

HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES

Screening and Screening Outreach Standards

Proposed readoption with amendments: N.J.A.C. 10:31
Proposed Readoption with Amendments: N.J.A.C. 10:31
Proposed Repeal: N.J.A.C. 10:31-1.4
Proposed New Rules: N.J.A.C. 10:31-2.6, 9, 10.2, 10.3, 11 and 12 and N.J.A.C.
10:31 Appendices A through D
Proposed Repeal and New Rule: N.J.A.C. 10:31-2.4
Proposed Recodification with Amendments: N.J.A.C. 10:31-6 as 10:31-10

Authorized By: Jennifer Velez, 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 2009-294.

Submit comments by January 1, 2010 to:

Lisa Ciaston, Esq.
Legal Liaison
Division of Mental Health Services
P.O. Box 727
Trenton, New Jersey 08625-0727

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66 (1978) and N.J.S.A. 52:14B-5.1,
N.J.A.C. 10:31, Screening and Screening Outreach Program Standards, expires on

September 9, 2009. This date is extended 180 days to March 8, 2010, pursuant to N.J.S.A. 52:14B-5.1c. The Department of Human Services (the Department) has reviewed these rules and has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated. Therefore, the Department is proposing to readopt with amendments, new rules, repeals and recodifications, N.J.A.C. 10:31, Screening and Screening Outreach Program Standards.

As the Department has provided a 60-day comment period for 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.

Background

The legislation authorizing these rules was enacted in 1989 and established legally mandated procedures and standards for involuntary commitment. (N.J.S.A. 30:4-27.1 et seq.) The screening law delegated to the Division of Mental Health Services (Division) the responsibility for the care, treatment and rehabilitative services for persons with mental illness who are dangerous to themselves, others or property, yet who do not seek appropriate voluntary treatment. The intent of the law was to encourage the development, in each county or designated area, a screening service and short-term care facility to meet the needs for evaluation and acute care treatment of mentally ill persons in the county or area. The Legislature envisioned the role of screening services 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.” (N.J.S.A. 30:4-27.1(d)) The stated goals were to “strengthen the Statewide community mental health system, lessen inappropriate hospitalization and reliance on psychiatric institutions and enable State and county facilities to provide rehabilitative care needed by some mentally ill persons following their receipt of care.” (N.J.S.A. 30:4-27.1(d))

The Legislature further noted that because involuntary commitment involved the deprivation of an individual’s civil liberties, it was necessary to balance our society’s basic value of liberty with the important considerations of safety and treatment. It emphasized that individuals who are mentally ill and in need of treatment are entitled to receive that treatment in the least restrictive, clinically appropriate setting as close to their own communities as possible.

For almost 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, wherever the need is present in the outside community through mobile outreach. Extensively trained and credentialed screening staff assess an individual’s psychiatric condition, make any necessary medical referrals and, after examination and consultation with an appropriately licensed psychiatrist, determine whether the legal process for involuntary commitment should be invoked, or whether other, less restrictive forms of in-community

treatment are appropriate. An individual can be referred for commitment only after a certified screener and a psychiatrist affiliated with a designated screening service have determined that the individual is mentally ill and dangerous to him or herself, others, or property, all stabilization options have been considered or exhausted, and the person has refused 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 in-patient hospitalizations. Each case must be evaluated individually and a complete assessment made before a treatment plan 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), and 36 N.J.R. 4468(a), respectively) In 2007, amendments reflecting screening services' obligations under the Advance Directives for Mental Health Care Act were adopted. (39 N.J.R. 2346(a)) With the single exception of those amendments, the screening rules have not been substantively updated since they were first adopted in 1989. Thus, this notice of proposal covers a large number of amendments, reflecting the numerous developments in the mental health field in the last nearly 20 years.

Developments in the Mental Health Field

One of the most significant developments in the mental health system in recent years has been the emergence of a robust consumer movement, through which those arguably most directly affected by the system have made their voices heard. Through published works, advocacy organizations, testimony at legislative and regulatory bodies and participation in policy and rule development, consumers have shaped the perspective that recovery is possible and that mental health programs must embrace Wellness and Recovery values. These values include an emphasis on a consumer's strengths and abilities, respect for consumer choice and autonomy and consumer empowerment through participation in treatment planning and other decision-making (where clinically appropriate). Along with the consumer movement, families have sought and achieved a larger role in the loved ones' recovery, through parallel participation in the venues mentioned above, where appropriate and consistent with patient confidentiality laws.

The above developments have been aided by research identifying evidence-based, best and promising practices, new medications, and improved treatment modalities. In addition, expanded services beyond inpatient treatment, focusing on housing, employment, education, physical health care and substance abuse treatment, have also contributed to wellness, recovery and community integration.

The Wellness and Recovery philosophy was embraced in the President's New Freedom Commission Report of 2003, which called for a transformation of the mental health system, with the goal of achieving a system that emphasizes prevention, early detection, recovery through access to treatment and support for living, working, learning and participating fully in the community. The Federal Substance Abuse and

Mental Health Services Administration (SAMHSA) has identified specific measures to implement wellness and recovery goals (<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits>).

New Jersey has taken several measures to transform its mental health system into one that is reflective of the wellness and recovery philosophy. In 2005, the Governor's Task Force on Mental Health, after meeting over several months to complete a full review of the system, issued their findings and recommendations in a report. (see "Final Report of the Governor's Task Force on Mental Health" at <http://www.state.nj.us/humanservices/dmhs/recovery>) Specifically, the report recommended that the system be designed to meet individual needs by providing an array of evidence-based treatments, with consumer and family participation, in safe and supportive environments, staffed by competent professionals who will create opportunities that foster wellness and recovery. (*Id.* at p.12) The report further recommended that Division rules be reviewed and revised to allow for a shift to a system based on wellness and recovery; one that is inclusive of consumer participation in treatment planning through such mechanisms as Psychiatric Advance Directives for Mental Health Care. (*Id.* at p. 13-14) With specific reference to the screening program, the report supported Acting Governor Richard J. Codey's \$10 million expansion of county-based mental health screening services, with the goal of adding new master's degree level clinicians for emergency screening, and enhancing mobile outreach teams and on-call resources for community-based assessment and treatment. (*Id.* at p. 17) The report noted that "[C]onsumers want alternative crisis services, including crisis respite housing, to be available when needed, to avert prison or disastrous outcomes."

(Id. at p. 82) The report also contended that outreach services at all levels, including screening, to “maintain stability and deal with crises before they go too far,” were of particular need. (Id. at p. 89)

By Executive Order 78 (issued on January 13, 2006) Governor Codey directed the implementation of many of the Task Force’s recommendations, including state-of-the-art treatment alternatives, recovery-based programming services, and regulations allowing a shift to a system based on wellness and recovery. (<http://liberty.state.nj.us/infobank/circular/eoc78.htm>)

One of the Division’s responses to Executive Order 78 was the issuance of a Transformation Statement (February 2006), which envisioned a recovery-oriented mental health system that is “inclusive and collaborative” and that “incorporates the recovery-model into every policy, regulation, contract and expectation.” (<http://www.state.nj.us/humanservices/dmhs/recovery>).

In June 2006, the Division commenced a stakeholder input process, encompassing nine subcommittees and over 120 stakeholders, which were charged with recommending actionable methods by which wellness and recovery goals could be incorporated into mental health programs. The resulting “Wellness and Recovery Transformation Plan January 1, 2008 – December 31, 2010” (dated October 2007) emphasized the need for more respectful, active treatment with meaningful roles for both consumers (to the extent possible) and families (consistent with confidentiality law). (<http://www.state.nj.us/humanservices/dmhs/recovery>). The plan noted the program areas in which implementation of these goals had begun (pp. 8-9) and recommended further advancements, such as “peer delivered alternate screening

services” (p.11) and the use of tools promoting consumer empowerment (for example, Psychiatric Advance Directives) (p.19). An update to the Transformation Plan, issued in October 2008, delineated the accomplishments to date (<http://www.state.nj.us/humanservices/dmhs/recovery>). Screening-related milestones included the creation of an Acute Care Task Force, which has met and discussed ways to ensure relevant stakeholder input and to develop program, policy, regulatory and data recommendations with the Division. In addition, the Department is forming a task force that will examine issues related to creating a “co-occurring competent system.”

The Process of Developing These Amendments

From the outset of the amendment process, the Division was mindful of the importance of input from consumers, families, providers, hospitals and the community at large. In addition to its regular and continuing dialogue with stakeholder groups through various venues, the Division convened specific methods of inquiry and discussion that were focused on the Statewide screening system. In 2004, the Division met three times with a regulatory work group comprised of interested constituencies, including consumers, families, providers and advocacy organizations such as the New Jersey chapter of the National Alliance on Mental Illness (NAMI-NJ), the New Jersey Association of Mental Health Agencies (NJAMHA), the New Jersey Hospital Association (NJHA), Mental Health Emergency Services Association (MHESA) and the New Jersey Association of County Mental Health Administrators (NJACMHA). In addition, the Division sought feedback from System Review Committees, the Acute Care Task Force, and the Mental Health Planning Council. Work group members described how

increased demand on screening services, exacerbated by already strained resources, had stressed the capacity of screening programs. By virtue of both its continuous accessibility and a diminishment of services in other health care sectors, screening services have encountered increased demand from populations not originally envisaged in its legislative mandate – for example, consumers with drug and alcohol issues, acute and untreated medical conditions, HIV-AIDs, pregnancy and dementia and other organic brain syndromes. Often located in hospital emergency rooms screening services have had to develop a practice of service triage by prioritizing their limited capabilities to provide services to those who are most urgently in need of care. The difficulty of hiring and retaining qualified staff to do difficult work for low pay was also an issue.

In view of the scope and number of the possible amendments, the Department sought to obtain the broadest spectrum of public commentary by holding a public meeting prior to publication of this notice of proposal. The public meeting was held on September 17, 2008 at the Department offices at 222 South Warren Street in Trenton, New Jersey. Members of the general public had the opportunity to give oral testimony at the meeting and to submit written comments after the meeting. The range of public comments included concerns about the presence of children in screening centers, telepsychiatry, staffing qualifications and waiting times in screening services and/or hospital emergency rooms,

The commentary offered through the above-described means informed the Department's efforts to develop proposed amendments, repeals, and new rules that would respond to the current needs of the screening system.

On June 25, 2009, both houses of the New Jersey Legislature passed Senate Bill 735, which provides for involuntary commitment to outpatient treatment for individuals in need of such treatment. Governor Corzine signed this bill into law on August 11, 2009. By allowing mental health care in the least restrictive environment, this new law attempts to balance the preservation of personal freedoms with the State's concerns for individual and public safety. The law permits court-ordered commitment to outpatient treatment for individuals whose mental illness if left untreated would likely present a danger to themselves, others or property in the reasonably foreseeable future. The statute applies to those who meet the criteria above and have a history of responding favorably to outpatient treatment and are unwilling to accept treatment after it has been offered. The bill becomes effective one year from the date signed into law and will be phased in Statewide over a three-year period. Seven counties will be selected to implement outpatient commitment each year. In the near future, the Department will propose amendments to N.J.A.C. 10:31, to reflect the requirements of the Involuntary Outpatient Commitment bill.

Summary of Amendments

Grammatical and technical changes are made throughout the rules. In addition, the following amendments appear throughout the text: (1) the term "client" has been updated and replaced with "consumer"; (2) "screening center" has been deleted and replaced with "screening service," consistent with the term used in the screening law; and (3) "emergency services" has been changed to "affiliated emergency services" to indicate an affiliation with a screening service.

Subchapter 1. General provisions

N.J.A.C. 10:31-1.1 Scope

At N.J.A.C. 10:31-1.1(a), proposed amendments state that screening services may be provided at a designated screening location, or wherever the individual who may be in need of such services is located. The intent of this addition is to make clear that the concept of screening services should not be limited to, nor identified with specific, physical, stationary location, but can take the form of a more mobile, flexible and accessible service any place in the community.

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

At N.J.A.C. 10:31-1.2(a)1, proposed amendments add the requirement that screening services be delivered “in a manner that is culturally competent and recovery-oriented and that assists the consumer in achieving a self-directed transition to wellness,” consistent with current values and philosophy in the mental health field.

N.J.A.C. 10:31-1.2(a)2 contains the following amendments: (1) “at a minimum” is proposed for deletion, as it is unnecessary within the context of the section; (2) “location” is proposed to clarify that the reference is the area in which screening services are administered; and (4) the reference to Public Law 1987, chapter 116 has been replaced with the statutory citation, “N.J.S.A. 30:4-27.5(d),” as that public law has been codified.

At N.J.A.C. 10:31-1.2(a)3, proposed amendments add language reflecting the statutory obligation to “provide outreach services for the purpose of crisis intervention and stabilization and removes the qualifier “whenever possible.”

At N.J.A.C. 10:31-1.2(a)4, proposed amendments delete language that is superfluous and specifies that referral and linkage services will be to “appropriate community mental health and social services.”

At N.J.A.C. 10:31-1.2(a)5, technical corrections are proposed to update language: “crisis house” becomes “crisis housing” and “partial care” becomes “partial hospitalization/care.”

At N.J.A.C. 10:31-1.2(a)6, “standards for involuntary commitment” becomes “in need of involuntary commitment” to reflect current usage, and “N.J.S.A. 30:3-27.2m” is corrected to “N.J.S.A. 30:4-27.2m.

At N.J.A.C. 10:31-1.2(a)8, “law enforcement” is added, as screening services provide training to these community entities.

New N.J.A.C. 10:31-1.2(a)10 has been proposed to include one of the current functions of a screening service – that is, “To provide leadership within the acute care network of services and advocate for services to meet consumers’ needs and encourage the system to respond flexibly.”

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

Definitions for the following terms have been added: “affiliated emergency service coordinator,” “commitment,” “consensual admission,” “consumer protected health information,” “continuous quality improvement,” “covered entity,” “enhanced screening service,” “extended crisis evaluation bed (ECEB),” “general hospital,” “in need of involuntary commitment,” “integrated case management services (ICMS),” “mental health care representative,” “peer advocate,” “physician,” “programs of assertive community treatment (PACT),” “psychiatric unit of a general hospital,” “psychotherapy notes,” “screener,” “screening document,” “screening service,” and “special psychiatric hospital.”

There are several proposed amendments in the existing definitions. Under the definition for “acute care system,” the following changes appear: (1) “identified” has been added, as some participants are identified but not designated; (2) the name of the Division has been updated; (3) the phrase “in consultation with the appropriate county mental health board” has been added to indicate that the Division will consult with the relevant board when identifying acute care services in each county; (4) the services “include” has been modified to “may include” to allow for Statewide variations in the availability of services; (5) “screening center” has been updated to “screening services”; (6) “emergency services” has been changed to “affiliated emergency services” to indicate relationship with screening services; (7) “affiliated voluntary inpatient service” has been changed to the more inclusive “inpatient psychiatric service”; (8) “acute partial

care” has been updated to “acute partial hospitalization/care”; (9) “clinical case management” has been updated to “integrated case management services (ICMS),” the current name of this program; (10) “programs of assertive community treatment (PACT) has been added; and (11) “crisis companion services” has been updated to “peer support, self-help, and acute family support services.”

The definition for “acute in-home service” has been deleted because the term is not used in the text.

“Acute partial care” has been updated to “acute partial hospitalization/care.”

In the definition for “assessment,” “psychiatric” has been added to define the type of crisis that can be addressed by an AES.

The existing definition for “certified screener” is proposed for deletion and will be replaced with the new definition for “screener.”

The term “client” has been updated and replaced with “consumer.”

The term “clinical case management” and its definition have been replaced with the term and definition for “integrated case management,” a community mental health program that has been developed since the last readoption of N.J.A.C. 10:31 and to which screeners may refer individuals. ICMS are outreach services designed to engage

individuals with serious mental illness in the community and facilitate their use of available resources and supports to maximize their independence.

The term “clinical certificate” has been changed to “screening certificate,” and its definition has been changed to “screening certificate,” and its definition has been updated to reflect that it is a physician’s certification, that the form shall state the specific facts upon which the examining physician has based its conclusion and that it shall be certified in accordance with the Rules of Court. The proposed definition also adds that the certificate may not be extended by a person who is a relative, by blood or marriage, of the person who is being screened.

The term “clinical/medical director” is proposed for deletion and has been updated and relocated. The same definition now appears as “medical director.”

The term “community gatekeeper” had been updated to “community referral source.”

The definition for “crisis companion” has been deleted because it is not referenced in the rule text.

The definition for “crisis housing” has been amended to indicate that it is a residential program for individuals who are in crisis but do not meet the standard for commitment. Also, the phrase “emergency screening service” has been replaced with “screening

service,” as that is the current and proper name for this service and is used consistently throughout the rule text.

The definition for “crisis intervention specialist” has been updated to reflect current references (“screening services” and “affiliated emergency service”).

The definition for “crisis outreach” has been amended to indicate that this service may be performed by a screening center, as well as by an AES. An additional amendment specifies that crisis outreach does not include the screening process.

The definition for “crisis stabilization” has been revised to (1) indicate the term can be applied to the efforts to achieve stabilization or to the result of stabilization; and (2) to replace “symptomatology” with the clearer and more accurate term, “symptoms.”

The definition for “crisis stabilization services” has been deleted because it is not used in the text and is redundant with the previous definition for “crisis stabilization.”

The term “designated screening center” is replaced with “screening service.” The definition is generally the same, with the following additions: (1) “mobile care” has been added to indicate that screening services must be capable of going into the community wherever there is a need; (2) “crisis or early intervention” and “stabilization” have been added, as these services can prevent more traumatic and expensive situations; (3) “specific geographic area” has been replaced with the more informative phrase, “certain

geographic areas, as specified in N.J.A.C. 10:31-2.1;” and (4) the phrase, “in addition to affiliated emergency services,” has been added to indicate that an AES can also assess individuals to determine appropriate mental health services.

The definition for “Division” has been updated to reflect the Division’s current name.

The term, “Emergency Service” has been deleted and replaced with the updated term, “Affiliated Emergency Service” (or “AES”). The definition remains the same, with the following amendments: (1) “psychiatric” has been added to specify the type of crisis at issue; (2) services available at an AES include “where indicated, the initiation of involuntary commitment proceedings or the referral of a consumer to a screening service for that purpose.” For the same reason, the term “emergency service coordinator” has been deleted and replaced with “affiliated emergency service coordinator,” with no change in the definition.

The term “holding bed” has been deleted and replaced with the current term, “extended crisis evaluation bed (ECEB).” The definition bears the following proposed amendments: (1) “secluded” has been deleted because while these beds are in a “secure area,” they are often not secluded, due to space limitations, safety concerns or other considerations; and (2) the word “psychiatric” has been inserted to specify the type of supervision rendered.

Consistent with (N.J.S.A. 30:4-27.2.m), a new term, “in need of involuntary commitment,” has been added to clarify the status of an adult with mental illness, whose mental illness causes the person to be dangerous to self, 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 or available to meet the person’s mental health care needs.

The term “involuntary commitment” has been updated and appears as the new definition for “commitment.” Within the new definition, “enacting treatment” has been replaced with the more descriptive and accurate term, “authorizing the admission to a treatment facility.”

The definition for “linkage” contains the following proposed amendments: (1) “voluntary” now describes “enrollment” rather than “referral,” for accuracy; and (2) “non-mental health program” has been changed to “ancillary programs.”

