

iii. Document its findings in the clinical record.

(d) [All] **A** patient[s] ordered "Conditional Extension Pending Placement" by the court shall be accorded the highest level that provides the necessary supervision. [A]

1. The treatment team **shall enter a** note [shall be entered] into the patient's medical record [which documents] **documenting** the clinical considerations justifying the supervision level [determined] **that the treatment team determines to be** necessary [by the treatment team].

[10:36]**8:135-**1.5 Level I definition, criteria**,** and program structure

(a) [Patients who warrant] **A patient who warrants supervision at** Level I [supervision] are those who [pose]**:**

1. Pose a serious risk of harm to themselves, others**,** or property [were less] **if a lower level of** supervision **were to be** provided [or who have]**;**

2. Have not yet been evaluated for level of risk**;** or [have]

3. Have been recently admitted.

(b) [All programming for] **A patient who is assigned to supervision** Level I [patients is provided on-ward] **shall be provided programming on-unit** except for [those] diagnostic and treatment services that are medically and therapeutically necessary and [that] cannot be provided [on the ward] **on-unit**. [Determination of]

1. The treatment team shall determine and document these services [is the responsibility of the treatment team and shall be documented] in the patient's clinical record. [All attendance at off-ward]

2. Staff shall escort a patient assigned to supervision Level I who attends off-unit services [shall be staff escorted]. [Brief]

3. A patient assigned to supervision Level I is not permitted to have home visits [and] **or participate in** off-grounds programming [are not permitted at Level I]. [All]

4. A patient[s on] **who is assigned to supervision** Level I shall [be provided] **have** access to the outdoors and appropriate recreation unless clinically contraindicated.

(c) (No change.)

(d) Staff shall provide [for] **a** patient[s at] **who is assigned to supervision** Level I [a]**:**

1. An activity level [of activity] that is highly supportive and structured to facilitate the beginning of successful participation and maximizes the opportunity for successful experiences in treatment for individuals who exhibit Level I criteria[. On-ward]**; and**

2. On-unit individual or small group sessions [shall be provided] to introduce and reinforce processes that elicit information about the patient's needs, problems, and priorities of treatment and introduce expectations regarding the patient's responsibility and ability to influence the course of treatment while hospitalized.

[10:36]**8:135-**1.6 Level II definition, criteria**,** and program structure

(a) [Patients at] **A patient who warrants supervision at** Level [of Supervision] II [are those who have]**:**

1. Has begun to form a therapeutic alliance with staff[, have]**;**

2. Has shown signs of progress in self-management[, exhibit]**;**

3. Exhibits improved mental status or reduction in symptoms[,]**;** [and have]

4. Has improved behavioral controls and increased level of functioning[. Patients at Level II still]**; and**

5. Continues to require supervision at most times, though not at the intensity present at Level I.

(b) [Programming] **A patient who is assigned to supervision Level II** [and services] shall be provided **programming and services** both [on-ward and off-ward] **on-unit and off-unit** (on or off hospital grounds).

1. Attendance and appropriate participation in [on-ward] **on-unit** activities are the primary responsibility of the patient.

2. While [there is less need for] **a patient who is assigned to supervision Level II requires less** staff support and direct supervision **than a patient assigned to supervision Level I**, **the patient shall receive** such support and supervision, when necessary[, shall be provided and shall] **to** promote the goals of the **patient's** treatment plan.

3. Staff escort is required for all [off-ward] **off-unit** activities provided on or off hospital grounds. [Brief]

4. A patient who is assigned to supervision Level II may attend brief home visits [are permitted at this level], if [clinically indicated] **risk level permits** and [if] the **patient's** family is capable and willing to provide direct supervision for the duration of the visit.

(c) In addition to the risk factors associated with Level I, factors to be considered in determining the appropriateness of [placing] **assigning** a patient [at] **to supervision** Level II [of supervision] include, but are not limited to:

1.-3. (No change.)

4. Follows general directions and generally attends [on ward] **on-unit** therapies and programs on a regular basis;

5.-8. (No change.)