The definition of “mental illness” has been revised to include an impairment of an individual’s “capacity to control” behavior and to state that the term is not limited to “psychosis” or “active psychosis,” but includes “all conditions that result in the severity of impairment described herein.”

The definitions for “off site” and “on site” are proposed for deletion because the concept of screening services has evolved to the point where such a distinction is obsolete.

These terms were added when the locus of most screening functions was centered at a discrete location such as a hospital. The authorizing statute does not require a stationary site for screening services, but rather, envisions a service that is mobile and accessible wherever a psychiatric crisis occurs in the community.

A definition for “peer advocate” is proposed. A peer advocate is a person who is, or has a family member who is, a consumer of mental health services. Responsibilities include raising awareness of mental health-related issues, providing education, serving as a resource, administering conflict resolution, serving as a role model and documenting and referring consumer concerns and complaints to appropriate professional staff.

A definition for “physician” has been added to clarify that, for the purposes of N.J.A.C. 10:31, a physician must hold an active license to practice medicine in any state, commonwealth or territory of the U.S., or in the District of Columbia, and must comply with all relevant New Jersey professional licensing laws, including, but not limited to, the requirements of the New Jersey State Board of Medical Examiners.

A definition for “programs of assertive community treatment (PACT)” has been proposed and states that the community mental health program provides comprehensive rehabilitation, treatment and support services to individuals with serious and persistent mental illness who have had repeated rehospitalizations and are at serious risk of rehospitalization.

“Psychiatrist” has been defined as a person who has completed the training requirements of either 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.

Proposed amendments in the definition for “psychoeducation” clarify that this program is available to consumers, as well as to families.

The term “quality assurance (QA)” had been deleted and replaced with the updated term, “continuous quality improvement.” The definition remains the same.

The term “referral” has the following proposed amendments: (1) the phrase “provided by community resources outside of the organization itself” is proposed for deletion as it is inaccurate; and (2) to further describe the services that are the subjects of referrals, the phrase “which promote the achievement of the goals of wellness and recovery and which include diversion from hospitalization, as clinically appropriate” has been added thereto.

A definition for “screener” has been added to clarify that this individual must meet the requirements of N.J.A.C. 10:31-3.3 and must be certified by the Division to assess eligibility for involuntary commitment.

A definition for “screening document” has been added to specify that this form, developed by the Division, must be completed and signed by a screener after the screener has assessed the consumer. The screening document is the first step in the involuntary commitment process .

In the definition for “screening outreach,” the term “off site” is proposed for deletion for the reasons explained previously.

The term “screening service” has been defined as a public or private ambulatory 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, 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.

The definition for “short-term care facility” has been revised to be consistent with the definition currently in effect in standards pertaining to these facilities (N.J.A.C. 10:37G). Specifically, the proposed amendments adds greater detail, stating that an STCF facility is a closed acute care adult psychiatric unit in a general hospital for short term admission of individuals who meet the legal standard for commitment and require intensive treatment. The STCF shall be designated by the Division to serve residents of

specific geographic areas within the State. All admissions to short term care facilities shall be referred through a designated screening service.

In the definition for “stabilization options,” proposed amendments add “early intervention programs,” “acute partial care/hospitalization” and “extended crisis evaluation bed.”

Finally, in the definition for “treatment facility,” the term “mental retardation” has been updated to “developmental disability” and “nursing” and “rehabilitative facilities” have been added.

N.J.A.C. 10:31-1.4 Waiver

The Division is proposing to repeal the existing section regarding waivers and to replace it with an updated section containing greater detail (see summary of Subchapter 11 below.)

Subchapter 2. Program Requirements

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

Several amendments are being proposed to clarify descriptions of a screening service’s required functions. First, at N.J.A.C. 10:31-2.1(a), the word “direct,” modifying “service

functions,” has been deleted because not all functions performed by a screening service may be considered “direct services,” for example, arranging for after-care. At N.J.A.C. 10:31-2.1(a)1, grammatical clarifications change the phrase the “need for stabilization and support services” to “identification of stabilization, diversion, and support services needed.” The function of “diversion” (from hospitalization) has been added, to reflect wellness and recovery principles encouraging the least restrictive type of care for a consumer. The cross reference to N.J.A.C. 10:31-2.2, regarding affiliated emergency services, is proposed for deletion as it appears to be extraneous. Also in this section, the phrase “both on and off site” is proposed for deletion to update the understanding of screening services to a more mobile, flexible, community-oriented service. Further, jails and nursing homes have been added to the list of locations in which screening services may take place.

New N.J.A.C. 10:31-2.1(a)2, regarding the function of providing emergency and consensual treatment to the person receiving an assessment has been added.

At proposed N.J.A.C. 10:31-2.1(a)3 (recodified from existing N.J.A.C. 10:31-2.1(a)2), amendments add “early intervention” as another form of intervention counseling. Early intervention services can address mental health issues at an earlier stage of the development of mental illness, potentially preventing the trauma of advanced illness and avoiding more extensive, restrictive and expensive forms of treatment.

At N.J.A.C. 10:31-2.1(a)4 (recodified from existing N.J.A.C. 10:31-2.1(a)3), additional descriptions of the functions of assessment and referrals have been added to require conformance with current standards of care. Specifically, consumers must be referred to the “most appropriate, least restrictive treatment settings indicated” and to services that are “licensed by the appropriate authority where applicable.” The phrase “accepted for case management” is being deleted, because consumers may be referred to other forms of services.

New N.J.A.C. 10:31-2.1(a)5 was added to incorporate an existing function provided by screening services: the initiation of involuntary commitment procedures, where appropriate and pursuant to N.J.A.C. 10:31-2.3.

At proposed N.J.A.C. 10:31-2.1(a)6 (recodified from existing N.J.A.C. 10:31-2.1(a)4), proposed amendments require that the 24-hour hotline be answered directly and “at all times” by a certified screener, crisis intervention specialist or other clinical personnel under the supervision of the screener or crisis intervention specialist. These changes were added to ensure the delivery of quality services by competent professionals.

The existing requirement that the screening service provide mobile outreach services in any location throughout the geographic area under certain, enumerated circumstances has been moved to proposed N.J.A.C. 10:31-2.1(a)7 (recodified from N.J.A.C. 10:31-2.1(a)5). In addition to grammatical changes, the word “mobile” (as a descriptor of screening services) has been removed because it is redundant within the context of the

sentence. In addition, at proposed N.J.A.C. 10:31-2.1(a)7iii, amendments clarify that mobile outreach services shall be available where there are safety concerns that cannot be resolved through consultation by screening outreach staff with the police and coordination of transportation to the screening service with the police.

“Holding beds” are now called “extended crisis evaluation beds” (ECEBs), and an amendment to proposed N.J.A.C. 10:31-2.1(a)8 (recodified from existing N.J.A.C. 10:31-2.1(a)6) reflects this change. Additional amendments clarify that ECEBs are to be used for the purpose of assessment, intensive supervision, medication monitoring and crisis stabilization.

The requirement that screening services have written protocols and procedures for the use of various medication techniques, including emergency stabilization, has been relocated from existing N.J.A.C. 10:31-2.1(a)7 to a new paragraph delineating all requirements for written procedures (N.J.A.C. 10:31-2.6(b)7).

Proposed new N.J.A.C. 10:31-2.1(a)9 reflects the existing function of directly or indirectly providing appropriate medical services for consumers who are receiving screening services.

The function of providing medication monitoring remains, but is recodified from N.J.A.C. 10:31-2.1(a)8 to proposed N.J.A.C. 10:31-2.1(a)10.

Proposed new N.J.A.C. 10:31-2.1(a)11 incorporates the existing function of arranging transportation of consumers in need of commitment to the receiving facility.

Existing N.J.A.C. 10:31-2.1(a)9 has been recodified as N.J.A.C. 10:31-2.1(a)12. For the reasons explained hereinabove, proposed amendments delete the phrase “either on-site or off-site.” Amendments add “telephone calls” to the possible forms that required follow-ups may take. A new subsection states that referral for after-care services with mental health care providers who are licensed by the appropriate authority, as applicable, must be made in compliance with the agency’s policy regarding informed consent (proposed N.J.A.C. 10:31-2.1(a)12.i). The requirements of existing N.J.A.C. 10:31-2.1(f)4 have been amended and relocated to proposed N.J.A.C. 10:31-2.1(a)12ii, which specifies that the existing responsibility of developing and maintaining affiliation agreements for priority access with other community agencies must ensure that a consumer must receive psychiatric evaluation for medication within seven days of referral and be referred to other mental health services within 14 days of the initial referral. Proposed N.J.A.C. 10:31-2.1(a)12ii also contains the requirement, currently within existing N.J.A.C. 10:31-2.1(c), that the screening service shall maintain responsibility for medication until this function is transferred to another agency pursuant to the affiliation agreement.

A new provision codifies the existing responsibility of assessing the committability of consumers who are returned for screening services because they fail to meet the conditions of their release. (N.J.A.C. 10:31-2.1(a)13) This new provision reflects the

Appellate Division's ruling in In re Commitment of B.L., 346 N.J. Super. 285 (App. Div. 2002).

The existing requirement that psycho-educational and/or supportive services shall be provided to family members who are involved at the time of the initial crisis has been recodified from N.J.A.C. 10:31-2.1(a)10 to (a)14 and a requirement that these services be offered to consumers has been added.

At N.J.A.C. 10:31-2.1(a)15, a proposed amendment adds the requirement that screening services shall advocate flexibly to meet consumers' needs.

At proposed N.J.A.C. 10:31-2.1(a)16 (relocated from existing N.J.A.C. 10:31-2.1(f)2), the requirement that screening services maintain affiliation agreements with STCFs has been amended to specify that this affiliation be memorialized in a written agreement with the designated STCF(s) serving the geographic area.”

At proposed N.J.A.C. 10:31-2.1(a)17 (relocated from existing N.J.A.C. 10:31-2.1(f)5), the requirement that screening services must provide training or technical assistance to police has been expanded. One proposed amendment would require the screening service to develop and maintain a written plan for this purpose. Other amendments delineate the location, frequency and substance of police training: (1) the screening service may accomplish this training through presentation of a Division-approved curriculum at the police academy and through periodic consultation and advisement to

the police and other community referral sources (proposed N.J.A.C. 10:31-2.1(a)17) and, (2) training shall be provided on a continuing basis and shall include, but shall not be limited to, orientation to the screening system, provisions contained within the screening law, explanation of mental illness, crisis intervention skills, systems interaction, and transportation (N.J.A.C. 10:31-2.1(a)16ii).

At proposed N.J.A.C. 10:31-2.1(a)18 (relocated from existing N.J.A.C. 10:31-2.1(f)6), the existing requirement that screening services assure the transportation of consumers in crisis has been amended to require that the screening service develop a plan for this purpose and would assure the Division that the transportation would be in accordance with all applicable federal and State laws. An additional amendment specifies that the plan provide for transportation from affiliated emergency or screening services to State or county psychiatric hospitals or short-term care facilities.

At proposed N.J.A.C. 10:31-2.1(a)19 (relocated from existing N.J.A.C. 10:31-2.1(f)7), the requirement that screening services provide crisis intervention training to affiliated emergency services (AES) providers has been amended to include the provision of consultation services, as needed, to AES, police and other community referral sources.

At proposed N.J.A.C. 10:31-2.1(a)20 (relocated from N.J.A.C. 10:31-2.1(f)8), the requirement that the screening service develop and coordinate mechanisms for acute care system review has been amended to specify that this be done in accordance with

additional requirements found in N.J.A.C. 10:31-5, System Review in the Acute Care System.

Proposed N.J.A.C. 10:31-2.1(a)21 (relocated from N.J.A.C. 10:31-2.(f)9), requires screening services to 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.

An additional responsibility for screening services is proposed at N.J.A.C. 10:31-2.1(a)22, namely, ensuring that services are publicized throughout the community at large through, among other modalities, publication of services in the local telephone directory.

Proposed N.J.A.C. 10:31-2.1(a)23 (relocated from N.J.A.C. 10:31-2.1(f)10 requires screening services to comply with N.J.A.C. 10:37-6.79 regarding records of all persons seen and to compile information regarding disposition of such persons for review by the Systems Review Committee.

A new requirement, that enhanced screening services shall perform additional duties, as negotiated and agreed to in their contracts with the Division, is proposed at N.J.A.C. 10:31-2.1(b).

Proposed new N.J.A.C. 10:31-2.1(c) requires a screening service to maintain a physical environment that demonstrates that the provider is cognizant of, and responsive to, the varying needs and vulnerabilities of the diverse population its serves, especially as regards children and the elderly. Screening staff must ensure that consumers are protected from dangerous, upsetting or inappropriate stimuli.

At proposed N.J.A.C. 10:31-2.1(d) (recodified from existing N.J.A.C. 10:31-2.1(b)), the requirement that each screening service submit a plan for prioritizing responses to screening outreach calls has been amended to specify that this plan must be submitted to the appropriate Division regional office. The requirements concerning the plan's substance have been reorganized for improved clarity: (1) the requirement that response timeframes must reflect the unique characteristics of the geographic area has been recodified at N.J.A.C. 10:31-2.1(c)1; and (2) the existing requirement that the plan delineate a protocol for police involvement has been recodified as N.J.A.C. 10-31-2.1(d)3 and revised to include "other emergency response personnel and other professionals." Two new requirements are proposed: (1) outreach shall be provided in a timely manner when the screener determines, based on clinically relevant information, that the person is dangerous by reason of a mentally illness, and unable or unwilling to come to the screening service (N.J.A.C. 10:31-2.1(d)2); and (2) when resources are available, a plan be submitted for the expansion of screening services to provide additional prevention, intervention and stabilization services. (N.J.A.C. 10:31-2.1(d)4)

Existing N.J.A.C. 10:31-2.1(c) has been deleted and relocated to proposed N.J.A.C. 10:31-2.1(a)12ii.

Existing N.J.A.C. 10:31-2.1(d) is proposed for deletion because its requirements appear in greater detail at proposed N.J.A.C. 10:31-2.1(a)1 and (a)3. Existing N.J.A.C. 10:31-2.1(e), stating that the functions of a screening service may be delegated in accordance with a county plan approved by the Division, is proposed for deletion, as county plans are no longer used for this purpose.

Existing N.J.A.C. 10:31-2.1(f)1 is proposed for deletion, because the issues are covered in the contracts between the screening service and the Division.

As noted above, existing N.J.A.C. 10:31-2.1(f)5 through 10 are proposed for deletion and recodification as N.J.A.C. 10:31-2.1(a)16 through 22.

Existing N.J.A.C. 10:31-2.1(f)3, requiring that the screening service notify the provider of liaison services whenever an individual is involuntarily hospitalized at a STCF or State or county psychiatric hospital, is proposed for deletion because it is the responsibility of State and county hospitals and STCFs to inform providers when a consumer is admitted.

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

At N.J.A.C. 10:31-2.2(a), proposed amendments change “emergency services” to “affiliated emergency services” (AES) and indicate that an AES must operate in accordance with contractual agreements with the Division and affiliation agreements with the designated screening center. At proposed new N.J.A.C. 10:31-2.2(a)2, AES are required to provide or arrange for appropriate medical services for consumers receiving care at the AES. At N.J.A.C. 10:31-2.2(a)3 (recodified from N.J.A.C. 10:31-2.2(a)2), proposed amendments require AES to administer medication in accordance with N.J.S.A. 30:4-27.11e.a(1) and in non-emergency situations, only with the consumer’s consent. Also in the section, the phrase “on-site” is proposed for deletion, to reflect a more flexible, mobile concept of screening services. An additional proposed amendment in this paragraph also requires an AES to operate in accordance with contractual agreements with the Division and affiliation agreements with the designated screening service.

Existing N.J.A.C. 10:31-2.2(a)3 is recodified as N.J.A.C. 10:31-2.2(a)4. Proposed N.J.A.C. 10:31-2.2(a)4i requires an AES to document its efforts, where applicable and unless contraindicated, to refer consumers to the most appropriate and least restrictive treatment setting licensed by the appropriate authority. Proposed N.J.A.C. 10:31-2.2(a)4ii (recodified from N.J.A.C. 10:31-2.2(a)5) requires that the AES facilitate linkage to acute care mental health services (such as crisis housing, acute partial and acute in-home services). Proposed N.J.A.C. 10:31-2.2(a)4iii (recodified from N.J.A.C. 10:31-2.2(a)6) requires the AES to provide linkage to necessary follow-up mental health and non-mental health services. N.J.A.C. 10:31-2.2(a)4 is recodified as N.J.A.C. 10:31-

2.2(a)5, with only grammatical changes in the text regarding the hot line. As noted above, N.J.A.C. 10:31-2.2(a)5 and 6 have been recodified, respectively as N.J.A.C. 10:31-2.2(a)4ii and iii.

At N.J.A.C. 10:31-2.2(b)1, the phrase “holding beds” has been changed to “extended crisis evaluation beds,” to reflect current usage.

The requirement that AES provide protocol and procedures for use in various medication techniques involving emergency stabilization regimes is proposed for deletion (at N.J.A.C. 10:31-2.2(b)2) because it is subsumed within the broader requirement at proposed N.J.A.C. 10:31-2.2(a)2.

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

The following changes are proposed in this section, delineating screening process and procedures. Consistent with State law (at N.J.S.A. 30:4-27.5.a), proposed N.J.A.C. 10:31-2.3(a) states that, upon entry of the consumer to the screening service, staff may detain the consumer for up to 24 hours from entry thereto for the purpose of providing emergency and consensual treatment, medical clearance and conducting an assessment. The screening service, or AES, shall provide a thorough assessment of the consumer to determine the meaning and implication of the presenting problem(s) and efforts, which have already been made to address the latter. (N.J.A.C. 10:31-2.3(b)1) The screening service, or AES, consistent with State and Federal laws

regarding patient confidentiality, shall contact the consumer's family, civil union partner, significant others and current or previous service providers to determine the consumer's clinical needs and appropriate care. (N.J.A.C. 10:31-2.3(b)1) At N.J.A.C. 10:31-2.3(b)2, proposed amendments require that the screening service or AES staff determine whether the consumer has an advance directive for mental health care. The Department is proposing to delete from existing N.J.A.C. 10:31-2.3(b)1 the requirement that screening service staff advocate for flexible, appropriate services to meet consumers' needs, and include this function under a different section at N.J.A.C. 10:31-2.1(a)10 (functions of a screening service). Similarly, the prohibition against administering medication to consumers in non-emergency situations without their consent has been moved from N.J.A.C. 10:31-2.3(b)1 to 2.1(a)10.

Proposed N.J.A.C. 10:31-2.3(b)3 requires a screening service and AES to record pertinent consumer information, including but not limited to: basic identifying data as it relates to the presenting crisis; history and nature of the presenting problem, psychiatric and social history; medical history, including current medical status problems, allergies, and current medication; mental status and level of functioning; drug and alcohol use and history; indication of dangerousness; exploration of available resources and natural support system; preliminary diagnosis and, whether or not the consumer has executed an Advance Directive for Mental Health Care. (N.J.A.C. 10:31-2.3(a)3i through x)

At proposed N.J.A.C. 10:31-2.3(c) (recodified from N.J.A.C. 10:31-2.3(b)), a screening service's responsibility to explore stabilization options before pursuing involuntary

hospitalization of a consumer has been strengthened by deleting the qualifying phrase “whenever possible and appropriate” and by adding the words “fully” before “explored”

In addition, the term “acute hospitalization” has been updated to “acute hospitalization/partial care” (N.J.A.C. 10:31-2.3(c)5) and “holding bed” has been updated to “extended crisis evaluation bed” (N.J.A.C. 10:31-2.3(c)7). At N.J.A.C. 10:31-2.3(c)10, “in-patient” has been replaced with the more accurate term, “psychiatric unit of a general or special hospital.”