(d) The [patient's] demonstrated ability **of a patient who is assigned to supervision Level II** to participate in treatment activities by virtue of a greater degree of self-initiated responsible participation shall result in **the patient's** involvement **in,** and assignment to more [off-ward] **off-unit** activities and programs.

1. To maximize the probability of success in the change in the **patient's** treatment regimen, [these off-ward] **off-unit** activities shall be structured and supportive with staff escort at all times. [On-ward]

2. On-unit therapies and activities[, however,] shall [utilize] **use** the patient's developing sense of responsibility and initiative as staff **members** provide[s] less direct supervision and structure while [continuing] **they continue** to **frequently** evaluate **the patient's** progress [frequently].

[10:36]**8:135**-1.7 Level III definition, criteria**,** and program structure

(a) [Patients] **A patient who warrants supervision** at Level [of Supervision] III [are those who]**:**

1. Is generally [are] able to control dangerous impulses**;** and [who thus require]

2. Requires less **staff** supervision than [that present at] **a patient who is assigned to supervision** Level II.

(b) [Programming and services are] **A patient who is assigned to supervision Level III shall be** provided [on-ward and off-ward] **programming and services on-unit and off-unit** (on or off hospital grounds) with an increasing emphasis [upon off-ward] **on off-unit** programming.

1. The **treatment team shall determine the** frequency, duration**,** and types of unescorted [off-ward] **off-unit** activities [are determined by the treatment team]**, in which a patient who is assigned to supervision Level III is to participate**.

2. The [patient's participation] **treatment team shall determine whether a patient who is assigned to supervision Level II is to participate** in [each] **a** scheduled [off-ward] **off-unit** program [and] on hospital grounds [shall be defined by] **based on** time accountability and the clinical relevance of the program. [Participation]

3. The treatment team shall implement incrementally the participation of a patient who is assigned to supervision Level III in unescorted [off-ward] **off-unit** activities [shall be implemented incrementally]. [Staff]

4. A patient who is assigned to supervision Level III may participate in staff-escorted community activities [are permitted at this level]. [Brief]

5. A patient who is assigned to supervision Level III may attend brief home visits [are permitted at this level] if the **patient's** family is capable and willing to provide the level of supervision [considered] **that the treatment team determines to be** necessary [by the treatment team] in consideration of the **patient's** clinical needs [of the patient].

(c) In addition to the risk factors associated with **supervision** Levels I and II, factors **that the treatment team is** to [be considered] **consider** in determining the appropriateness of [placing] **assigning** a patient [at] **to supervision** Level III [of supervision] include, but are not limited to:

1.-3. (No change.)

4. Appropriate on and [off ward] **off-unit** behavior resulting in no precautions for a certain number of [days/weeks] **days or weeks** (to be set by treatment team);

5.-6. (No change.)

7. If recent history and behavior indicates substance abuse risk, or risk of other dangerous behavior, cooperation with search and/or other procedures that the treatment team determines necessary and documents in [master] **the patient's** treatment plan;

8.-12. (No change.)

13. Ambulatory patients and non-ambulatory patients who have demonstrated an ability to [utilize] **safely use** their adaptive equipment [safely]; or

14. Medical problems requiring only intermittent evaluation by [ward] **unit** staff.

(d) The patient's responsible and cooperative participation in activities [both on-ward and off-ward] **while on-unit, off-unit** but on hospital grounds, and [escorted] off hospital grounds [activities] **with staff escort,** is expected to result in the **treatment** team encouraging **a patient who is assigned to supervision Level III to participate in** more independent activity by gradually increasing the number of unescorted [off-ward] **off-unit** programs.

1. These programs and activities generally include centralized ([off-ward] **off-unit**) social and rehabilitative programs and activities.

2. Staff shall monitor **a patient who is assigned to supervision** Level III [patients] to ensure **that the patient participates in the** program**s** [participation].