In addition to clarifying existing requirements by providing further description, the proposed amendments to this section delineate the steps to be followed by a certified screener in determining whether commitment is indicated. Grammatical, non-substantive changes are proposed at N.J.A.C. 10:31-2.3(d) (recodified from N.J.A.C. 10:31-2.3(c)) to provide for improved readability. Remaining are the existing requirements that screeners, after concluding that stabilization options and less restrictive or in-community treatment are inappropriate or unavailable, must determine whether an individual has a mental illness and is dangerous to self, others or property because of that mental illness. (N.J.A.C. 10:31-2.3(d)1 and 2) Proposed N.J.A.C. 10:31-2.3(d)3 also requires that the screener determine whether the individual understands the nature of the recommended treatment and is unwilling to accept appropriate, available inpatient treatment at an STCF, psychiatric facility or special psychiatric hospital.

Proposed N.J.A.C. 10:31-2.3(e) states that if the screener determines that the aforementioned criteria are met and all stabilization options have been exhausted, the screener must fully complete, within 24 hours of the individual's presentation for screening services, the screening document (included in the rule as N.J.A.C. 10:31 Appendix A). The screening document certifies that the person is in need of involuntary commitment. Proposed N.J.A.C. 10:31-2.3(e)1 states that where the individual is willing to accept appropriate inpatient treatment, the screener shall complete all relevant sections of the screening document, indicating that the individual has agreed to voluntary admission.

After completing the screening document, the screener must contact the screening psychiatrist for further evaluation of the individual. (N.J.A.C. 10:31-2.3(f)) After reviewing the screening document and consulting with the screener, the screening psychiatrist must conduct and document a thorough psychiatric evaluation of the consumer. (N.J.A.C. 10:31-2.3(f)2, recodified from N.J.A.C. 10:31-2.3(d)) At N.J.A.C. 10:31-2.3(f)2, the phrase "face-to-face" is proposed for deletion to allow for the psychiatric assessment to be accomplished through telepsychiatry.

Through discussions of the Screening Regulations Task Force and the Division's ongoing interaction with providers, consumers, families and other stakeholders, the Division is keenly aware of the difficulties presented by a shortage of psychiatrists available to service the public mental health system. In order to assure the effective operation of vital emergency psychiatric services, the Division is proposing amendments

to allow psychiatric assessments of consumers of screening services to occur through the technologically assisted means, known as telepsychiatry. Telepsychiatry uses interactive videoconferencing technologies to allow psychiatrists to examine patients at remote locations.

Proposed amendments require that the screening service obtain a waiver for this purpose and maintain a Division-approved plan delineating a procedure for psychiatric evaluation through telepsychiatry. (N.J.A.C. 10:31-2.3(f)2i) 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 during the hours to be covered by the telepsychiatry program (N.J.A.C. 10:31-2.3(f)2ii)

A screening services' plan to utilize telepsychiatry must include 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 (N.J.A.C. 10:31-2.3(f)2iii(1)); (2) Telepsychiatry shall not be used where it is clinically contraindicated (N.J.A.C. 10:31-2.3(f)2iii(2)); (3) Screening staff shall obtain and document the consumer's valid consent to being assessed through the means of telepsychiatry (N.J.A.C. 10:31-2.3(f)2iii(3)); (4) A screener or registered nurse must be with, or available to, the consumer at all times during the telepsychiatric assessment (N.J.A.C. 10:31-2.3(f)2iii(4)); (5) Pursuant to State and Federal laws, confidentiality must be preserved by electronic safeguards and by training on-site and

off-site staff in the telepsychiatric protocol (N.J.A.C. 10:31-2.3(f)2iii(5)); (6) The psychiatrists involved in telepsychiatry may be employed as staff of the screening service or may be under contract with the screening service; however, contracts for telepsychiatry shall in no way restrict the screening service from hiring and credentialing psychiatrists for any other duties or services that are required by the screening service (N.J.A.C. 10:31-2.3(f)2iii(6)); (7) The psychiatrist performing the telepsychiatric assessment shall hold a full, unrestricted medical license in New Jersey (N.J.A.C. 10:31-2.3(f)2iii(7)); (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 (N.J.A.C. 10:31-2.3(f)2ii(8)); (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 quality improvement activities of the screening service (N.J.A.C. 10:31-2.3(f)2iii(9)); (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 (N.J.A.C. 10:31-2.3(f)2ii(10)); and (11) The technology used in the assessment must be consistent with the state of the art acknowledged in the profession. (N.J.A.C. 10:31-2.3(f)2.iii(2))

Proposed N.J.A.C. 10:31-2.3(f)3 requires that the psychiatrist, after concluding that the consumer meets the standards for commitment, complete all sections of the screening

certificate on forms approved by the Administrative Office of the Courts. This form is designated a “screening/clinical certificate” and is also known as the “physician’s certificate.”

Proposed N.J.A.C. 10:31-2.3(f)3.i requires that the screening psychiatrist be the only person to complete the screening certificate, except in those circumstances where the Division’s contract with the screening service provides that another physician may conduct the assessment and complete the certificate.

Pursuant to the screening statute (at N.J.S.A. 30:4-27.9c) and the Rule of Court (R. 4:74-7), proposed N.J.A.C. 10:31-2.3(f)3ii requires that within 72 hours of the psychiatrist’s completion of the screening/clinical certificate: (1) the consumer must be admitted to a short-term care facility or a psychiatric facility, or a special psychiatric hospital; (2) a psychiatrist on the consumer’s treatment team at the admitting facility must complete the clinical certificate; and (3) staff at 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 admitting facility).

Proposed N.J.A.C. 10:31-2.3(f)4 states that if the consumer is dangerous by reason of mental illness, but is willing and able to consent to admission to a psychiatric facility, the psychiatrist shall document this fact in the consumer’s medical record and recommend

that the consumer be admitted consensually, without need to complete the screening/clinical certificate.

Proposed amendments at N.J.A.C. 10:31-2.3(g) reflect the statutory mandate that, with limited exceptions, an individual shall be evaluated by two different psychiatrists before being committed to a psychiatric facility. (N.J.S.A. 30:4-27.5.b and 27.10.a) The statutes require that the screening service's policies and procedures specify that the psychiatrist who assesses the patient in the screening service shall not be the psychiatrist who treats the patient in the short-term care facility, unless reasonable, but unsuccessful attempts, were made to have another psychiatrist conduct the assessment and execute the screening certificate. These "reasonable attempts" must be documented and shall include, but not be limited to, reassignment and scheduling changes. (N.J.A.C. 10:31-2.3(g)1i and ii)

N.J.A.C. 10:31-2.3(e) and (e)2 are proposed for deletion because they use outdated language to articulate the prerequisite conditions to a finding that a person requires involuntary commitment. This language has been replaced by proposed amendments to N.J.A.C. 10:31-2.3(d), which delineates the current legally enforceable commitment standard and N.J.A.C. 10:31-2.3(h), which delineates the current referral process in the event that the involuntary commitment is not indicated.

N.J.A.C. 10:31-2.3(e)1 is recodified as N.J.A.C. 10:31-2.3(h)) and includes a reference to community mental health agencies and voluntary admission to the psychiatric units of

general hospitals or special; psychiatric hospitals as appropriate entities to which screening services may refer a consumer in the event that the consumer does not meet the commitment standard or is dangerous by reason of a mental illness and is willing to accept inpatient treatment. The reference to the responsibility of the screening service to “facilitate the necessary linkages to mental health services” has been deleted from N.J.A.C. 10:31-2.3(g) because it is included at proposed N.J.A.C. 10:31-2.3(c)2.

Proposed new N.J.A.C. 10:31-2.3(i) is consistent with statutory mandates at N.J.S.A. 30:4-27.4(b) and state that after the screening psychiatrist has completed the screening certificate, the screener shall take the next three steps. First, the screener must determine the appropriate facility for the consumer, taking into account the prior history of hospitalization and treatment. (N.J.A.C 10:31-2.3(i)1) If a person has been admitted three times or has been an inpatient for 60 days at an STCF during the preceding 12 months, consideration shall be given to placements other than at an STCF. (N.J.A.C. 10:31-2.3(i)1.i) The second step is to arrange for transportation of the consumer to the receiving facility. (N.J.S.A. 10:31-2.3(i)2) The third step is to assure medical clearance for the transfer. (N.J.A.C. 10:31-2.3(i)3)

Proposed N.J.A.C. 10:31-2.3(j) and (k) concern documentation requirements under which screening services must record clinical decision-making in the clinical record and keep copies of screening documents in the consumers’ charts (N.J.A.C. 10:31-2.3(j)1 and 2). Screening services must maintain, review and update annually written policies and procedures concerning the involuntary commitment process. (N.J.A.C. 10:31-

2.3(k)) These policies must clearly describe the procedures and individuals authorized to complete screening documents (N.J.A.C. 10:31-2.3(k)1); address conflict resolution between screeners and psychiatrists (N.J.A.C. 10:31-2.3(k)2) and includes copies of all forms. (N.J.A.C. 10:31-2.3(k)3)

Proposed amendments at N.J.A.C. 10:31-2.3(l) (recodified from N.J.A.C. 10:31-2.32(f)), regarding mobile screening delete the qualifying words “preferable” and “should” before “be utilized; require that outreach shall occur where it is appropriate to do so, after an evaluation of clinical and safety considerations; occur if the person is “unwilling and/or unable to come to the screening center for an evaluation” and whenever clinically relevant information indicates that a person may meet the commitment standard.

At proposed N.J.A.C. 10:31-2.3(m) (recodified from N.J.A.C. 10:31-2.3(g)), reference to “ES” has been changed to “AES,” for “affiliated emergency screening service.” In addition, the phrase “as determined by the screening center” is proposed for deletion because the affiliation agreement between the AES and screening service determines the procedure by which consumers are screened in the AES. A proposed amendment recodified at N.J.A.C. 10:31-2.3(m)1 changes the timeframe within which a screener must be available to provide outreach from “one hour” to that “stipulated in the affiliation agreement,” to provide greater flexibility. At N.J.A.C. recodified 10:31-2.3(m)4, proposed amendments stipulate the same prohibition against the same psychiatrist completing the screening certificate and being the treating psychiatrist as required of screening services (see N.J.A.C. 10:31-2.3(g)). Further, if an AES consumer is on a

hospital inpatient unit, the treating psychiatrist cannot complete the screening certificate. (N.J.A.C. 10:31-2.3(m)4.i) These procedures must be delineated in a Division-approved affiliation agreement between the AES and the screening service. (N.J.A.C. 10:31-2.3(m)4ii)

10:31-2.4 Confidentiality

To reflect a synthesis between existing state law and new developments in Federal confidentiality law, this section is proposed for repeal and a separate subchapter on confidentiality is proposed at N.J.A.C. 10:31-12.

N.J.A.C. 10:31-2.4 Procedures for Rehospitalization of Consumers Who Violate Their Conditions of Release

This new section is proposed to reflect the requirements of an Appellate Division decision prescribing certain procedures to be followed when a consumer fails to meet the terms of a conditional release order (In re Commitment of B.L., 346 N.J. Super. 285 (App. Div. 2002)).

Proposed N.J.A.C. 10:31-2.4(a) follows the statutory provision (N.J.S.A. 30:4-27.15 (c)1 and 2) allowing a consumer who has been involuntarily committed to be discharged from that commitment by a court, subject to conditions recommended by the facility and mental health agency staff, with the consumer's participation. The mental health agency designated in the order must notify the court if the consumer fails to meet the

order's conditions. (N.J.A.C. 10:31-2.4(b)) The judge may then authorize the agency or the police to transport the person to the appropriate screening service for further assessment and evaluation. If the order is verbal, the judge will subsequently sign an order reciting the same information. (N.J.A.C. 10:31-2.4(c)) Where the consumer is unable or unwilling to come to the screening service, the mental health agency shall contact the screening service to arrange for mobile outreach. If the outreach indicates the need for further assessment or services available through screening services, the screening staff shall arrange to have the consumer transported to the screening service, in compliance with screening standards and existing affiliation agreements. (N.J.A.C. 10:31-2.4(d))

If, after assessing the consumer's condition, the screener determines that the consumer meets the standard for commitment, the screener shall complete the "Certification for Return Following Conditional Release," found at N.J.A.C. 10:31 Appendix B, (N.J.A.C. 10:31-2.4(e)) This certificate must be completed in detail sufficient to enable a judge to make the requisite findings of fact and must contain: a description of the violated conditions of release; evidence of mental illness and dangerousness and the basis for recommending re-hospitalization; and a recommendation as to the appropriate type of facility for the psychiatric treatment of the consumer. (N.J.A.C. 10:31-2.4(f)) Next, the screener must convey to the committing judge, via fax or telephone (following up with a written signed certification), the information included on the Certificate for Return Following Conditional Release. If the information is conveyed verbally, a written, signed

certification with the same information shall be sent to the judge as soon as possible.
(N.J.A.C. 10:31-2.4(g))

After review of the certificate, the judge may complete an “Order for Temporary Rehospitalization Following Conditional Release” found at N.J.A.C. 10:31 Appendix C), ordering the consumer to an STCF, or other inpatient setting, without a screening certificate or any further court order until the 20-day hearing required by N.J.S.A. 30:4-27.10 may be held. (N.J.A.C. 10:31-2.4(h)) If the judge issues a verbal order or faxes the completed order to the screening service, the time, date and name of the person receiving the order shall be documented on the order and in the chart. (N.J.A.C. 10:31-2.4(i))

The screening service shall then arrange to transport the consumer, with the certification and the order, to the appropriate facility for rehospitalization. (N.J.A.C. 10:31-2.4(j))

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

The section regarding staff availability contains several proposed amendments. A new proposed sentence in N.J.A.C. 10:31-2.5(a)1 states that psychiatrist availability may be accomplished through telepsychiatry, upon prior approval from the Division and consistent with N.J.A.C. 10:31-2.5(f)2. A psychiatrist must be available to provide off-site evaluation when indicated, based upon contractual agreement with the Division.

(N.J.A.C. 10:31-2.5(a)1ii) A written protocol shall indicate the procedures, timeframes and circumstances for the response of a psychiatrist, who must be on scheduled duty at the screening service as the screening service psychiatrist. (N.J.A.C. 10:31-2.5(a)1iii)

Proposed amendments to N.J.A.C. 10:31-2.5(a)2 delineate the availability requirements for screeners. A written protocol shall indicate the procedures, circumstances and timeframes within which screeners will respond to off-site locations.

Regarding the availability of screeners, a new provision requires a written protocol to indicate the procedures, circumstances and timeframes within which screeners will respond to off-site locations. (N.J.A.C. 10:31-2.5(a)2i) When screeners are available via an on-call system, agency protocol shall indicate the timeframes and circumstances under which screeners will be required to respond on-site. (N.J.A.C. 10:31-2.5(a)2ii)

Regarding the screening center or AES coordinator or designee, written protocols must also indicate the chain of command, procedure for, and situations warranting contact. (N.J.A.C. 10:31-2.5(a)4.i and ii)

At N.J.A.C. 10:31-2.5(a)5, “clinical director” is updated to “medical director.”

A proposed amendment at N.J.A.C. 10:31-2.5(a)6 specifies that personnel referenced in the contract between the screening service and the Division must be qualified for their respective job functions from both an educational and licensing perspective.

Amendments to the personnel requirements relevant to AES are proposed: (1) as with screening services, psychiatrist availability may be accomplished through telepsychiatry, upon prior approval from the Division and consistent with the terms of N.J.A.C. 10:31-2.3(f)2; and (2) for AES with ECEBs, personnel must be qualified to treat and monitor patients. (N.J.A.C. 10:31-2.5(b)3)

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

This new section was created to clarify and organize, in a central place, the requirements regarding the establishment of written policies and procedures that must comply with Federal and State laws. (N.J.A.C. 10:31-2.6(a)) The aim of each policy shall be to ensure accessibility and delivery of services in the least restrictive, clinically appropriate setting available, balancing liberty and safety interests with the achievement of wellness and recovery as its ultimate goal. (N.J.A.C. 10:31-2.6(b))

The policy and procedures manual must be reviewed and revised annually, with this process documented. (N.J.A.C. 10:31-2.6(b)1) Provider policies shall: (1) require attempts to gain consumer consent to treatment, except where involuntary treatment is legally authorized and consistent with State law (N.J.A.C. 10:31-2.6(b)2); (2) consistent with the confidentiality provision, require documented contact with the consumer's family, spouse, civil union partner or significant others, and current and previous service providers to determine the clinical needs of, and best treatment for, options for the

consumer (N.J.A.C. 10:31-2.6(b)3); (3) describe the provision of outreach services and the role of the screening service staff with police at the scene of an outreach (N.J.A.C. 10:31-2.6(b)4 and 5); (4) describe the provision of extended crisis evaluation services, with the description of the use of physical restraints and the monitoring of medication being consistent with Department of Health and Senior Services rules and applicable Federal and State laws and a requirement that screening services submit aggregate data on restraint use to the Division on a quarterly basis (N.J.A.C. 10:31-2.6(b)6); (5) describe the use of various medication techniques, including emergency stabilization regimes (N.J.A.C. 10:31-2.6(b)7); (6) require that interventions on behalf of the consumer be documented in a clinical record (N.J.A.C. 10:31-2.6(b)8); (7) address the supervision of screeners possessing temporary certification in the completion of their assessment process (N.J.A.C. 10:31-2.6(b)9); (8) describe all duties to be performed by psychiatrists (N.J.A.C. 10:31-2.6(b)10); and (9) maintain records of screener certification and completion of recertification requirements. (N.J.A.C. 10:31-2.6(b)11)

Subchapter 3, Screening and Screening-Outreach Personnel Requirements

N.J.A.C. 10:31-3.1 Composition of screening and screening outreach staff

The proposed amendments require screening services to employ certified screeners and a screening service coordinator and state that staff may also include crisis intervention specialists, social workers, registered professional nurses, psychologists and other mental health professionals, as well as peer advocates. An additional

sentence, requiring a certified screener to be present on each shift, has been relocated to N.J.A.C. 10:31-3.1 from its original location in N.J.A.C. 10:31-3.3(a).

N.J.A.C. 10:31-3.2 Screening Center Coordinator Requirement, Qualifications, and Duties.

The qualification requirements for the screening service coordinator have been clarified and now include a requirement that: (1) the master's degree of the screening service coordinator be from "an accredited educational institution"; (2) the supervisory experience must be of at least one year in duration and must be post-master's and in the mental health field; and (3) successful completion of the Division-sponsored certification course and passage of the proficiency exam must occur within six months of the date of hire. (N.J.A.C. 10:31-3.2(a)1 through 4)

At N.J.A.C. 10:31-3.2(b), several proposed amendments augment the duties of the screening service coordinator. First, the coordinator must devise and implement a written staffing plan that ensures that a screener is available on-site or on-call at all times; provide appropriate coverage in the event of an unscheduled absence of staff and ensure adequate levels of clinical staff supervision, skill development and support. (N.J.A.C. 10:31-3.1(b)1i through iii). Second, the coordinator must facilitate access to all acute services in the screening services' geographic area. (N.J.A.C. 10:31-2.7(b)2) Third, the coordinator must devise, implement, and document compliance with a written plan regarding affiliation agreements with acute services, police, corrections, and other

mental health, social service, and health service systems (N.J.A.C. 10:31-3.2(b)3). Fourth, the coordinator must create and document formal liaison activities with law enforcement and human services organizations regarding intersystem issues, transportation, screening outreach, escort/accompaniment and similar matters (N.J.A.C. 10:31-3.2(b)4). Fifth, the coordinator must establish a procedure for monitoring and documenting the performance of all screening service functions (N.J.A.C. 10:3.2(b)5). Sixth, proposed amendments require coordinators to delineate, in an Division-approved affiliation agreement, coordination between the screening service and short-term care facility, psychiatric facility, and special psychiatric hospital (N.J.A.C. 10:31-3.2(b)7(i)). Proposed amendments in this provision replace “State psychiatric hospital and county psychiatric hospital” with “psychiatric facility, and special psychiatric hospital” because the latter terms are consistent with statutory language at N.J.S.A. 30:4-27.2.u and cc.

Existing N.J.A.C. 10:31-3.2(b)8 is proposed for deletion because it has been relocated to proposed N.J.A.C. 10:31-3.2(b)2. Finally, proposed amendments require the coordinator to coordinate the required emergency service training and education in the geographic area. (N.J.A.C. 10:31-3.2(b)9)

N.J.A.C. 10:31-3.3 Screener Certification Requirement, Qualifications, and Duties

The subsection currently promulgated as N.J.A.C. 10:31-3.3(a) (requiring each screening service to have one or more certified screeners available on each shift) has been deleted because the same requirement is now located at N.J.A.C. 10:31-3.1. In

addition to the existing requirement of completion of the Division's screener certification course, screeners must also possess the qualifications delineated at N.J.A.C. 10:31-3.3(b) and pass the screener certification proficiency examination (proposed N.J.A.C. 10:31-3.3(a) recodified from existing N.J.A.C. 10:31-3.3(b)). Screening services must maintain records indicating fulfillment of these requirements. (N.J.A.C. 10:31-3.3(a)1)

At proposed N.J.A.C. 10:31-3.3(b) (recodified from existing N.J.A.C. 10:31-3.3(c)), several pre-requisites to taking the Division's screener certification course have been amended. No longer optional, the following educational standards are prerequisites for applying for admission to the Division's screener certification course and to subsequent temporary or full certification status and are applicable to individuals who seek certification after the effective date of these amendments: (1) the master's degree must be in a mental health-related field from an accredited educational institution and the one year of experience must be full-time, post-master's and professional (N.J.A.C. 10:31-3.3(b)1, recodified from N.J.A.C. 10:31-3.3(c)1.i); (2) the bachelor's degree must be in a mental health-related field from an accredited institution and the three years of experience must be full-time, post-bachelor's professional and in a mental health-related field (N.J.A.C. 10:31-3.3(b)2); (3) in the case of a person with a bachelor's degree who is currently enrolled in a master's degree program, the bachelor's degree must be in a mental-health-related field from an accredited institution, and the two years of experience must be full-time, post-bachelor's, professional, and in the mental health field (N.J.A.C. 10:31-3.3(b)3); and (4) a licensed registered nurse must have three years of full-time, post-R.N., professional mental health experience in the mental health field.

(N.J.A.C. 10:31-3.3(b)4) Existing N.J.A.C. 10:31-3.3(c)2 is proposed for deletion because the requirement that certified screeners complete a training course is proposed at N.J.A.C. 10:31-3.3(a).

New provisions delineate temporary screener status. Prior to achieving full status as a certified screener, an individual shall serve as a temporary screener and shall receive a "T" number. (N.J.A.C. 10:31-3.3(c)) Temporary screener certification entitles a mental health professional to perform emergency screening in a screening service for one year from the issuance of the "T" number. (N.J.A.C. 10:31-3.3(c)1) While a temporary screener may perform all the functions of a certified screener during this one-year period, a certified screener must review and approve the screening document completed by the temporary screener. (N.J.A.C. 10:31-3.3(c)2) Within one year of submitting an application for temporary status, the temporary screener shall attend and successfully complete a Division-approved Basic Screening Certification Training Series and shall pass the Screener Proficiency Exam. (N.J.A.C. 10:31-3.3(c)3)

Screeners who have not attended and completed every class in the training series shall not be allowed to sit for the proficiency exam. (N.J.A.C. 10:31-3.3(c)3i) Temporary screeners who fail to complete each class in the training series must make up the missed class(es) in the next Basic Screener Training Certification series. (N.J.A.C. 10:31-3.3(c)3ii) Temporary screeners who fail to pass the proficiency exam must pass a make-up exam. (N.J.A.C. 10:31-3.3(c)3iii) Temporary screeners who fail to either complete each class in the basic training series or pass the exam before the one-year

expiration of their temporary status will be placed on conditional status, pursuant to the terms of N.J.A.C. 10:31-3.3(g). (N.J.A.C. 10:31-3.3(c)3iv) Temporary screeners who have successfully completed all basic certification classes and passed the proficiency exam shall be issued a permanent screening (or "S") number, which shall be effective for two years. (N.J.A.C. 10:31-3.3(c)3.v)

Proposed amendments at N.J.A.C. 10:31-3.3(e) specify that biennial (every two years) recertification shall be granted after the screener has submitted evidence of having completed 15 Division-approved continuing education hours approved by the Division on a case by case basis with regard to the relevance of the subject matter to emergency or screening matters. In addition, those amendments require that at a minimum, six of those 15 hours shall be provided by the Division-sponsored screener training course. These proposed amendments replace N.J.A.C. 10:31-3.3(e)2, proposed for deletion which contains less current and complete information. Screeners must be re-certified bi-ennially by submitting evidence of completion of 15 hours of continuing education hours relevant to emergency or screening services, six hours of which are approved by the Division. (N.J.A.C. 10:31-3.3(e)) This standard increases the required amount of training hours and provides more specificity to those seeking to be screeners. The Division believes these changes will result in a more qualified screening staff, enhancing the quality of services delivered.

Existing N.J.A.C. 10:31-3.3(f) (regarding temporary certification) is proposed for deletion because it is being replaced by provisions which are more detailed, comprehensive and clear. (proposed N.J.A.C. 10:31-3.3(c) and (g))

A new subsection delineates the consequences of a temporary screener's failure to complete the basic certification course and pass the screener proficiency exam within the required one-year period or of a certified screener's failure to complete the recertification requirements. (N.J.A.C. 10:31-3.3(f)) In either case, the individual shall be placed on conditional, or "C," status. Screening documents and police transport forms completed by a screener on conditional status shall be co-signed by the screening coordinator within one working day of the screener's completion (N.J.A.C. 10:31-3.3(f)1). All documents signed by a screener on conditional status shall indicate this status. (N.J.A.C. 10:31-3.3(f)2). A screener on conditional status shall have six months from the date of conversion to such status to satisfy all outstanding requirements. (N.J.A.C. 10:31-3.3(f)3) Failure to remediate the conditions resulting in conditional status within six months shall result in the loss of all screening status until these requirements are met. (N.J.A.C. 10:31-3.3(g)4) In addition, the screening coordinator, agency director, Division Regional Coordinator, and Department's Office of Licensing shall be notified as to this loss of screening status.

Three functions have been added to the list of the screener's duties – (1) screening of consumers who may be in need of commitment (N.J.A.C. 10:31-3.3(g)1); (2) arranging for a consumer's discharge or transfer out of the screening service (N.J.A.C. 10:31-

3.3(g)11); (3) arranging for a consumer's appropriate transport to a receiving facility (N.J.A.C. 10:31-3.3(g)12); and (4) determining whether the consumer has executed an Advance Directive for Mental Health Care.

N.J.A.C. 10:31-3.4 Crisis Intervention Specialist Qualifications and Duties

A proposed amendment requires the screening service to maintain records concerning the educational and experiential background of crisis intervention specialists (N.J.A.C. 10:31-3.4(b)) and written policies describing orientation and training for these specialists. (N.J.A.C. 10:31-3.4(f)) Proposed amendments also detail the education and experience requirements for this position: (1) a master's degree in a mental-health-related field from an accredited institution; (2) a bachelor's degree in a mental-health-related field from an accredited institution, plus two years of experience in a psychiatric setting; or (3) licensure as a registered professional nurse. (N.J.A.C. 10:31-3.4(c)1 through 3). Notwithstanding this provision, the Division may waive the educational requirements to allow a peer advocate to serve as a crisis intervention specialist to allow greater participation by consumers. (N.J.A.C. 10:31-3.4(d))

Two substantive amendments are proposed to the provision delineating the duties of the crisis intervention specialist: (1) assessments must be performed under the supervision of a certified screener (proposed N.J.A.C. 10:31-3.4(e)3, recodified from existing N.J.A.C. 10:31-3.4(c)3); and (2) the duties of referral and linkage, including referral to a screening service, if indicated, have been added. (proposed N.J.A.C. 10:31-3.4(e)4) The requirement that written policies describe the orientation and training of

crisis intervention specialists prior to unsupervised performance of their duties has been amended to clarify that assessment is not included among these duties (N.J.A.C. 10:31-3.4(f)).

In recognition of market scarcity, the inclusion of at least one registered nurse in the crisis intervention specialist position remains as a recommendation, although superfluous language “but does not require” is proposed for deletion. (N.J.A.C. 10:31-3.4(g) recodified from N.J.A.C. 10:31-3.4(e))

N.J.A.C. 10:31-3.5 Psychiatrist Requirements, Qualifications and Duties

The provision delineating the qualifications required of psychiatrists has been amended to include the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry as alternative credentialing sources. (N.J.A.C. 10:31-3.5(a)) In addition, the screening psychiatrist must have complied with all relevant New Jersey professional licensing laws and the requirements of the New Jersey State Board of Medical Examiners. (Id.)

To ensure seamless and effective treatment, the duties performed by psychiatrists must be documented. The proposed amendments augment these duties with the addition of the following: (1) psychiatric assessment, which may be accomplished by means of a Division-approved telepsychiatry program, to determine if the consumer meets the standard for commitment, regardless of consensual or involuntary status (N.J.A.C. 10:31-3.5(b)1 and (b)1i); (2) psychiatric evaluation, changed from “assessment” to

distinguish the latter from a screening assessment and management (N.J.A.C. 10:31-3.5(b)2); (4) consultation with other treating psychiatrists and physicians, as needed (N.J.A.C. 10:31-3.5(b)7); and (5) consultation with ER doctors involved in the case and those at the receiving facilities. (N.J.A.C. 10:31-3.5(b)8)

N.J.A.C. 10:31-3.6 Medical Director Requirement, Qualifications and Duties

In addition to grammatical changes, proposed amendments at N.J.A.C. 10:31-3.6 change “clinical director” to “medical director” to reflect common usage. Also, the “grandfathering” provision, exempting those serving in this position as of the date of the original adoption of these rules, is proposed for deletion, as it is no longer relevant.

At proposed N.J.A.C.10:31-3.6(b)4, a new responsibility for the medical director: 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 the quality standards and clinical practices of the screening service.

Subchapter 4 Emergency Service Personnel Requirements

N.J.A.C. 10:31-4.1 Composition of Affiliated Emergency Service (AES) Staff

Proposed amendments specify that the staff composition of an AES must include “psychiatrists and other mental health professionals, such as registered nurses, social workers, and psychologists” and “may include peer and family advocates.”

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

Substantive proposed amendments to N.J.A.C. 10:31-4.2(a) affect AES coordinator qualifications as follows: the master's degree must be from an accredited educational institution (N.J.A.C. 10:31-4.2(a)1); one year of supervisory experience in the mental health field (N.J.A.C. 10:31-4.2(a)3); and successful completion of the Division-sponsored screener certification course, passage of the proficiency exam within six months of the date of hire and maintenance of re-certification credentials. (N.J.A.C. 10:31-4.2(a)4)

N.J.A.C. 10:31-4.3 Crisis Intervention Specialist Requirements, Qualifications and Duties

At existing N.J.A.C. 10:31-4.3(a), the second sentence, regarding education and experience requirements applicable to the AES crisis intervention specialist, is proposed for deletion because proposed new N.J.A.C. 10:31-4.3(b) require the AES crisis intervention specialist to have qualifications consistent with crisis intervention specialists serving in screening services.

At proposed N.J.A.C. 10:31-4.3(c)3 (recodified from existing N.J.A.C. 10:31-4.3(b)), the duties of an AES crisis intervention specialist have been amended to include "referral to a screening service, if indicated." Screening services peer advocates may serve as

crisis intervention specialists provided they meet the qualifications at N.J.A.C. 10:31-3.4(d).

The recommendation that at least one crisis intervention specialist be a registered nurse has been made mandatory. (proposed N.J.A.C. 10:31-4.3(d) recodified from existing N.J.A.C. 10:3.1-4.3(c))

N.J.A.C. 10:31-4.4 Psychiatrist Requirements, Qualifications and Duties

The provision delineating the qualifications required of psychiatrists has been amended to include the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry as alternative credentialing sources. (N.J.A.C. 10:31-3.5(a)) In addition, the AES psychiatrist must have complied with all relevant New Jersey professional licensing laws and the requirements of the New Jersey State Board of Medical Examiners.

The psychiatrist's duties have been amended to include: (1) documentation of each activity (N.J.A.C. 10:31-4.4(b); (2) psychiatric evaluation, instead of "assessment," to distinguish it from the screener's assessment (N.J.A.C. 10:31-4.4(b)1); (3) consultation with crisis intervention specialists, as well as with screeners (N.J.A.C. 10:31-4.4(b)4); (4) consultation with other treating psychiatrists (N.J.A.C. 10:31-4.4(b)6); (5) consultation with emergency room physicians involved in the case and those at the receiving facility (N.J.A.C. 10:31-4.4(b)7); (6) completion of the screening certificate

(N.J.A.C. 10:31-4.4(b)8) and (7) other duties as appropriate and as defined in a Division-approved affiliation agreement. (N.J.A.C. 10:31-4.4(b)9)

Subchapter 5 Systems Review in the Acute Care System

N.J.A.C. 10:31-5.1 Acute Care System Review

In N.J.A.C. 10:31-5.1(a), the existing requirement that the development of a monitoring process be monitored by screening services is proposed for deletion because it is obsolete, as this process has been developed and is handled by the systems review committee (SRC) (as specified in proposed amendments to N.J.A.C. 10:31-5.1(a)1). A new provision requires the screening service to coordinate the SRC to ensure discussion of relevant issues and follow-up with the Division and county mental health board. (N.J.A.C. 10:31-5.1(a)2) Existing N.J.A.C. 10:31-5.1(b), stating that the monitoring process shall be integrated with the system-wide quality assurance process, where it exists, is proposed for deletion, as this function has been subsumed within the SRC. The provision stating that the technical assistance shall be provided by the Division as necessary (in existing N.J.A.C. 10:31-5.1(a)) is proposed for inclusion as new N.J.A.C. 10:31-5.1(a)3.

N.J.A.C. 10:31-5.2 Composition of the Systems Review Committee

At N.J.A.C. 10:31-5.2(a)2, a proposed amendment adds representatives from special psychiatric hospitals to the composition of the SRC. New N.J.A.C. 10:31-5.2(a)5 states

that the SRC chair, who is a screening coordinator, may name additional members to the SRC, as appropriate and necessary and upon prior approval of the Division. Proposed N.J.A.C. 10:31-5.2(a)5.i states that the Division shall base its approval upon its determination that the additional party would contribute a perspective that is unique or without existing representation on the SRC and that the additional party is knowledgeable and experienced in issues relating to the screening system. Another proposed amendment adds detail to the existing confidentiality requirement: SRC members must comply with all State and Federal laws regarding confidentiality of consumer records. (N.J.A.C. 10:31-5.2(b))

N.J.A.C. 10:31-5.3 Role of Systems Review Committee

Ensuring the effectiveness of referrals and linkages to other mental health and social services has been added to the functions of the SRC. (N.J.A.C. 10:31-5.3(a)3) Another proposed amendment creates a case conferencing committee within the SRC, composed of relevant parties approved by the SRC, to review disputed cases which are indicative of possible service gaps and indicate the need for systems change. (N.J.A.C. 10:31-5.3(a)9 and 5.2(a)9i) Finally, a proposed amendment requires the SRC to conduct data analysis (N.J.A.C. 10:31-5.2(a)10).

The discussion of Subchapter 6 – 8 below are referenced in this as recodified locations due to the recodification of Subchapter 6 as 10, discussed in more detail below.

Subchapter 6 Termination of Services

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

The word “person” is replaced with “consumer,” for greater clarification and consistency within the rule text. At proposed N.J.A.C. 10:31-6.1(a)3, proposed amendments replace “been successfully linked to” with has “an appointment with” to provide greater specificity as to the obligation of screening services staff. Also in this provision, “clinical case management” has been replaced with the updated reference, “ICMS or PACT.” At proposed N.J.A.C. 10:31-6.1(a)5, “special psychiatric hospital” has been added to the list of facilities to which a consumer may be committed.

At proposed N.J.A.C. 10:31-6.1(b), “emergency services” has been updated to “affiliated services.” At proposed N.J.A.C. 10:31-6.1(b)4, amendments replaced “clinical case management” with the updated references, “ICMS or PACT.”

Subchapter 7 Police Involvement

N.J.A.C. 10:31-7.1 Transportation of Consumers

A proposed amendment requires that, before requesting police transport of a consumer who has been evaluated during an outreach visit, the screener must complete the form included in the N.J.A.C. 10:31 Appendix D. (N.J.A.C. 10:31-7.1(a)) The screening service must maintain written policies and procedures outlining the conditions and steps to be followed in instances of police involvement. (N.J.A.C. 10:31-7.1(b)) An additional proposed amendment states that the mere fact that a private residence is the location of

an outreach does not alone justify police involvement. A proposed amendment requires that, in instances where a police officer, at the request of the screening service, investigates a call and has reasonable cause to believe that involuntary commitment of a person is necessary, the screening service shall remain in contact with the law enforcement agency to determine the outcome of the investigation for those consumers who are brought to the screening service. (N.J.A.C. 10:31-7.1(c))

A proposed amendment requires the screening service to maintain written procedures describing the circumstances under which a screener may request continuation of police involvement at the screening service. (N.J.A.C. 10:31-7.3(b))

Subchapter 8 Consumer's Rights

N.J.A.C. 10:31-8.1 Consumer's Rights

A proposed amendment requires screening services to provide services in compliance with all State statutory and regulatory law.

Subchapter 9. Continued Quality Improvement

N.J.A.C. 10:31-9.1 Continued Quality Improvement

This new subchapter outlines the requirements for maintaining a continued Quality improvement plan at the screening service. The quality and appropriateness of care and services provided by a screening services and an AES shall be evaluated in

accordance with their continued quality improvement plan and with Division standards for continued quality improvement, as delineated at N.J.A.C. 10:37-9. (N.J.A.C. 10:31-9.1(a)) The screening service coordinator or AES coordinator (or their designee) is responsible for implementing the monitoring and evaluation process. (N.J.A.C. 10:31-9.1(a)1) The issues to be analyzed shall include: access to screening services, appropriateness of commitment; use and frequency of mobile outreach, including police involvement; and all other aspects of the screening process, as well as systems review data. (N.J.A.C. 10:31-9.1(a)2)

Subchapter 10. Planning

As noted above, existing Subchapter 6 is proposed for recodification as Subchapter 10, with the following amendments.