[10:36]**8:135**-1.8 Level IV definition, criteria**,** and program structure

(a) [Patients] **A patient who warrants supervision** at Level [of Supervision] IV [are those who pose]**:**

1. Poses no or minimal risk of harm to self, others**,** or property; and [who may]

2. May be discharged upon finalization of after-care and housing plans.

(b) [Attendance] **A patient who is assigned to supervision Level IV is expected to initiate attendance** and appropriate participation at [any] approved [activity on-ward, off-ward] **activities on-unit, off-unit**, or off-grounds [is expected through the self-initiated behavior of the patient], [and is] without staff escort. [Determination of recommended]

1. The treatment team shall recommend the programs and activities [is the responsibility of the treatment team] **for the patient**.

(c) In addition to the risk factors associated with **supervision** Levels I, II**,** and III, factors **that the treatment team is** to [be considered] **consider** in determining the appropriateness of [placing] **assigning** a patient [at] **to supervision** Level IV [of supervision] include, but are not limited to:

1.-6. (No change.)

7. No [physical/medical] **physical or medical** contraindications.

(d) [Programming] **The programming** and activities [at this level] **in which a patient who is assigned to supervision Level IV is to participate** are the least structured.

1. [While staff] **Staff** shall evaluate the patient's behavior for compliance with the **patient's** schedule[, direct]**.**

2. Direct supervision **of the patient** shall [be decreased] **decrease**. [Most often,]

3. The overall program of a patient who is assigned to supervision Level IV typically comprises community-based programs and activities ([for example,] **such as** transitional programs, community day programs, **and** community trips)[, as well as] **and** larger group activities[, shall be part of the individual's overall program at Level IV].

SUBCHAPTER 2. CLINICAL REVIEW PROCEDURES FOR SPECIAL STATUS PATIENTS

[10:36]**8:135-**2.1 Statement, purpose**,** and scope

(a) The Division recognizes that the management of some patients within [its] **the State psychiatric** hospital system requires a more comprehensive and complete evaluation of the clinical, judicial**,** and administrative factors relevant to [treatment plan] **the** development and implementation **of those patients' treatment plans**.

(b) The purpose of this **subchapter is to:**

1. Establish a procedure [is to establish a mechanism] **by** which [provides a comprehensive] **hospital staff are to comprehensively** review [of the] **a special status patient's** clinical treatment and management [of special status patients through] **by** ensuring appropriate treatment interventions[, levels of supervision] and planning [at

the time of movement] **when the patient moves** to **a** less restrictive setting[s], [decrease of] **the patient's** structures and security **decrease**, or [discharge,] **the patient is discharged;** and [to ensure]

2. Ensure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges. [However, nothing]

(c) Nothing in [these procedures is intended to alter] **this subchapter alters** the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients and [with] the Patient Bill of Rights at N.J.S.A. 30:4-24.2.

[(c)] **(d)** Special status patients are those who satisfy the definition of the term at N.J.A.C. [10:36]**8:135**-1.2.

[10:36]**8:135-**2.2 [Special Status Patient Review Committee composition] **Composition of special status patient review committee**

(a) Each State psychiatric hospital shall establish a special status patient review committee (SSPRC).

[(a)] **(b)** The [Clinical Director/Medical Director] **clinical or medical director of each State psychiatric hospital** shall appoint [the] members [comprising] **to** the [Special Status Patient Review Committee ("]SSPRC[" or "Committee")] and [shall] designate [a Committee Chairperson] **the chairperson**.

[(b)] **(c)** The composition of the SSPRC shall [include] **consist of**, but need not be limited to[:]**,** the [Medical/Clinical Director] **clinical or medical director** or [Chief] **the chief** of [Psychiatry] **psychiatry**, the [Director] **director** of [Psychology] **psychology**,

[the Director of Nursing Services, the Director of Rehabilitation Services,] and the [Director] **director** of [Social Services] **social services**. [One]

1. At least one of these individuals shall be a psychiatrist.

2. These [individuals] **members** may appoint designees to the [Committee] **SSPRC** who are of sufficient experience to appropriately review [these] **the** matters[. Such] **that the SSPRC is to consider, provided a** designee[s] shall not endorse **a** recommendation[s they may have already] **that the designee participated in making or** made as a **member of the special status patient's** treatment team [member].

[10:36]8:135-2.3 Procedures **for review of recommendations and determinations; final agency decision**

(a) [Whenever] **If** a **special status** patient objects to the **supervision level to which the** treatment [team's recommendation regarding the levels determination] **team assigns the patient**, the SSPRC [Chairperson] **chairperson** shall designate a [committee] member **of the SSPRC** to interview the patient within the [10-day time frame for the SSPRC's decision-making established in] **period specified** [in] **at** (d) below.

(b) The treatment team shall prepare and forward to the SSPRC [Chairperson/designee] **chairperson,** in as timely a manner as possible**,** [the] information concerning the patient whose status requires [clinical] **SSPRC** review.

1. [Whenever a recommendation regarding a level of supervision is forwarded to the SSPRC and the] **If a** special status patient [has an opinion that differs from his or her] **disagrees with the treatment team's supervision level determination**, **the**

treatment team[,] **shall obtain from the patient** a statement [by the patient] **as to the basis of the disagreement** and/or **prepare** a summary of the patient's opinion [shall be included in] **and add the statement or summary to** the information [forwarded] **that the treatment team forwards** to the SSPRC.

(c) The SSPRC [Chairperson] **chairperson** may designate [a committee] **an SSPRC** member to interview the patient prior to the committee review [whenever, in his or her judgment,] **if the chairperson determines that** the situation warrants **an interview**. [One]

1. A member of the special status patient's treatment team [members] **who is** familiar with the current level recommendation shall meet with the SSPRC during [their] **its** review process.

(d) The SSPRC shall meet and review the [team proposals] **treatment team's determination as to the special status patient's supervision level assignment, and the statement or summary of the patient's position,** within 10 working days of receipt of the information.

I The SSPRC [Chairperson or designee] **chairperson** shall forward the [committee's] recommendations [in response to the team proposals] **of the SSPRC** to the [Clinical Director] **clinical or medical director** within two working days **of its review**.

(f) The [Clinical Director/Medical Director] **clinical or medical director** shall review the SSPRC recommendations [regarding endorsement of the team proposals] and respond to the [Chairperson] **SSPRC chairperson** within two working days **of receipt of the SSPRC recommendation** by either endorsing**, or withholding endorsement of,** the SSPRC recommendation[, or withholding endorsement].

1. The [Clinical Director/Medical Director] **clinical or medical director** may request additional information from the treatment team[; however, such]**, provided the** request and the **treatment** team's response shall be made within the [same] two-day period **specified at (f) above**. [All]

2. The clinical or medical director must endorse a recommendation[s must be endorsed by the Clinical Director/Medical Director] prior to **its** implementation.

(g) The [Clinical Director/Medical Director] **clinical or medical director** shall periodically attend **the hospital's** SSPRC meetings [in his or her institution in order] to monitor the thoroughness and quality of clinical recommendations and compliance with this [policy and procedure. Additionally, the Quality Assurance Department] **chapter.**

(h) The quality assurance officer within each hospital or [other] **a** designee of the hospital CEO shall [also] monitor the hospital's compliance with [the rules within] this subchapter.

[(h)] **(i)** [Whenever a hospital] **If a special status patient's** treatment team and the [hospital's] SSPRC **both** recommend the [granting of a supervision decrease to Level III or Level IV or the discharging of any patient subject to the hospital's SSPRC's review procedures, the documentation regarding those supervision and] **patient's** discharge [reviews shall be forwarded to the Division Medical Director and his or her designee by the SSPRC Coordinator]**, then,** within two days of **the SSPRC** finalizing [such] **its** recommendation [to ensure that an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties has been performed]**, 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 [Final] Division Medical Director **shall issue a determination as to the special status patient's discharge, which will be a final agency** action**,** [shall be communicated to] **and notify** hospital staff **of the determination by** no [more] **later** than five working days after **the Division Medical Director's** receipt of the [hospital Clinical/Medical Director approval] **material transmitted pursuant to this subsection**.