Proposed amendments at N.J.A.C. 10:31-10.1(a) insert the statutory authority by which the Division may designate screening services in each geographic area.

Additional amendments are proposed to update and clarify the planning and designation processes. Proposed N.J.A.C. 10:31-10.1(b) states that the Division shall designate a screening service for each geographic area at the conclusion of the process concerning the awarding of public contracts through public solicitation of bids or in accordance with emergency designation procedures delineated in N.J.A.C. 10:31-10.2. Proposed N.J.A.C. 10:31-10.1(c) is relocated from existing subsection (e) and states that once designated, the screening service shall have the sole authority to provide screening is, and for the geographic area in which it is located, and shall assume all of the functions

listed in N.J.A.C. 10:31-2.1. Proposed N.J.A.C. 10:31-10.1(c)1 states that screening contracts shall be funded on a yearly basis, consistent with the legislature's annual funding appropriation.

Proposed N.J.A.C. 10:31-10.1(c) is recodified from existing N.J.A.C. 10:31-10.1(e) and states that once designated, the screening service shall have the sole authority to provide screening is, and for, the geographic area in which it is located, and shall assume all of the functions listed in N.J.A.C. 10:31-2.1. Proposed N.J.A.C. 10:31-10.1(c)1 states that contracts shall be funded on a yearly basis, consistent with the legislature's annual funding appropriation.

Proposed N.J.A.C. 10:31-10.1(d) states that in order to maintain designation status, a designated screening service must comply with chapter provisions and must demonstrate satisfactory performance of its screening functions in the region., including but not limited to: clinical assessment, crisis stabilization, referral, linkage, and mobile outreach services; documentation and record-keeping requirements such as data reporting and performance measurement specifications; compliance with State and federal confidentiality laws; implementation of wellness and recovery and cultural competency principles; maintenance of appropriate working relationships with all components of the Statewide acute care system; and maintenance of appropriately trained and credentialed staff.

Proposed N.J.A.C. 10:31-10.1(e) sets forth the terms under which the participation of the county mental health board shall be included. Proposed amendments to N.J.A.C. 10:31-10.1(e)1 require that whenever the Division is considering a change to existing geographic areas, the Division shall so notify the affected counties and each county mental health board shall make a recommendation to the Division regarding the changed area to be covered by the screening service. Proposed N.J.A.C. 10:31-10.1(e)2 states that the Division shall include in the competitive designation process participation by the relevant county mental health board. Prior to Division designation, the county mental health board shall review all proposals and at a public meeting, take and make a record of all public comments concerning the entities that applied for designation before making a written recommendation.

Existing N.J.A.C. 10:31-10.1(b), requiring that a designated screening center be physically located in a hospital and operated by or formally affiliated with the hospital is proposed for deletion, to allow for greater flexibility and access to screening services.

Existing N.J.A.C. 10:31-10.1(c) is proposed for recodification as N.J.A.C. 10:31-10.1(f) and proposes that the Division designate a screening service after reviewing all the public comments and the mental health board's recommendation considering the abilities of all entities applying to meet this chapter, as identified in the RFP. The existing sentence stating the continued designation is contingent upon the center's ability to perform mandated functions is proposed for deletion because this subject is covered more fully at proposed N.J.A.C. 10:31-10.2.

Existing N.J.A.C. 10:31-10.1(e) is proposed for deletion because the same requirements now appear at proposed N.J.A.C. 10:31-10.1(c). Existing N.J.A.C. 10:31-10.1(d) and (f) are proposed for deletion because they are obsolete.

New N.J.A.C. 10:31-10.2(a) delineates procedures to be followed in the event that the Division withdraw designation as a screening service from a particular entity. Proposed N.J.A.C. 10:31-10.2 states that the Division may act to withdraw designation status before expiration if: (1) the screening service notifies the Division of its intent to terminate its contract for no cause; (2) the Division notifies the screening service that the contract will be terminated for cause or because of default (defined as the screening services' failure to fulfill or comply with the terms and conditions of the contract); (3) the screening service has failed to comply or is no longer able to comply with the screening law (N.J.S.A. 30:4-27.1 et seq.) or this chapter; (4) the screening service has made a willful misstatement of or omitted revealing a material fact or facts in its dealings with the Division, consumers or the public that have or could have impacted on its receipt of designated status in the first instance; (5) the screening service failed to provide all information required by these regulations or reasonably requested by the Division; (6) the screening service acted or failed to act in a manner that was or could have been detrimental to the Department, consumers, screening service or hospital staff, or the general public, including but not limited to adjudged criminal activity that has been committed by the screening service staff, board members or officers; (7) continued designation threatens the efficient and expeditious operation of the screening service's

mission in the Statewide acute care system, such that it interferes with the delivery of vital psychiatric services to consumers; or (8) continued designation presents a risk of harm to the health, safety, welfare of consumers, staff or the general public.

Proposed N.J.A.C. 10:31-10.2(b) states that the screening service shall be advised of the Division's written notice that: (1) its designation status is being withdrawn; (2) the effective date of the withdrawal; (3) that within five days of its receipt of the notice, the screening service may request a meeting with the appropriate Regional Assistant Director and Regional Coordinator to informally review the grounds for the withdrawal; and (4) that a request for an informal review of the withdrawal does not stay the withdrawal of designation.

Proposed N.J.A.C. 10:31-10.2(c) states that after conclusion of the informal review process, the screening service may request further review by the Assistant Commissioner for Mental Health Services or his or her designee. Proposed N.J.A.C. 10:31-10.2(c)1 states that the decision of the Assistant Commissioner or designee shall be the final agency decision. Proposed N.J.A.C. 10:31-10.2(c)2 states that any challenge to the Division's final agency decision applying the criteria in N.J.A.C. 10:31-10.2(a)(3) through (8) may be appealed to the Appellate Division of the Superior Court of New Jersey. Proposed N.J.A.C. 10:31-10.2(c)3 states that any challenge to the Division's decision to withdraw designation based on N.J.A.C. 10:31-10.2(a)(1) or (2) may be challenged by bringing an action pursuant to the New Jersey Contractual Liability Act.

Proposed N.J.A.C. 10:31-10.3 regulates emergency termination or suspension of a screening services' designation status or interim designation. Proposed N.J.A.C. 10:31-10.3(a) states that the Division may act immediately to suspend or terminate the designation status of a screening service without following the procedures delineated in N.J.A.C. 10:31-10.2, in the event that the Division determines that one of the following emergent circumstances exists and threatens public health, safety, and welfare: (1) a screening service has failed to perform its responsibilities in a manner that is consistent with the screening law and this chapter, including but not limited to, failure to comply with the terms of a waiver or waiver conditions; (2) a screening service has lost the capacity to do so; or (3) a significant change in conditions has occurred since designation and has impaired the screening service's ability to perform its responsibilities.

Proposed 10:31-10.3(b) states that a screening service whose designation status has been suspended or terminated on an emergency basis may appeal such suspension or emergency termination by complying with the follow procedures: (1) the screening service and other interested parties may request a meeting with the appropriate Regional Assistant Director and Regional Coordinator within three business days of the suspension or emergency termination to resolve the issues; (2) if the parties fail to timely resolve the dispute by mutual agreement, the screening service may submit, within three business days of its meeting with the Regional Division representative, a written appeal request to the Assistant Commissioner for Mental

Health Services, justifying its position that the designation should not be suspended or terminated; (3) the Assistant Commissioner for Mental Health Services shall issue a final agency decision within seven days after receiving the request, upholding the suspension or termination, or reversing it and reinstating the screening designation; and (4) an adverse final agency decision may be appealed to the Appellate Division of the Superior Court.

Proposed N.J.A.C. 10:31-10.3(c) states that where the emergent termination or suspension of screening service status leaves the relevant geographic area without such vital services and, to ensure the full protection of public health, safety and welfare, the Division may designate, on an interim basis, screening service status to an entity that meets the qualifications of N.J.S.A. 30:4-27.1, et seq. and N.J.A.C. 10:31 et seq. without invoking the full process for designation delineated in N.J.A.C. 10:31-10.1.

Proposed N.J.A.C. 10:31-10.3(c)1 states that interim designation shall be of duration sufficient to provide screening services to the relevant area until a new screening service can be designated under the procedures contained in N.J.A.C. 10:31-10.1.

Proposed N.J.A.C. 10:31-10.3(c)2 states that where necessary and according to the Department's determination, interim designation may be issued with one or more waivers, in accordance with the standards delineated at N.J.A.C. 10:31-11.1.

Subchapter 11. Waiver

In place of existing N.J.A.C. 10:31-1.4, the Division is proposing a new waiver subchapter to provide more current and detailed information.

Proposed N.J.A.C. 10:31-11.1(a) states that the Division, in accordance with the screening statute, may relax or waive, with or without conditions, sections of N.J.A.C. 10:31 in specific circumstances, provided that the Division finds the following conditions are present: (1) the rule is not mandated by any provision of N.J.S.A. 30:4-27.1 et seq.; (2) the provision of screening services in accordance with the purpose and procedures contained in N.J.S.A. 30:4-27.5 would not be compromised if the waiver was granted; and (3) no significant risk to the welfare and safety of individuals subject to screening services or the staff of designated screening or emergency services would result from the granting of the waiver.

The existing prohibition against waiver of N.J.A.C. 10:31 in its entirety (existing N.J.A.C. 10:31-1.4(a)) is proposed at N.J.A.C. 10:31-11.1(b), which also prohibits permanent waivers.

The provisions preconditioning waiver issuance upon availability of contract funding, in existing N.J.A.C. 10:31-1.4(a), have not been carried over into proposed N.J.A.C. 10:31-11. Instead, financial hardship is enumerated as a factor that the screening service must explain as a basis for its waiver request. (N.J.A.C. 10:31-11.2(b)1ii)

Proposed N.J.A.C. 10:31-11.2 sets forth the procedures relevant to the waiver of any provision of N.J.A.C. 10:31, except those related to personnel standards. (N.J.A.C. 10:31-3 and 4) (The requirements for personnel waiver requests are proposed at N.J.A.C. 10:31-11.3.) Proposed N.J.A.C. 10:31-11.2(b) maintains existing language regarding the timing of the waiver, with the following change: a screening service may also choose to request a waiver “at any time should unforeseeable circumstances arise and necessitate” such a request.

Proposed N.J.A.C. 10:31-11.2(b) maintains the current requirement (at existing N.J.A.C. 10:31-1.4(b)) that waiver applications be submitted to the Division regional office. New provisions at N.J.A.C. 10:31-11.2(b)1 further require that the waiver request: (1) specify the rule(s) or part(s) of the rule(s) for which a waiver is requested; (2) explain the reasons for requesting a waiver, including a statement specifying the type and degree of hardship that would result if the waiver is not granted; (3) outline a plan to make the waiver unnecessary and a timetable for doing so; and (4) include a documentation supporting the waiver request.

The following requirements appear in existing N.J.A.C. 10:31-1.4(b)1 and are carried over, with added amendments, to proposed N.J.A.C. 10:31-11.2(b)2. The existing requirement that screening services send copies of their waiver requests to their county’s mental health board, systems review committees, and any locally active mental health family, consumer, and advocacy organizations has been expanded to include submittal to all mental health providers, hospitals, acute care or long-term care facilities

treating mental illness or co-occurring disorders in the geographic area to be served. The screening service shall also inform these parties of the address of the Division regional office and the county mental health board where comments may be sent for at least 30-day from the date of the waiver request. The notice shall include the date of the waiver request. The notice shall also include the time, location, and date of the first county mental health board meeting scheduled after the thirty-day comment period. The screening service shall submit to the Division documentation indicating compliance with this provision.

Proposed N.J.A.C. 10:31-11.2(c)1 sets forth procedures regarding the Division's disposition of a waiver application. The waiver application, and any comments received, shall be discussed at the first county mental health board meeting after close of the 30-day comment period, as a part of the regular agenda and in an open public meeting. By motion, the county mental health board will either endorse the waiver application or record its objections to the granting of the waiver by the Division.

Proposed N.J.A.C. 10:31-11.2(c)2 details the Division's review process. After the mental health board has rendered its recommendation, the Division shall review each waiver application in accordance with the standards delineated in this section. The Division may deny, grant with or without conditions, or grant in part and deny in part, a waiver for a period of up to one year. The decision shall be based on the full record, including any public comments and discussion that occurred at the mental health board

meeting, the motion approved by the board, and any written comments received by the Division.

Proposed N.J.A.C. 10:31-11.2(c)3 details issuance of the Division's waiver decision. The Division shall issue a written decision to the screening service and shall indicate which provisions, if any, have been waived, the expiration date of the waiver, and any conditions or limitations that have been placed on the waiver. A copy of the waiver shall be appended to and become a part of the screening services' contract.

Proposed N.J.A.C. 10:31-11.2(c)4 sets forth provisions regarding appeal of a waiver denial. A screening service may appeal a waiver denial to the Assistant Commissioner for Mental Health Services (formerly "Division Director"). Other interested parties may communicate their opinions about the appeal to the Assistant Commissioner. The Assistant Commissioner shall uphold or reverse the original waiver denial of the regional assistant director and communicate this decision in a written final agency decision.

Proposed N.J.A.C. 10:31-11.2(c)5 states that failure to comply with any conditions contained in the waiver shall constitute grounds for emergency suspension of screening service designation, in accordance with N.J.A.C. 10:31-10.2.

Proposed N.J.A.C. 10:31-11.3 regulates waivers of personnel requirements. In order to protect a job candidate's privacy and to expedite hiring decisions, requests for waivers

of personnel requirements are subject to a distinct and abbreviated set of procedures. Such requests need be submitted only to the appropriate regional office and are exempt from the public review process, as long as the Division finds that the waiver request meets the standards set forth in N.J.A.C. 10:31-11.1(a). The request must contain the same information required for all other screening waiver requests, specified at N.J.A.C. 10:31-11.2(b)1, along with clear clinical or programmatic justification (N.J.A.C. 10:31-11.3(a)2). A personnel waiver decision shall be issued within 14 days of the Division's receipt of the request. (N.J.A.C. 10:31-11.3(b)).

Proposed N.J.A.C. 10:31-11.3(c) provides that the Division shall base its decision to grant or deny a personnel waiver request according to whether or not the request adversely affects the health, safety, welfare or rights of consumers and whether it meets the standards set forth in N.J.A.C. 10:31-11.1(a). A decision granting a personnel waiver request shall indicate which personnel requirements have been waived, the expiration date and any relevant conditions or limitations. (N.J.A.C. 10:31-11.3(c)1) A personnel waiver may be for a maximum time period of one year, subject to renewal upon a request made in accordance with the process delineated in at N.J.A.C. 10:31-11.4. (N.J.A.C. 10:31-11.3(c)2)

The renewal and extension procedures delineated at N.J.A.C. 10:31-11.4 apply to both personnel and non-personnel waivers. Renewal requests must be submitted in writing to the appropriate Division regional office 60 days prior to the waiver's expiration. (N.J.A.C. 10:31-11.4(a)) Requests for extensions of waiver granted for less than one

year must be submitted to the appropriate Division regional office 60 days prior to its expiration. (N.J.A.C. 10:31-11.4(b)) Both requests for renewal and extension must meet the parameters for waiver issuance delineated N.J.A.C. 10:31-11.1(a) or 11.3, as applicable. In addition to the aforementioned provisions, the Division, upon request of a screening service, may issue a new waiver renew an existing waiver, or extend a waiver and/or waiver conditions on an emergent basis, to protect public health and safety. Such an issuance or extension shall precede public notice and comment, if the Division determines that public health and safety concerns require immediate action.

10:31-12 Confidentiality of Consumer Records

Proposed N.J.A.C. 10:31-12.1(a) confirms that consumer records held by screening services are confidential protected health information (PHI).

Proposed N.J.A.C. 10:31-12.1(b) references the obligation of screening services to comply with all State and Federal confidentiality laws to maintain the confidentiality of consumer PHI.

Consistent with State confidentiality law (N.J.S.A. 30:4-24.3.a) and HIPAA (45 CFR 164.508(a)), proposed N.J.A.C. 10:31-12.2(a) states that consumer PHI may be disclosed to the extent permitted by a valid, written, unrevoked authorization, signed by the consumer or the consumer's legal guardian or mental health care representative. Proposed N.J.A.C. 10:31-12.2(b) states that the authorization must conform to the

requirements of the HIPAA Privacy Rule at 45 CFR 164.508(a). Proposed N.J.A.C. 10:31-12.2(c) states that authorizations for the release of psychotherapy notes, HIV/AIDS information and individual drug and alcohol abuse information must specifically identify those records as being subject to release, as required in 45 CFR 164.508(a)(2).

Proposed N.J.A.C. 10:31-12.3 states that consumer PHI may be disclosed pursuant to court order, as permitted under N.J.S.A. 30:4-24.3(c).

Proposed N.J.A.C. 10:31-12.4 sets forth the conditions under which consumer PHI may be disclosed absent the consumer's authorization or a court order. The first such condition, treatment of the consumer, is delineated at N.J.A.C. 10:31-12.4(a)1: professional screening staff may disclose the minimum necessary consumer PHI relevant to a consumer's treatment and or referral to treatment, pursuant to N.J.S.A. 30:4-27.5(c), to staff at a community mental health agency, as defined in N.J.S.A. 30:9A-2, another screening service, or a short-term care or psychiatric facility or a special psychiatric hospital, as defined at N.J.S.A. 30:4-27.2. This provision is drawn from N.J.S.A. 30:4-24.3 (allowing disclosure for treatment purposes) and from N.J.S.A. 30:4-27.5.c (regarding referral from a screening service to an appropriate community mental health agency or psychiatric inpatient unit).

The second condition allowing disclosure without consumer authorization or court order is delineated at N.J.A.C. 10:31-12.4(a)2: screening staff may disclose consumer PHI to

the extent necessary to conduct an investigation into the financial ability to pay of the consumer or his or her chargeable relatives. This provision is consistent with both State confidentiality law (N.J.S.A. 30:4-24.3d) and HIPAA (45 CFR 164.510(b)(1)).

According to proposed N.J.A.C. 10:31-12.4(a)3, the third condition allows disclosure to individuals who are directly involved in the consumer's care, provided that screening staff comply with the conditions delineated in N.J.A.C. 10:31-12.4(4) or (5). Specifically, screening staff may disclose to a family member, other relative, or a close personal friend of the consumer, or any other person identified by the consumer, PHI directly relevant to the person's involvement in the consumer's care or payment related to the consumer's care (N.J.A.C. 10:31-12.4(a)3i; and 45 CFR 164.510(b)(1)). Screening staff may also disclose PHI to notify or assist in the notification of (including identifying or locating) a family member, a personal representative of the consumer or another person responsible for the care of the consumer, of the consumer's location, general condition, or death (N.J.A.C. 10:31-12.4(a)3ii; N.J.S.A. 30:4-24.3; and 45 CFR 164.510(b)(1)(ii)).