[(i)] **(j)** [Whenever] **If** N.J.S.A. 30:4-27.17[b] requires **the treatment team to issue a** written notice [to a county prosecutor or deputy attorney general who participated in a patient's commitment] **of a determination as to a special status patient's supervision level assignment or discharge determination**, [a designated hospital staff member] **the hospital CEO** shall [notify] **ensure that the treatment team issues the required notification to** the appropriate individual**s and officials** in accordance with that [statutory provision] **statute**.

[(j)] **(k)** The **SSPRC chairperson shall ensure that the** rationale supporting the [levels] **discharge** decision [shall be] **is** entered into the SSPRC's meeting minutes and the patient's records.

(l) The SSPRC shall ensure that the treatment team adheres to supervision and discharge procedures at N.J.A.C. 8:135-2.5 when recommending the discharge or a change in supervision level of a special status patient.

[10:36]**8:135-**2.4 SSPRC [Coordinator] **coordinator**

(a) Each hospital shall designate a staff person to be responsible for coordination of all activities relative to the functioning of the SSPRC. The responsibilities of the coordinator shall include:

1.-2. (No change.)

3. Functioning as executive secretary to the SSPRC (that is, recording, distributing**,** and filing [of] minutes); [and]

4. [Being responsible for the coordination of] **Coordinating** information flow among treatment teams, SSPRCs, hospital administration**,** and Central Office regarding special or extenuating circumstances, current or pending legislation, etc., relative to cases under consideration of the SSPRC[.]**; and**

5. Obtaining records of prior hospitalizations, arrest records, and collateral materials.

8:135-2.5 Treatment team procedures

(a) The treatment team for a special status patient shall:

1. Assess the patient's risk of violence using an evidence-based risk assessment tool approved by the Division Medical Director that addresses the violence risk in less restrictive settings:

i. Upon the patient's admission and at least annually thereafter;

ii. Upon the request of any party to change the patient's supervision level;

iii. As part of the patient's discharge planning; and

iv. When a treating psychiatrist, medical director, or chief of psychiatry determines that a change in the patient's behavior warrants an updated risk assessment; and

2. Develop a treatment plan for patients to treat and mitigate risks identified in the risk assessment.

(b) A psychiatrist who testifies before, and/or writes a report for, a court regarding a discharge decision must include in the testimony and/or report:

1. The risk assessment formulation that the psychiatrist used in conducting the risk assessment of a patient; and

2. The decisions and recommendations of the SSPRC and the Division Medical Director regarding the patient.

SUBCHAPTER 3. TRANSFERS OF INVOLUNTARILY COMMITTED PATIENTS BETWEEN STATE PSYCHIATRIC [FACILITIES] **HOSPITALS**

[10:36]**8:135-**3.1 Purpose

(a) The purpose of this subchapter is to [define the] **identify:**

1. The factors [to be used by] **that** State psychiatric facility staff **are to use** in evaluating the need for inter-hospital transfers among the facilities [cited in] **listed at** N.J.A.C. [10:36]**8:135**-3.2[. The subchapter also delineates the]**; and**

2. The procedures related to such transfers.

[10:36]**8:135-**3.2 (No change in text.)

[10:36]**8:135-**3.3 Factors

(a) [Any] **Subject to (c) below, any one** of the **following** factors [described below may serve] **serves** as a basis for the transfer of [a] **an involuntarily committed** patient from and to any facility [cited in] **listed at** N.J.A.C. [10:36]**8:135**-3.2:

1. To place [him or her] **the patient** in closer proximity to family members;

i. If a patient and [his or her] **the patient's** family members disagree on a transfer request **that is** based on proximity to family members, **hospital staff shall make** a clinical determination [shall be made by the hospital staff] based solely on the clinical best interest of the patient;

2.-9. (No change.)

(b) A patient's stated preference for treatment at a particular State psychiatric facility [shall] **is** always [be] a relevant consideration in transfer decisions[. Transfers]**; provided, and subject to (c) below:**

1. Subject to (b)2 below, a transfer over [the] **a patient's** objection [of a patient are] **is** permitted[, however,] when a clinical determination [has concluded] **concludes** that the transfer is [in]**:**

i. In the [transferee's] **patient's** clinical best interest [or necessary]**;**

ii. Necessary for the safety of other patients**;** or [administratively]

iii. Administratively necessary due to a factor listed [in] **at** (a) above. [A transfer is permitted only when, in the judgment of the treatment team, the transfer's permissible purpose outweighs any potential harm to the patient from the transfer.]

[1.] **2.** [When] **If** a transferring facility [is capable of meeting] **can achieve** the clinical or administrative purpose [for a proposed transfer as contained in] **that the clinical determination specifies, from among** the factors at (a) above, [an objecting] **as the basis of a transfer and the** patient **objects to the transfer, the facility** shall not [be transferred] **transfer the patient**.

[2.] **3.** [Transfers] **The transfer of a patient** shall be to the least restrictive available treatment [alternative available to] **setting that will** achieve the purpose[s of the transfer request as contained in] **that the clinical determination specifies, from among** the factors at (a) above**, as the basis of the transfer**.

(c) A transfer is only permitted when, in the judgment of the treatment team, the transfer's permissible purpose outweighs any potential harm to the patient from the transfer.

[10:36]**8:135-**3.4 General procedures

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

(c) [A] **The transfer coordinator of a hospital that is requesting a patient's transfer (sending hospital) shall transmit a** written request for **the** transfer [, supported by] **that includes** a statement of the factors [justifying] **that** the [request, shall be forwarded] **clinical determination specifies,** from **among the factors specified at N.J.A.C. 8:135-3.3(a), as the basis of** the transfer [coordinator of the sending hospital]**,** to the transfer coordinator of the **hospital to which the patient's transfer is proposed (**receiving hospital**)**.

1. All requests for transfers shall be supported by clinical considerations.

(d) [Transfers occurring] **A transfer that is proposed** as a [result of] **response to** overcrowding, life-safety concerns, natural catastrophes, or consolidation of services shall require the approval of the [Division's] Assistant Commissioner **of the Division**.

(e) [The] **A facility shall adhere to the** following procedures [shall be followed] in [cases of] **conducting a** [non-emergent] **non-emergency** transfer[s] **of a patient**:

1. The transfer coordinator**s** of the sending **and receiving** hospital**s** shall [consult with the transfer coordinator of the receiving hospital. If they agree] **confer as** to the **proposed** transfer**.**

i. If both concur as to the proposed transfer, they shall arrange [for] a specific date and time for the transfer to occur.

[2.] **ii.** Hospital staff shall actively [promote resident] **encourage patient** input into non-emergency transfer decisions.

[3.] **iii.** At least seven days prior to the transfer date, staff at the sending [institution] **hospital** shall notify the [relevant County Adjusters,] **county adjuster for each affected county**, **and the transferring patient's** family and attorney [of the patient being transferred] of the transfer decision, the reason for the transfer, and [the] **their respective** procedural rights**, as specified** in this chapter.

[4.] **iv.** [It is the responsibility of the] **The sending** hospital [initiating the transaction to make arrangements for transporting the patient from one facility] **shall arrange a transferring patient's transportation** to the [other] **receiving hospital**.

[5.] **2.** If the transfer coordinators do not [agree on] **concur as to** the **proposed** transfer, [the matter] **each coordinator** shall [be referred] **refer the transfer request** to the CEOs of the respective [institution] **hospitals** for resolution.

[6.] **3.** If the CEOs do not [agree] **obtain a resolution**, the case shall be referred for resolution to the [Division's Assistant Directors in the Office of State Hospital Management] **Division Medical Director**, who [may], in making [their] **a** decision **on the proposed transfer**, **may** request clinical and technical input from hospital central office staff.

4. [Resolution, in] **In** instances of continuing disagreement, [rests with] the [Division's] Assistant Commissioner [or the Assistant Commissioner's designee] **of the Division shall resolve the disagreement**.