Before making the a disclosure in the absence of an authorization or court order and where the consumer is present for or otherwise available prior to a disclosure permitted by N.J.A.C. 10:31-12.4(a)3 and has the capacity to make mental health care decisions, screening staff must first: (1) obtain the consumer's verbal agreement; (2) provide the consumer with the opportunity to object to the disclosure, and the consumer does not express an objection; or (3) reasonably infer from the circumstances, based on the

exercise of professional judgment, that the consumer does not object to the disclosure.
(N.J.A.C.10:31-12.4(a)4; 45 CFR 510(b)(2))

If the consumer is not present, or the opportunity to agree or object to the use or disclosure cannot practically be provided because of the consumer's incapacity or an emergency circumstance, screening staff may, in the exercise of professional judgment, determine whether the disclosure is in the best interest of the consumer and, if so, disclose only the consumer PHI that is directly relevant to the person's involvement with the consumer's care. (N.J.A.C. 10:31-12.4(a)5; 45 CFR 164.510(b)(3)). Screening staff may use professional judgment and their experience with common practice to make reasonable inferences of the consumer's best interest in allowing a person to act on behalf of the consumer to pick up filled prescriptions, medical supplies, x-rays or other similar forms of PHI.

All disclosures of consumer PHI shall be documented in the consumer's record and shall describe the consumer PHI disclosed, the individual to whom the consumer PHI was disclosed, the date of disclosure and the basis upon which the decision to disclose was made. (N.J.A.C. 10:31-12.4(b))

All decisions to disclose consumer PHI pursuant to this section shall be made individually, on a case-by-case basis. (N.J.A.C. 10:31-12.4(c)) Further, a disclosure of consumer PHI under this section does not authorize, or provide a basis for, future or additional disclosures (N.J.A.C. 10:31-12.4(d)).

Proposed N.J.A.C. 10:31-12.5 sets for the procedures and standards that screening staff must follow when denying a consumer's request to review the consumer's own PHI. The denial decision must be in writing and given to the consumer. The written denial to shall state the reason for the denial and shall describe the consumer's right to a review of the denial and how the review can be obtained. The written denial shall comply with the additional requirements of the HIPAA Privacy Rule set forth in 45 CRF 164.524.

Consumers shall be given access to the consumer PHI that is not part of the denial.
(N.J.A.C. 10:31-12.5(a)2)

Upon the consumer's request, the denial decision shall be reviewed by a supervisory licensed health care professional who was not directly involved in the initial denial decision. (N.J.A.C. 10:31-12.5(a)3) The reviewing official shall uphold the denial decision if: (1) the requested information was obtained from someone other than a health care provider under a promise of confidentiality and where the access requested would be reasonably likely to reveal the source of the information; (2) disclosure of the requested information, in the professional judgment of a licensed health care professional, is reasonably likely to endanger the life or physical safety of the consumer or another person; or (3) the requested information, which makes reference to another person (unless such other person is a health care provider) and in the professional judgment of a licensed health care professional, access is reasonably likely to cause

substantial harm to such other person. (N.J.A.C. 10:31-12.5(a)4) Screening staff shall provide written notice to the consumer of the reviewing official's determination and shall perform whatever other action is necessary to carry out the reviewing official's determination. (N.J.A.C. 10:31-12.5(a)5)

Consistent with HIPAA, a reasonable, cost-based fee may be charged for the duplication and production of the consumer PHI. (N.J.A.C. 10:31-12.6)

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

The screening document (referenced at N.J.A.C. 10:31-2.3(e)) is included in the rule as N.J.A.C. Appendix A. The "Certificate for Return Following Conditional Release (referenced in N.J.A.C. 10:31-2.4(e)) is included in the rule as N.J.A.C. 10:31 Appendix B. The "Order for Temporary Rehospitalization Following Conditional Release" (referenced at N.J.A.C. 10:31-2.4(g)) is included in the rule as N.J.A.C. 10:31 Appendix C. The "Authorization for Police Transport pursuant to N.J.S.A. 30:4-27.5" (referenced in N.J.A.C. 10:31-8.1(a)) is included in the rule as N.J.A.C. Appendix D.

Social Impact

The goals of the rule proposed for readoption with amendments, new rules and repeals ensure that persons suffering from mental illness receive a higher quality of screening and assessment prior to being considered for involuntary commitment and that all available service options be available to consumers, regardless of geographic

area in which they live. Previously, persons could be evaluated and involuntarily committed to State hospitals by a wide range of service providers.

Screening services are an integral part of a system of acute care services in the community to ensure that whenever possible a person receive 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. Thus, providers benefit from clear, uniform standards that set expectations for their performance.

Consumers, family members, providers and the general public will benefit from the proposed amendments because they update and clarify the standards, while the proposed repeal will removed outdated and obsolete language. The incorporation of wellness and recovery principles require screening services to provide services in a manner that is culturally competent and assists the consumer in exercising, to the extent possible, autonomy in transitioning to wellness. At proposed N.J.A.C. 10:31-12, confidentiality provisions have been updated and expanded to reflect HIPAA requirements and balance privacy rights with the need for appropriate disclosure to enhance treatment. The general public will benefit from the proposed amendments which provide greater detail as to the requirements for screener certification and recertification as these requirements will ensure that appropriately qualified personnel are providing these services. Providers will benefit from proposed amendments delineating the standards for telepsychiatry and commitment after violation of a conditional discharge order. Proposed amendments adding greater detail and public notice and comment requirement and the procedure for waiver issuances will benefit all.

Similarly, proposed amendments requiring an open, competitive process for the designation of screening service status will lead to an improved quality in these services, to the benefit of all concerned.

Economic Impact

The Department does not anticipate that the rules proposed for reoption with amendments, repeal, and new rules would have a negative economic impact on providers of screening services. First, these entities contract with and receive funding from the Division of Mental Health Services to provide emergency psychiatric screening services. Second, screening programs received an extra infusion of \$10 million as a in 2004. The general public, the mentally ill, and the families of the mentally ill, can be expected to experience both social and personal savings by the anticipated increase in diversions from more costly in-patient hospitalizations to less costly community-based services that screening services will provide. Increases in State psychiatric hospital costs can be better contained through a combination of screening services and short-term care in general hospitals. Costs to implementing agencies, that is, screening services, will be borne by contracts with the Division.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for reoption with amendments, repeals and new rules comply with, but do not exceed any Federal requirements or standards as stated in the Summary above.

Jobs Impact Statement

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

Agriculture Industry Impact Statement

The rules proposed for readoption, amendments, repeals and new rules would have no impact on agriculture in the State of New Jersey.

Regulatory Flexibility Analysis

The rules proposed for readoption with amendments, new rules, and repeals may impact small businesses in New Jersey, as they are defined in N.J.S.A. 52:14B-16, as some screening services may have fewer than 100 full-time employees. The rules require documentation and recordkeeping requirements that are necessary to ensure effective delivery of quality services by qualified staff in the most cost-effective manner assuring the least restrictive method of assessment and treatment as discussed in the Summary above. Screening services should be able to comply with these documentation and record-keeping requirements through the efforts of existing staff and without the hiring of outside experts. The screening services are individually funded by the Division to be able to meet the requirements and, therefore, incur no costs of compliance.

The rules proposed for readoption at N.J.A.C. 10:31 impose reporting and other compliance requirements on screening services regarding situations in which waivers may be requested (N.J.A.C. 10:31-11), the distribution of medication (N.J.A.C. 10:31-2.2) and the transportation of consumers (N.J.A.C. 10:31-8.1).

Screening services must develop and maintain affiliation agreements with other community agencies to ensure priority access to psychiatric evaluation for medication within seven days of referral and to other mental health services within 14 days of referral (N.J.A.C. 10:31-2.1(a)12ii); and the designated short-term care facility serving the screening services' geographic area. (N.J.A.C. 10:31-2.1(a)16)

Screening services must also develop and maintain written plans regarding: training or technical assistance for police and other community referral sources directly or through affiliations with other agencies (N.J.A.C. 10:31-2.1(a)17); transporting consumers in crisis to or from appropriate treatment facilities (N.J.A.C. 10:31-2.1(a)18); and prioritizing response to outreach calls. (N.J.A.C. 10:31-2.1(d))

Screening services must maintain a system for tracking currently available treatment openings in the acute care mental health services system for which screening services are granted access either directly, by subcontract or by affiliation agreement. (N.J.A.C. 10:31-2.1(a)21) They must compile records regarding all persons seen by the screening service and their case disposition, which records shall be subject to review by the systems review committee (N.J.A.C. 10:31-2.1(a)23).

Affiliated emergency services (AES) must operate in accordance with contractual agreements with the Division and in accordance with affiliation agreements with the screening services (N.J.A.C. 10:31-2.2(a)). AES must also complete the paperwork associated with the initiation of involuntary commitment proceedings (N.J.A.C. 10:31-2.2(a)7).

The screening service or AES must record pertinent consumer information (N.J.A.C. 10:31-2.3(a)). The screener must complete the screening document within 24 hours of the consumer's presentation for screening services (N.J.A.C. 10:31-2.3(e)). The screening psychiatrist must document the psychiatric assessment and complete the screening certificate (N.J.A.C. 10:31-2.3(f)2 and 3). Screening staff shall obtain and document the consumer's valid consent to being assessed through telepsychiatry (N.J.A.C. 10:31-2.3(f)2iii(3)). Where the consumer consents to treatment, the psychiatrist must document these findings in the medical record (N.J.A.C. 10:31-2.3(f)4). Screening staff must ensure that the commitment process is documented in the clinical record: clinical decision-making and rationale must be documented in the clinical record; and copies of the screening document and certificate must be maintained in the consumers chart N.J.A.C. 10:31-2.3(j)).

Screening staff shall maintain annually written policies and procedures concerning the involuntary commitment process (N.J.A.C. 10:31-2.3(k)). Where screening staff disclose protected health information, they shall document the basis for

that disclosure (N.J.A.C. 10:31-12). Screening services shall maintain written protocols indicating the circumstances under which screeners will respond to off-site locations (N.J.A.C. 10:31-2.6(a)2i). Written agency protocol shall delineate the chain of command and the procedure and circumstances for contacting the screening coordinator (N.J.A.C. 10:31-2.6(a)4).

N.J.A.C. 10:31-2.7 sets forth in detail the required written policies and procedures governing screening services operations. N.J.A.C. 10:31-3.2(b) requires the screening coordinator to devise and implement a staffing plan ensuring staff availability, a plan to facilitate access to acute care services, affiliation agreements and liaisons, and procedures for monitoring performance of service functions. N.J.A.C. 10:31-3.4(f) requires written policies describing orientation and training for new staff.

The above-cited reporting, documentation and compliance requirements imposed upon such screening services must be uniformly applied, regardless of the size of the service, 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.

Housing Affordability Impact

The rules proposed for readoption with amendments, new rules and repeals will have an insignificant impact on affordable 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 rule pertain to the screening and screening outreach program of the Division of Mental Health Services.

Smart Growth Impact

The rules proposed for readoption with amendments, new rules and repeals 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 screening outreach programs.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:31-1.4 and 2.4.

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

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

SUBCHAPTER 1. GENERAL PROVISIONS

10:31-1.1 Scope

- (a) The Screening and Screening Outreach Program is designed to provide [on and off site] screening and crisis stabilization services, 24[-]hours per day, 365 days per year, in every geographic area in the State of New Jersey. These services may be provided at a designated screening location or wherever the individual who may be in need of such services is located. The mode of stabilization will depend on the seriousness of the impairment, degree of potential dangerousness and the availability of appropriate services. The locus of treatment will be as close to the individual's home as circumstances permit.
- (b) The Screening and Screening Outreach Program shall be established in every geographic area as a new program or as an expansion of an existing emergency service. The Screening and Screening Outreach Program shall be provided by a screening [center] service, designated by the Division.

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 and recovery-oriented and assists the consumer in achieving a self-directed transition to wellness;

2. To provide [, at a minimum,] outreach to individuals who may need involuntary commitment and are unable or unwilling to come [in] to the screening [center] service location, as stipulated in [P.L. 1987, c.116,] N.J.S.A. 30:4-27.5(d);
3. To [expand] provide outreach [to include other crisis and emergency situations whenever possible] for the purpose of crisis intervention and stabilization;
4. To assure referral and linkage, which is voluntary in nature [to persons provided screening and/or screening outreach services] to appropriate community mental health and social services;
5. To coordinate access, where appropriate, to the publicly affiliated acute care psychiatric resources serving a designated geographic area; that is, acute partial hospitalization/care, crisis [house,] housing or voluntary inpatient services;

6. To screen individuals so that only those persons who [meet the standard for] are in need of involuntary commitment, as set forth in N.J.S.A. [30:3]30:4-27.2m, are committed;
7. (No change.)
8. To provide training and technical assistance concerning psychiatric emergencies to other social service, law enforcement and mental health providers in the geographic area; [and]
9. To coordinate a system for review and monitoring of the effectiveness and appropriateness of screening and screening outreach service use, including impact upon admissions to State and county psychiatric hospitals[.]; and
10. To provide leadership within the acute care network of services and advocate for services to meet consumers' needs and encourage the system to respond flexibly.

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 psychiatric services designed to provide stabilization during the acute phase of psychiatric illness.

"Acute care system" means those services either contracted for or [designated] identified by [DMH&H] the Division of Mental Health 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 [center,] service, affiliated emergency services, short-term care facility, [affiliated voluntary] inpatient psychiatric service, acute partial care/hospitalization, crisis housing, [clinical] integrated case management services (ICMS), programs of assertive community treatment (PACT), and [crisis companion service] peer support, self-help and acute family support services.

["Acute in-home service" means family or significant other focused interventions provided on an outreach basis in the consumer's residence (for example, boarding home, own home, etc.) to prevent a more restrictive placement by assisting all individuals in the client's living situation.]

"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.

"Affiliated emergency service (AES)" means a mental health provider responsible for the provision of service 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.

"Affiliated emergency service coordinator" means an individual employed by an affiliated emergency service who meets the educational and experiential requirements set forth in N.J.A.C. 10:31-4.2(a) and fulfills the duties set forth in N.J.A.C. 10:31-4.2(b).

"Assessment" means evaluation of the individual in psychiatric crisis in order to ascertain his or her current and previous level of functioning, psychosocial and medical history, potential for dangerousness, current psychiatric and medical condition factors contributing to the crisis[,] and support systems that are available.

"[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 to assess a patient's eligibility for involuntary commitment.]

["Client"] "Consumer" means an individual 18 years of age or older receiving assessment or treatment in a screening [Center] or any ambulatory mental health service.

"Clinical Case Management Program (CCMP)" means the case management program provided to mentally ill individuals who do not accept or engage in facility-based mental health programs and/or have multiple service needs and require extensive service coordination. The CCMP ensures a coordinated and integrated [client service system for the targeted mentally ill individual.

"Clinical certificate " means a form developed by the Division of Mental Health and Hospital Services and approved by the Administrative Office of the Courts that is completed by a psychiatrist or other physician, which states that the person designated therein is in need of involuntary commitment.

"Clinical director" means the person who is designated by the director or chief executive officer of the screening center to provide medical leadership in a screening center. This may be a full or part-time position.]

"Commissioner" means the Commissioner of the Department of Human Services.

"Community [gatekeeper] referral source" means an individual such as a police officer, religious leader, family member or other person who may refer an individual for mental health services.

"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.

["Crisis companion" means an individual who is trained and experienced in the care of the acutely mentally ill patient and provides supervision on an as-needed basis in a variety of settings.]

"Consumer" means an individual 18 years of age or older receiving assessment or treatment in a screening service or any ambulatory mental health service.

"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.

“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.

“Continuous quality improvement” means the ongoing objective and systematic monitoring and evaluation of a service's or system's components to ensure the quality, effectiveness and appropriateness of care and the pursuit of opportunities to further improve the care.

“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.

"Crisis housing" means a community-based crisis residential stabilization program providing an alternative setting for stabilization of individuals who are assessed by [an emergency center] a screening service as being in acute psychiatric crisis, but who do not meet the standard for commitment.

...

"Crisis intervention specialist" means an individual employed by a screening [center] service or an affiliated emergency service who meets the educational and experiential requirements set forth in N.J.A.C. 10:31-3.4 and 4.3[,] and provides assessment, crisis stabilization services, hotline coverage, outreach and referral to people who are in crisis.

"Crisis outreach" means outreach provided by a screening service or an affiliated emergency service for the purpose of crisis stabilization. It does not include the screening process.

"Crisis stabilization" means [that] means intensive crisis intervention efforts [have resulted in] toward or the result of a significant reduction of positive [symptomatology] symptoms and some improvement in level of functioning, bringing the individual closer to the level of functioning demonstrated prior to the crisis.

["Crisis stabilization services" means acute care services.]

["Designated screening center" means a public or private ambulatory care service designated by the Commissioner, which provides mental health services including assessment, screening, emergency and referral services to mentally ill

persons in a specified geographic area. A designated screening center is the facility in the public mental health care treatment system wherein a person believed to be in need of commitment to a short-term care, 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.]

"Division" means the Division of Mental Health [and Hospitals] Services, Department of Human Services.

["Emergency Service (ES)" means a mental health provider responsible for the provision of service to people in crisis. ES includes mental health and social service provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning.

"Emergency service coordinator" means an individual employed by an emergency service who meets the educational and experiential requirements set forth in N.J.A.C. 10:31-4.2 (a) and fulfills the duties set forth in N.J.A.C. 10:31-4.2 (b).]

“Enhanced screening service” means interventions that are made available to assist consumers who are hearing impaired to meaningfully access screening services. Enhanced screening services may also include consultative services for consumers who are developmentally disabled.”

“Extended crisis evaluation bed (ECEB)” means a bed provided in a secure area where an individual can be held for up to 24 hours while being assessed and receiving intensive psychiatric supervision and medication monitoring.

“General hospital” means any hospital that maintains and operates organized facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity and in which all diagnosis, treatment and care are administered by or performed under the direction of persons licensed to practice medicine or osteopathy in the State of New Jersey.

"Geographic area" means a geographically distinct area designated by the Commissioner to be served by one screening [center] service. This area may be a county, portion of a county or a multi-county area.

"Hotline" means a telephone line answered directly by a clinical worker 24[-] hours per day for the purpose of providing telephone crisis intervention counseling, information and referral.

["Holding bed" means a bed provided in a secluded secure area where an individual can be held for up to 24 hours while being assessed and receiving intensive supervision and medication monitoring.]

["Involuntary commitment" means the procedure for enacting treatment 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.]

"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.

"Integrated case management service ("ICMS") means personalized, collaborative and flexible outreach services, offered primarily off-site, designed to engage, support, and integrate individuals with serious mental illness into the

community of their choice, and facilitate their use of available resources and supports in order to maximize their independence.

"Linkage" means [voluntary] referral to and voluntary enrollment in a mental health and/or [non-mental health] ancillary program.

"Medical director" means the person who is designated by the director or chief executive officer of the screening center to provide medical leadership in a screening center. This may be a full or part-time position.

...

"Mental health care representative" means the individual designated by a consumer pursuant to the proxy directive part of the consumer's advance directive for mental health care for the purpose of making mental health care decisions on the consumer's behalf, and includes an individual designated as an alternate mental health care representative who is acting as the consumer's mental health care representative in accordance with the terms and order of priority stated in an advance directive for mental health care.

"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 unless it results in the severity of impairment as defined in this definition. The term mental illness is not limited to “psychosis” or “active psychosis,” ut shall include all conditions that result in the severity of impairment described in this definition.

["Off site" means service provided in any location other than the screening center.

"On site" means service provided at the screening center.]

“Peer advocate” means a person who works for a screening service and is or has a family member who is a consumer of mental health services. The responsibilities of a peer advocate are to raise awareness, provide education and serve as a resource to other consumers and family members on issues related to the effective management of mental illness in areas, such as symptom reduction, relapse prevention, stress management, social skills, depression, anxiety and healthy relationships. The peer advocate may resolve conflicts, and document and refer consumer concerns and complaints to professional staff, where appropriate. Peer advocates also serve as positive role models and demonstrate positive decision-making skills in both their personal and professional lives.

"Personal contact" means either face to face, or telephone contact.

“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 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.

“Programs of assertive community treatment (PACT)” means the community mental health program that provides comprehensive, integrated rehabilitation, treatment and support services to individuals with serious and persistent mental illness, who have had repeated psychiatric hospitalizations, and who are at serious risk for psychiatric hospitalization. PACT, provided in vivo by a multi-disciplinary service delivery team, is the most intensive program element in the continuum of ambulatory community mental health care. Services to an individual may vary in type and intensity.

“Psychiatric unit of a general hospital” means an inpatient unit of a general hospital that restricts its services to the care and treatment of persons with mental illness who are admitted on a voluntary basis.

"Psychiatrist" means 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.

"Psycho-education" means information dissemination, professional guidance and consultation and skill development to families of consumers and consumers themselves, aimed at assisting families and consumers in becoming essential contributors and participants in the rehabilitation process.

"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).

["Quality assurance (QA)" means the ongoing objective and systematic monitoring and evaluation of a service's or system's components to ensure quality, effectiveness and appropriateness of care and the pursuit of opportunities to further improve the care.]

"Referral" means services, which are voluntary in nature and which direct, guide[,] and link a [recipient] consumer with appropriate services [provided by community resources outside of the organization itself], 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 for involuntary commitment.

...

"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 the person designated therein is in need of commitment. 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 [center] coordinator" means an individual who is employed by a [designated] screening [center] service, who meets the educational and experiential requirements set forth in N.J.A.C. 10:31-3.2(a) and fulfills the duties set forth in N.J.A.C. 10:31-3.2(b).

“Screening document” means a form developed by the Division and completed and signed by a screener after that screener has assessed the consumer. The screening document serves as the first step of the involuntary commitment process.

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

“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.

["Short-term care facility (STCF)" means an inpatient, community-based mental health treatment facility which provides acute care and assessment services to a mentally ill person whose mental illness causes the person to be dangerous to

self, or dangerous to others, or property] “Short-term care facility” (STCF) means a closed acute care adult psychiatric unit in a general hospital for short term admission of individuals who meet the legal standard for commitment and require intensive treatment. The STCF shall be designated by the Division to serve residents of specific geographic areas within the State. All admissions to short term care facilities shall be referred through a designated screening service.

“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, crisis housing, acute in-home services, [holding] extended crisis evaluation bed with medication monitoring or emergency stabilization regimes, 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.

"Treatment facility" means a legal entity, public or private, providing mental health, [mental retardation] developmental disability, nursing, rehabilitative and/or drug and alcohol services.

SUBCHAPTER 2. PROGRAM REQUIREMENTS

10:31-2.1 Functions of a screening [center] service

(a) A screening [center] service shall perform the following [direct service] functions:

1. Assessment of the crisis situation[,] and [the need for] identification of stabilization, diversion and support services needed and/or screening for[, involuntary] commitment. This shall take place throughout the geographic area served by the [center] service including such sites as other emergency services, jails and nursing homes [(see N.J.A.C. 10:31-2.2)];

2. Provision of emergency and consensual treatment to the person receiving the assessment;

[2]3. Crisis/early intervention counseling;

[3]4. [Assessment, referral] Referral via personal contact to the most appropriate, least restrictive treatment setting indicated, linkage and follow-up in order to maintain contact with all [clients] consumers until they are engaged in another service [accepted for case

management] licensed by the appropriate authority, where applicable, or are no longer in crisis [(see N.J.A.C. 10:31-2.1(d)9];

5. Initiation of involuntary commitment proceedings, where appropriate and pursuant to N.J.S.A. 30:4-27.10 and N.J.A.C. 10:31-2.3;

[4]6. [A] 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 [hotline] shall receive calls [which] that have been forwarded from other [ES] AES during off hours;

[5]7. [Twenty-four] Maintenance of 24- hour per day screening outreach capability which shall include provision of [mobile] screening services in any location in the geographic area under the following circumstances:

- i. Whenever there is indication that there may be a reasonable likelihood of dangerousness to self, [or] others[,] or property due to mental illness;

- ii. Whenever the individual is unable or unwilling to come to the screening [center] service or when transporting the individual may put him or her or others at further risk; and
- iii If the [client's] consumer's history, behavior or location presents safety concerns[,] that cannot be resolved through consultation by the screening outreach team with the police, [if necessary,] and coordination [of the outreach with them;] of transportation to the screening service with the police;

[6]8. [Operation of holding] Provision of extended crisis evaluation bed(s) (ECEBs) with 24-hour capability, [which shall be used] for the purpose of assessment, intensive supervision, medication monitoring and crisis stabilization;

[7. Provision of protocol and procedures for use of various medication techniques including emergency stabilization regimes;]

9. Direct or indirect provision of appropriate medical services for consumers who are receiving screening services;

[8.] 10. Provision of medication monitoring, which shall include medication [on-site] for the purpose of crisis stabilization. Medication shall be

administered in accordance with P.L. 1991, [c.233] c. 223 and shall not be given to [clients] consumers in non-emergency situations without their consent;

11. Arranging transportation of consumers in need of commitment to the receiving facility;

[9]12. Provision [for] of face-to-face follow-up visits [(either on-site or off-site)] and/or telephone calls until the crisis is resolved or linkage completed[;].

- i. Consistent with the agency's policies regarding informed consent, the designated screening service shall make referral for aftercare services with mental health care providers who are licensed by the appropriate authority, as applicable.
- ii. Affiliation agreements shall be developed and maintained with other community agencies to ensure priority access to psychiatric evaluation for medication within seven days of referral and to other mental health services within 14 days of referral. The screening service shall be responsible for medication

until this responsibility is transferred to another agency;

13. In accordance with the procedures set forth at N.J.A.C. 10:31-2.4, assessment of the commitability of consumers who are returned for screening services when they fail to meet the terms of their conditional release orders;

[10]14. Psycho-educational and/or supportive services to consumers and family members who are involved at time of initial crisis[.];

15. Advocate, in conjunction with affiliated mental health care providers, for services to flexibly meet consumer needs;

16. Maintain a written affiliation agreement with the designated STCF(s) serving the screening services' geographic area;

17. Develop and maintain a written plan to provide training or technical assistance for police and other community referral sources directly or through affiliations with other agencies.

i. The screening service may accomplish police training through presentation of a Division-approved curriculum at the police academy, and through periodic consultation and advisement to the police and other community referral sources.

ii. Training shall be provided on a continuing basis and shall include, but not be limited to, orientation to the screening system, provisions contained within the screening law, explanation of mental illness, crisis intervention skills, systems interaction and transportation;

18. Develop a plan, in collaboration with the general hospital that houses the screening service, where applicable for transporting consumers in crisis, in accordance with all applicable Federal and State law. This plan shall include transportation between an AES or screening service and transportation from these services to an appropriate treatment facility (for example, psychiatric facility, psychiatric unit of a general hospital, special psychiatric hospital or STCF), once identified;

19. Provide, as needed, crisis intervention training and consultation for AES providers, other community referral sources and police, in the geographic area;

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;

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) Enhanced screening services shall perform additional duties, as negotiated and agreed to in their contracts with the Division.

(c) A screening service shall maintain a physical environment that is cognizant of, and responsive to, the varying needs and vulnerabilities of the diverse population it serves, especially children and older persons. When such vulnerable individuals are presented, screening staff shall take steps to ensure that they are protected from exposure to dangerous, potentially upsetting or inappropriate stimuli.

[(b)](d) Each screening [Center] service shall submit to the appropriate Division regional office and have approved by the Division a plan for prioritizing response to screening outreach calls, [and provide time frames for response. Time frames shall reflect the unique characteristics of the geographic area. The plan shall include a protocol for police involvement.]
The plan shall include the following provisions:

1. response timeframes that reflect the unique characteristics of the geographic area;
2. a requirement that outreach shall be provided in a timely manner when the screener determines, based on clinically relevant information, that the person is dangerous by reason

of mental illness and unable or unwilling to come to the screening service;

3. a protocol for the involvement of the police, other emergency response personnel and other professionals; and
4. a plan for the expansion of screening services to provide additional prevention, intervention and stabilization services, when resources are available.

(c) The center shall maintain responsibility for medication until this responsibility is transferred to another agency according to the procedure set forth in an affiliation agreement. Linkage shall be completed within seven days.

(d) Screening outreach services may be expanded to provide additional prevention, intervention, and stabilization services. This is strongly encouraged when resources are available.

(e) One or more functions of a screening center may be delegated in accordance with a county plan approved by the Division.

(f) In addition to the service functions listed in (a) above, for the geographic area's acute mental health services, the screening center shall:

1. Have exclusive access, assured by the Division through its contracting process, to a specifically designated portion of Division-funded acute care services in its geographic area. The intent of this provision is to ensure that acute care services are prioritized for use by persons in crisis, and that equitable utilization of resources occurs throughout the geographic area. These services shall include acute partial care, crisis housing (including a crisis house, foster home or crisis bed model), acute in-home services and crisis companion. The following options may be utilized:

- i. The screening center may itself operate the acute care services;
- ii. The screening center may sub-contract all or a portion of the acute care services; and/or
- iii. The screening center may affiliate with another provider which is under contract to the Division to provide some or all acute care services within the geographical area;

2. Maintain an affiliation with the STCF(s) serving the geographic area, which will be utilized for the involuntary hospitalization and screen admissions to the STCF;
3. Notify the provider of liaison services whenever an individual is involuntarily hospitalized at a STCF or State or county psychiatric hospital;
4. Develop written affiliation agreements with other community agencies which ensure immediate access to psychiatric evaluation for medication and other mental health support services;
5. Provide training or technical assistance for police and other community gatekeepers as needed, directly or through affiliations with other agencies;
6. Assure that a plan for transporting clients in crisis be developed which includes transportation to an emergency service or screening center and from these services to an appropriate treatment facility once identified;

7. Provide crisis intervention for ES providers in the geographic area as needed;
8. 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);
9. Maintain a system for tracking currently available treatment openings in acute mental health services for which the screening center is granted access either directly, by subcontract, or by affiliation; and
10. Comply with N.J.A.C. 10.37-6.79 regarding records of all persons seen by the center and compile information regarding disposition of such persons for review by the systems review committee (N.J.A.C. 10:31-5.)]

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

(a) In addition to the [designated] screening [center] service, a geographic area may include one or more [ES's] affiliated emergency services (AESs). All [emergency services] AESs shall be affiliated by written agreement with the geographic area's [designated] screening [center] service. [The] All AESs shall

operate in accordance with contractual agreements with the Division and affiliation agreements with the designated screening service. Each [ES] AES shall provide all of the following services:

1. Crisis intervention counseling for [clients] consumers, family members[,] and/or significant others;
2. Provision of or arrangement for appropriate medical services for consumers receiving care at the AES; and
- [2] 3. Provision and monitoring of medication [on site] for the purpose of crisis stabilization and provision for medication until this responsibility is transferred to another agency or service[;]. [medication] 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 [clients] consumers in non-emergency situations without their consent.
- [3] 4. Assessment, referral, linkage[,] and follow-up which shall include maintenance of contact with all [clients] consumers until they are engaged in another service or [their problem] the emergency has been resolved[;]. The AES shall also:

i. Refer the individual to the most appropriate and least restrictive treatment setting, licensed by the appropriate authority, where applicable, in the consumer's county of residence unless contraindicated. The AES records shall document these efforts;

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

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

[4] 5. A hotline, answered directly by clinical staff during peak hours, and [provision for calls to be] forwarded to the designated screening [center] service at other times[;].

[5. Linkage to acute care services (such as crisis housing, acute partial, and acute in-home services), facilitated through the designated screening center; and

6. Provision of linkage and necessary follow-up to other mental health and non-mental health services.]

(b) The following services may also be directly provided by the affiliated emergency service.

1. [Holding] Extended crisis evaluation beds with 24-hour capacity;
- [2. Protocol and procedures for use in various medication techniques including emergency stabilization regimes;]

Recodify existing 3. – 5. As 2. – 4. (No change in text.)

10:31-2.3 Screening process and procedures

(a) In accordance with N.J.S.A. 30:4-27.5.a, upon entry of a consumer to the screening service, staff at the screening service may detain the consumer for up to 24 hours from entry for the purpose of providing emergency and consensual treatment, medical clearance and conducting an assessment.

[a](b) The screening [center process] service or affiliated emergency service shall [involve] provide a thorough assessment of the [client] 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 [which] that have already been made.

1. The screening [center staff shall make every effort to gather information from] service or affiliated emergency service, consistent with State and Federal laws regarding patient confidentiality, shall contact the [client's] consumer's family, spouse, civil union partner [and] or significant others and current or previous service providers to determine what the clinical needs of the [client] consumer are and [to determine] what services are in the best interest of the [client] consumer.

2. The screening [center] service or affiliated emergency service staff shall consult with each adult [client] consumer, significant others as permitted by law[,] and the DMHS Registry established pursuant to N.J.A.C. 10:32-2.1, to determine whether the [client] 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. [The screening center staff, in conjunction with affiliated mental health care providers, shall advocate for services to meet client needs and encourage the system to respond flexibly. Throughout the screening process, medication shall not be given to clients in non-emergency situations without their consent.]

3. The screening service or affiliated emergency service procedures shall require recording of pertinent consumer information, where available, including, but not limited to:
- i. Basic identifying data as it relates to the presenting crisis;
 - ii. The history and nature of the presenting problem;
 - iii. The psychiatric and social history;
 - iv. The medical history, including current medical status problems, allergies and current medication;
 - v. The mental status and level of functioning;
 - vi. Any drug and alcohol use and history;
 - vii. Any indication of dangerousness;
 - viii. Exploration of available resources and natural support system;
 - ix. Preliminary diagnosis; and
 - x. Whether or not the consumer has executed an Advance Directive for Mental Health Care.

[(b)] (c) [Whenever possible and appropriate, all] All stabilization options [including the following] 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;
6. (No change.);
7. [Holding] Extended crisis evaluation bed with medication monitoring;
8. – 9. (No change.)
10. Voluntary admission to [local in-patient unit] a State psychiatric hospital or the psychiatric unit of a general hospital or special psychiatric hospital.

[(c)](d)After exploring the appropriateness of, and exhausting all options listed in [(b)] (c) above, the screener shall ascertain whether [the individual being considered for commitment:] commitment is indicated. In making this determination, the screener shall consider whether the individual:

1. [Meets the standard for] Has a mental illness [as defined in P.L. 1987, c.116 (N.J.S.A. 30:4-27.1 et seq.)]; and
- [2. [Meets the standard for dangerousness as defined in P.L. 1987, c.116 (N.J.S.A. 30:4-27.1 et seq.) and N.J.A.C. 10:31-1.3. If so, the screener shall complete the screening document and refer the patient to the psychiatrist for evaluation; and]

2. Is dangerous to self, others or property because of that mental illness;
and

3. Understands the nature of the recommended treatment and is
unwilling to accept appropriate, available inpatient treatment at an STCF,
psychiatric facility or special psychiatric hospital.

(e)If the screener determines that the individual is dangerous to self, others or
property by reason of mental illness under the standard referenced above, 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.

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

1. The screening psychiatrist shall review the screening document and consult with the screener.

[(d)] 2. The screening psychiatrist shall conduct and document [complete] a [face-to-face] thorough psychiatric evaluation [and complete the screening certificate if the client meets the standards for commitment] of the consumer.

i. Notwithstanding the above, 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 herein at N.J.A.C. 10:31-11, and has a Division-approved plan delineating a procedure for evaluation via telepsychiatry.

- 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 these regulations;

(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 commitment, the psychiatrist shall fully complete all 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. The screening certificate shall be completed by the screening psychiatrist, except in those circumstances where the Division’s contract with the screening service provides that

another physician may conduct the assessment and complete the certificate.

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

(1) The consumer must be admitted to a short-term care facility, psychiatric facility or special psychiatric hospital;

(2) A psychiatrist on staff at the admitting facility must complete the clinical certificate;
and

(3) Staff at 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) 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 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 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.

ii. The screening service policies and procedures shall require the documentation in the consumer’s medical record of all reasonable but unsuccessful attempts made to avoid the same psychiatrist completing both the screening and clinical certificates.

[(e) A client shall receive a thorough assessment if he or she is referred to a screening center because he or she 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 or death will result within the reasonably foreseeable future.]

[1.] (h) If the assessment reveals that a [client] consumer does not meet the commitment standard, the screening [center] service shall refer the [client] 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). It shall be the responsibility of such agencies to procure needed services. [If the client is in need of mental health services, the screening center shall facilitate the necessary linkages to mental health services.]

- [(2) If the assessment reveals that a client is mentally ill and 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 or death will result within the reasonably foreseeable future, it shall be the responsibility of the screening center to arrange the provision of such services for the client.]
- (i) After the screening psychiatrist has completed the screening certificate, the screener shall:
1. Determine the appropriate facility in which the consumer shall be placed taking into account the consumer's prior history of hospitalization and treatment and the least restrictive level of care that is locally available.
 - i. If a consumer has been admitted three times or has been an inpatient for 60 days at a short-term care facility during the preceding 12 months, consideration shall be given to not placing the consumer in a short-term care facility.

ii. The consumer shall be admitted to the appropriate facility as soon as possible;

2. Arrange for the transport of the consumer to the receiving facility; and

3. Ensure compliance with the medical clearance requirements of the accepting facility for the transfer.

(j) Screening staff shall ensure that the screening process is documented in the clinical record.

1. Clinical decision-making and rationale for decisions must be clearly delineated in documentation included in the clinical record.

2. Copies of the screening document and screening certificate shall be maintained in consumers' charts.

(k) Screening staff shall maintain, review, and update annually written policies and procedures concerning the screening process. Specifically, these policies and procedures must be located in a manual and must:

1. Clearly describe the procedures and contain those individuals authorized to complete screening documents;

2. Delineate individual responsibilities and authority of the members of the screening team, including a process that addresses conflict resolution between screeners and psychiatrists; and

3. Include copies of all forms used in the commitment process.

[(f)] (l) Each screening [center] service shall have the capability to provide mobile screening outreach in the community, 24 hours per day. Outreach teams [are preferable and should] shall be utilized, [based on both] when it is appropriate to do so after an evaluation of clinical and safety [factors] considerations. Such outreach shall take place whenever clinically relevant information indicates that a person may be mentally ill and a danger to himself, herself or others, and is unwilling and/or unable to come to the screening service for evaluation. The mobile team shall determine priority. Screening outreach shall take place wherever the [client] consumer is located, whether in a private home, hospital, boarding home or other location. Police shall be requested to accompany the mobile team when necessary. The outreach screener shall provide appropriate intervention, referral and linkage following a face-to-face

assessment whether or not the [individual] consumer is found to meet the commitment standard.

[(g)] (m) The screening of [clients] consumers seen in an [ES] AES (other than the [designated] screening center) may be accomplished in any of the following ways in accordance with affiliation agreements developed between the screening [center] service and the [emergency service, as determined by the screening center,] AES, based upon the best interest of the [client] consumer, and with the goal of avoiding the transportation of the [client] consumer, except where necessary for treatment purposes.