Recodify existing 7.-8. As **5.-6.** (No change in text.)

(f) [The] **A facility shall adhere to the** following procedures [shall be followed] in [cases of] **conducting an** emergency transfer[s] **of a patient**:

1. [Emergency shall be defined, for] **For** the purposes of this subchapter, [as] **the term, "emergency," means that a patient poses** imminent danger of serious bodily harm to self or others, as evidenced by a recent incident or a change in **the patient's** psychiatric status**,** which [less restrictive]**:**

i. An available treatment alternative[s other] **that is less restrictive** than transfer cannot adequately address**;** [and which requires]

ii. Requires removal **of the patient** from the patient's current setting [.Only the]**;**

iii. The factors [in] **at** N.J.A.C. [10:36]**8:135-**3.3(a)4 or 8 [may] **shall** serve as the **exclusive** basis for an emergency transfer.

2.-4. (No change.)

5. If, after transfer, the CEO of the receiving hospital objects to an emergency transfer, [he or she] **that CEO** shall review the case with the CEO of the sending hospital.

6. If [agreement] **the CEOs** cannot [be reached] **obtain a resolution,** the matter shall be referred to the [Division's Assistant] **Division Medical** Director [in the Office of State Hospital Management for resolution. Resolution] **who**, in **reviewing the transfer, may request clinical and technical input from hospital central office staff.**

7. In instances of continuing disagreement, [rests with] the [Division's] Assistant Commissioner [or the Assistant Commissioner's designee] **of the Division shall resolve the disagreement**.

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

[10:36]**8:135-**3.5 Procedures when **a** patient[s object] **objects** to transfer

(a) [Regarding non-emergency transfers, the] **The** following **procedure** [apply:

1. If] **applies when a treatment team proposes a non-emergency transfer to which** a patient **and/or the patient's representatives** object[s to such a transfer, he or she]**:**

1. The treatment team shall [be provided] **provide the patient and/or the patient's representatives** an opportunity to state the basis for [his or her] **the** objection, and present any relevant facts**,** including statements by other individuals, with

or through a representative if so desired, before an individual who is not a member of the treatment team [seeking] **that is recommending the** transfer.

2. The [hospital's Clinical Director/Medical Director] **clinical director or medical director of the hospital** shall designate [this] **the** individual who **is to review the objection, who** may be a member of the [office of the hospital's] clinical [director] **director's staff** or [other] **another** hospital staff member **who is** capable of providing an independent review of the [need for the] proposed transfer.

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

[3.] **4.** Patients and their representatives may submit**,** in writing**,** their views regarding a non-emergency transfer prior to its implementation.

i. Upon request [by]**,** or **with the** consent**,** of the patient, the patient and [his or her] **the patient's** representatives may request an opportunity to discuss the proposed[,] non-emergency transfer with a Division representative prior to implementation of the transfer.

(b) Regarding emergency transfers, the following apply:

1. In an emergency as defined at N.J.A.C. [10:36]**8:135**-3.4[(e)1]**(f)1**, a patient may be transferred in accordance with procedures outlined at N.J.A.C. [10:36]**8:135**-3.4[(e)]**(f)**.

2. If a patient [or a] **and/or the patient's** representative [of the patient] object[s] to [such a] **the** transfer, they may submit their position**,** in writing**,** to the Division after implementation of the transfer. A designee of the Division's Assistant Commissioner shall review the basis for the transfer after the transfer[,] and shall provide the patient [or his or her] **and/or the patient's** representative**s** [with] an opportunity to state the basis

for their objection and present any relevant facts or statements. The designee shall not be a member of the patient's treatment team at either the sending or receiving hospital and shall [provide]**:**

i. Conduct an independent review of the [need] **basis** for the transfer [after the transfer. The designee shall have the]**;**

ii. Have authority to approve or disapprove the transfer[. This decision shall be in writing and]**; and**

iii. Issue a written decision approving or disapproving the transfer that shall [become] **be made** part of the patient's clinical record.