1. Outreach by a screener to the [ES] AES. If this option is utilized, the screener shall be available within [one hour] the timeframe stipulated in the affiliation agreement to provide the outreach. There shall be sufficient staff and space at the [ES] AES to [maintain] care for the [client] consumer until the screener arrives.
2. By a screener stationed in the [ES] AES. If [ES] AES utilization justifies this option, a screener, employed by the designated screening [center] service and credentialed by the host [ES] AES, shall be stationed at the [ES] AES during peak hours.

3. By transportation of a [client] consumer to the screening [center] service. This option shall be utilized only after a telephone consultation with the screening [center] service confirms that there is reason to believe that the [person] consumer may meet the criteria for commitment and the screening center has given approval for the transfer. If this option is utilized, alternative treatment planning shall occur at the screening [center] service if the [client] consumer does not require commitment; that is, the [client] consumer shall not be transferred back to the [ES] AES for such alternative treatment planning. During the telephone consultation, if there is a disagreement about disposition, a face-to-face evaluation by the screener shall take place prior to transport.

4. In the case of [(g)1] (m)1 and 2 above, if the screener has seen the [person] consumer, explored all options and involuntary commitment is needed, the screener [may] shall fill out the screening document and the [person] consumer may be seen by the [emergency service] AES psychiatrist for assessment and, if necessary, the completion of a [clinical] screening certificate prior to admission to an inpatient service. The AES psychiatrist who completes the screening certificate shall not be the consumer's treating psychiatrist, unless the procedures described in N.J.A.C. 10:31-2.3(g) are followed.

- (i) If the consumer is in an inpatient unit at the hospital, the screening certificate cannot be completed by the consumer's treating psychiatrist.

- (ii) This process must be delineated in a Division approved affiliation agreement between the AES and the screening service.

10:31-2.4 Procedures for the rehospitalization of consumers who violate their conditions of release

- (a) A consumer who has been involuntarily committed may be discharged from that commitment by a court subject to conditions recommended by the facility and mental health agency staff, with the consumer's participation.

- (b) The mental health agency designated in the court order has the responsibility to notify the court if the consumer fails to meet the order's conditions.

- (c) The judge may authorize the mental health agency or the police to transport the consumer to the appropriate screening service for further assessment and evaluation. If the order is a verbal one, the judge will subsequently sign a written order containing the same information as set forth in the verbal order.
- (d) If the consumer is unable or unwilling to go to the screening service, the mental health agency shall contact the screening service to request a mobile outreach. If the screener determines that the consumer is in need of further assessment, or other services provided by the screening service, the screening staff shall arrange to have the consumer transported to the screening service. Transportation procedures shall comply with the screening standards and existing affiliation agreements.
- (e) Upon presentation of the consumer at the screening service, a screener shall assess the consumer's condition and, if the screener determines that the consumer meets the standard for commitment delineated at N.J.S.A. 30:4-27.1 et seq., the screener shall complete the "Certification for Return Following Conditional Release" (found at N.J.A.C. 10:31 Appendix B), incorporated herein by reference, indicating that the consumer is in need of involuntary commitment.

- (f) The screener shall complete the certification in a manner that will enable the judge to have all required findings of fact including: a description of the violation of condition(s); evidence of mental illness and dangerousness, including facts, observations and the basis for recommending rehospitalization; and a recommendation for the appropriate type of facility for psychiatric treatment (that is, STCF, county hospital, State hospital).
- (g) The screener shall convey, via telephone call or fax, to the committing judge, the information included on the “Certificate for Return Following Conditional Release.” If the information is conveyed verbally, a written, signed certification with the same information shall be sent to the judge as soon as possible.
- (h) Upon review of the findings of fact and conclusions of law supported by the information provided by the screener’s certification, the judge may complete an “Order for Temporary Rehospitalization Following Conditional Release” found at N.J.A.C. 10:31 Appendix C, incorporated herein by reference, ordering the consumer to be committed to an STCF or other inpatient setting without a screening certificate or any further court order until the 20-day hearing required by N.J.S.A. 30:4-27.10 is held.

- (i) If the judge provides a verbal order or faxes the completed order to the screening service, the time, date and name of the person receiving the order shall be documented on the order and in the chart.

- (j) The screening service shall arrange to transport the consumer to the appropriate facility for rehospitalization, which may be the place from which the consumer was conditionally released or any other appropriate inpatient treatment facility the screening service identifies that has the capacity to accept the consumer. Both the certification and the order must be sent to the receiving facility along with the consumer.

10:31-2.5 Availability of staff

- (a) A [designated] screening [center] 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[, with the]_. Psychiatrist availability may be accomplished through telepsychiatry, upon prior approval from the Division and consistent with the terms of N.J.A.C. 10:31-2.3(f)2.

- i. The amount of on-site coverage should be appropriate to the amount of volume experienced by this service[;].
 - ii. The psychiatrist shall be available to provide off-site evaluation when indicated based upon contractual agreement with the Division.
 - iii. A written protocol shall indicate the procedures, timeframes, and circumstances under which a psychiatrist is to respond. The psychiatrist must be on scheduled duty as the screening service psychiatrist while performing the screening process;
2. [Certified screener(s)] Screeners who shall be available 24 hours per day, 365 days per year, to provide screening as needed on site at the screening [center] service and [off site] off-site through mobile screening outreach services[;].
 - i. A written protocol shall indicate the procedures, circumstances and timeframes within which screeners will respond to off-site locations.

- iii. When screeners are available via on-call system, agency protocol shall indicate the timeframes and circumstances under which screeners will be required to respond on-site;
- 3. Personnel, as specified in the contract between the center and the Division,] Qualified personnel who shall be on-site to provide continuous monitoring of the patient in the [holding bed(s)] ECEBs and administration of medication, as needed;
- 4. A screening [center] service or affiliated emergency service coordinator or his or her designee who shall be available 24 hours per day, 365 days per year, to provide administrative and treatment planning direction as needed[;].

- i. A written agency protocol shall delineate the chain of command and procedure for contacting the coordinator or designee 24 hours per day;

- ii. A written protocol shall indicate situations when the coordinator or designee must be contacted;

5. A [clinical] medical director who shall be a psychiatrist, who shall be available on either a full-time or part-time basis to provide/coordinate medical services;[and].

 6. [Personnel] Qualified personnel, as specified in the contract between the [Screening Center] screening service and the Division, sufficient to provide required consultation and education, hotline coverage, psycho-education, and other appropriate services, including coordination of the acute care system review procedures.
- (b) An affiliated emergency service shall have, at 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 N.J.A.C. 10:31-2.3(f)2.

 2. (No change.)

3. Those emergency services [which] that have [holding bed(s)] ECEBs and administer medication must have personnel qualified to treat and monitor patients, as specified in the contract between the center and the Division.

10:31-2.6 Written policies and procedures

- (a) Written policies and procedures shall be developed to ensure that the screening service/affiliated emergency service system complies with Federal and State law (N.J.S.A. 30:4-27.1 et seq.), and rules and regulations governing these services for persons with mental illness.
- (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. The policy and procedures manual shall be reviewed and revised annually, and updated as necessary. The review and revision process shall be documented.

2. Provider policy and procedures shall require attempts to obtain informed patient consent to receive treatment except where involuntary treatment is legally authorized and consistent with State law.
3. The policies of the screening service/emergency service, consistent with confidentiality provisions at N.J.A.C. 10:31-12, shall require 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.
4. The screening service shall develop written protocols that describe the role of the screening service staff with police at the scene of an outreach.
5. The screening service shall have written policies and procedures for providing outreach services.
6. 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. Screening services shall submit aggregate data on restraint use to the Division on a quarterly basis.

7. The screening service shall develop and maintain written protocol and procedures for use of various medication techniques, including emergency stabilization regimes;

8. Interventions on behalf of the consumer shall be documented in a clinical record.

9. The screening service shall develop and maintain policies and procedures that address clinical supervision of screeners possessing temporary certification in the completion of their assessment process.
10. All duties to be performed by psychiatrists shall be described in the screening service's policies and procedures.
11. Records of the certification of screeners and completion or fulfillment of recertification requirements shall be maintained in the screening service.

SUBCHAPTER 3. SCREENING AND SCREENING-OUTREACH

PERSONNEL REQUIREMENTS

10:31-3.1 Composition of screening and screening outreach

staff

Screening service and screening outreach staff shall include psychiatrists, [registered professional nurses and] certified screeners and a screening service coordinator. The [Division recommends that the] screening staff may also include crisis intervention specialists, social workers, registered professional nurses, psychologists, and/or other mental health professionals[.], as well as peer advocates. Each screening service shall

have, on each shift, one or more screeners who are certified by the Division.

10:31-3.2 Screening [center] service coordinator requirement, qualifications and duties

(a) Each screening [center] service shall have a coordinator possessing [a] the following minimum [of a] requirements:

- (1) A master's degree from an accredited institution in social work, psychology, nursing[,] or a related field[who shall have a,];
- (2) A minimum of three years post master's work experience in the provision of mental health services[.];
- (3) [Previous] At least one year of post-master's supervisory experience [is desirable but not necessary. The coordinator shall have completed the Division's Crisis Training course, level 1 and 2] in the mental health field; and

(4) Successful completion of the Division-sponsored screener certification course and passage of the proficiency exam within six months of the date of hire.

(b) The duties of the screening [center] service coordinator shall include, at a minimum, the following:

1. Devise and implement a written staffing plan that:

(i) [Ensuring] Ensures appropriate staff availability 24 hours per day, 365 days per year[;].

(1) A certified screener shall be available on-site or on-call at all times;

(ii) Provides appropriate coverage in the event of unscheduled absence of staff; and

(iii) [Ensuring] Ensures adequate levels of clinical staff supervision, skill development and support;

2. Facilitate access to all acute services in the screening service's geographic area;

3. [Completion] Devise, implement and document compliance with a written plan for the completion and monitoring of affiliation agreements with acute services, police, corrections, other mental health, social service[,] and health service systems;
4. [Provision of] Create and document formal liaison activities with police agencies, [and] sheriff departments, and human services organizations regarding (interface) intersystem issues, transportation, screening outreach, escort/accompaniment [,.etc.] and similar matters;
5. [Monitor fulfillment and appropriate documentation of the various] Establish a procedure for monitoring and documenting the performance of [fulfillment and appropriate documentation of the various] all screening [center] service functions listed in N.J.A.C. 10:31-2.1 and 2.2;
6. [Participation] Ensure the participation of the screening service in local mental health, health and human services planning activities;
7. [Coordination] Ensure coordination between screening [center] service and short-term care facility, [State psychiatric hospital and

county psychiatric hospital] psychiatric facility and special psychiatric hospital.

i. This process must be delineated in a Division-approved affiliation agreement;

[8. Responsibility for ensuring access to all acute services in the screening center's geographic area;]

[9]8. [Coordination of] Coordinate the systems review committee; and

[10]9. [Coordination of] Coordinate the required emergency service training and education in the geographic area.

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

[(a) Each screening center shall have one or more screeners available on each shift, who shall be certified by the Division.]

[b](a) Screener certification shall be granted to individuals who possess the qualifications delineated in at (b) below, who have completed the

Division's screener certification course and who have passed the screener certification proficiency examination.

1.The screening service shall maintain records of the certification of screeners and their completion or fulfillment of re-certification requirements.

[(c)](b) [The following shall be] Individuals who apply for status as a certified screener after (the effective date of these amendments), shall possess the following educational credentials, which shall serve as pre-requisites to admission to the Division's screener certification course and to subsequent status as a temporary or fully certified screener:

[1.Evidence of the following educational/experiential background. Although a master's degree is preferable, any of the following is acceptable:]

[i]1. A master's degree in a mental-health-related field from an accredited institution, plus one year of post-master's, full-time, professional experience in a psychiatric setting; [or]

[ii]2. A bachelor's degree in a mental-health-related field from an accredited institution, plus three years [mental health] post-bachelor's,

full-time, professional experience in the mental health field, one of which is in a crisis setting; [or]

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

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

[2. Completion of the Division's Crisis Training Course.]

(c) Prior to achieving full status as a certified screener, an individual shall serve as a temporary screener and shall receive a "T" number.

1. Temporary screener certification entitles a mental health professional to perform emergency screening in a screening service for one year from the issuance of the "T" number.

2. While a temporary screener may perform all the functions of a certified screener during this one-year period, a certified screener must review and approve the screening document completed by the temporary screener.

3. Within one year of submitting an application for temporary status, the temporary screener shall attend and successfully complete a Division-approved Basic Screening Certification Training Series and shall pass the Screener Proficiency Exam.

i. Screeners who have not attended and completed every class in the training series shall not be allowed to sit for the proficiency exam.

ii. Temporary screeners who fail to complete each class in the training series must make up the missed class(es) in the next Basic Screener Training Certification series.

iv. Temporary screeners who fail to pass the proficiency exam must pass a make-up exam.

v. Temporary screeners who fail to either complete each class in the basic training series or pass the exam

before the one-year expiration of their temporary status will be placed on conditional status, pursuant to the terms of (g) below.

v. Temporary screeners who have successfully completed all basic certification classes and passed the proficiency exam shall be issued a permanent screening (or "S") number, which shall be valid for two years.

- (d) Screener certification shall be valid for two years from the date of certification, with recertification in accordance with [(e)] (d) below.
- (e) [Biannual] Biennial recertification shall be granted after a screener has submitted evidence of [1. Completion] completion of 15 continuing education [relevant] hours approved by the Division on a case by case basis, with regard to the relevance of the subject matter to emergency or screening services. These may include courses, conferences or in-service training[; and]. At a minimum, six of those 15 hours shall be provided by the Division-sponsored screener training course.

[2. Completion of periodic updated emergency service training provided by the Division (not to exceed eight hours per year).

These training hours can be applied towards the 15 continuing education hours required (e)1 above.]

- [(f) Temporary certification may be granted at the discretion of the Division. Temporary credentialing may be granted to those individuals who are eligible for the screener certification course. Individuals receiving temporary certification must enroll in the screener certification course within one year of receiving the certificate. Persons receiving a temporary certification who have not taken the crisis training course shall register in the next available session and within one year shall enroll in the screener certification course. Those individuals who possess a bachelors degree or are registered professional nurses, plus four years of acute psychiatric experience, or a master's degree plus two years of acute psychiatric experience and have met the necessary training requirements, may be granted temporary certification for a period of up to two years.]

(f) A temporary screener who fails to complete the basic certification training series and pass the screener proficiency exam within the required one-year period or, a certified screener who fails to complete the recertification requirements set forth at (e) above, shall be placed on conditional or "C" status.

1. Screening documents and police transport forms completed by a screener on conditional status shall be co-signed by the screening coordinator within one working day of the screener's completion.

2. All documents signed by a screener on conditional status shall indicate that status.

3. A screener on conditional status shall have six months from the date of conversion to such status to satisfy all outstanding certification requirements.

4. Failure to remediate the conditions resulting in conditional status within six months shall result in the loss of all screening status until these requirements are met. In addition, the screening coordinator, agency director, Division regional coordinator, and the Department's Office of Licensing shall be notified as to this loss of screening status.

(g) The duties of a screener shall include, but not be limited to, the following:

Recodify existing 1. – 6. as 2. – 7. (No change in text.)

[7.]8. Supervision and monitoring of [patients] consumers.

[8]9. (No change in text.)

[9. Screening of patients who may be in need of commitment; and]

10. Screening for admission to STCFs;

11. Arranging for a consumer's discharge or transfer out of the screening service;
12. Arranging for a consumer's appropriate transport to a receiving facility; and
13. Determining whether the consumer has executed an Advance Directive for Mental Health Care.

10:31-3.4 Crisis intervention specialist qualifications and duties

- (a) A screening [center] service may employ one or more crisis intervention specialist(s).
- (b) The screening service shall maintain records concerning the educational and experiential background of all crisis intervention specialists.

[b)](c) The crisis intervention specialist shall possess,

at a minimum:

1. A master's degree in a mental-health-related field from an accredited educational institution;

2. A bachelor's degree in a mental-health-related field from an accredited educational institution, plus two years of experience in a psychiatric setting; or

3. (No change.)

(d) The Division may waive the educational requirements delineated in (c) above to allow a peer advocate to serve as a crisis intervention specialist.

[(c)](e) The duties of the crisis intervention specialist shall include, but are not limited to, the following:

1. (No change.)
2. The monitoring and supervision of [patients] consumers;
3. Assessment [referral and linkage] under the supervision of a certified screener;
4. Referral and linkage, including referral to a screening service, if indicated;

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

[d](f) The screening [center] service utilizing [certified screeners shall orient] crisis intervention specialists shall have written policies describing

orientation and [provide] training for all new crisis intervention specialists, prior to unaccompanied and unsupervised performance of their duties, except for assessment.

[e](g) The Division recommends [,but does not require,] that at least one crisis intervention specialist employed by the screening [center] service be a registered professional nurse, who, in addition to the duties listed above shall:

i. - iii. (No change.)

10:31-3.5 Psychiatrist requirements, qualifications and duties

- (a) Each screening [center] 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) The duties of the psychiatrist shall include, but are not be limited to, the following activities with documentation:

1. Psychiatric assessment to determine if the consumer meets the standard for commitment, regardless of consensual or involuntary status.

i. The assessments in (b)1 above may be accomplished by means of a Division-approved telepsychiatry program, upon grant of a waiver under N.J.A.C. 10:31-11 and in accordance with the telepsychiatry standards in N.J.A.C. 10:31-2.3(f);

[1] 2. Psychiatric [assessment] evaluation and management;

Recodify existing 2. and 3. as 3. and 4. (No change in text.)

[4.]5. Participation in the planning of alternatives to hospitalization;

[and]

[5.] 6. Consultation with screeners[.];

7. Consultation with other treating psychiatrists and physicians, as needed; and

8. Consultation with emergency room doctors involved in the case and those at the receiving facility.

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

- (a) Each screening [center] service shall employ a [clinical] medical director in a full- or part- time capacity. The [clinical] medical director shall be a psychiatrist[, however those persons serving in a clinical director position as of the effective date of this chapter shall not be affected by this requirement].
- (b) The duties of a [clinical] medical director shall include, but not limited be, the following:
1. The organization of medical services provided by the screening [center] service;
 2. The organization and participation in clinical training for the screening [center] service staff; [and]
 3. The [ensurance] 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 the quality standards and clinical practices of the screening service.

SUBCHAPTER 4. AFFILIATED EMERGENCY SERVICE PERSONNEL REQUIREMENTS

10:31-4.1 Composition of affiliated emergency service (AES) staff

The [ES] AES staff shall [be made up of an appropriate balance of representatives from the following disciplines: medicine, nursing, social work, and psychology, or related field.] include psychiatrists and other mental health professionals, such as registered nurses, social workers and psychologists and may include peer and family advocates.

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

- (a) Each [ES] AES shall have a coordinator. The coordinator shall possess [a] the following minimum [of] requirements:

1. A master's degree from an accredited institution in social work, psychology, nursing[,] or a related field; [and have]

2. A minimum of three years post-master's work experience in the provision of mental health services;

Previous supervisory experience is desirable, but not required. The coordinator shall have completed the Division's Crisis Training course. Completion of the Division's]

3. One year of post-master's supervisory experience in the mental health field; and

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

[screener certification course is desirable, but not required.]

- (b) The duties of the [ES] AES coordinator shall be to ensure the following:

1. - 3. (No change.)
4. Monitoring of the fulfillment and appropriate documentation of the various [ES] AES functions.

10:31-4.3 Crisis intervention specialist requirements, qualifications and duties

- (a) Each [ES] AES may employ one or more crisis intervention specialist(s). [The crisis intervention specialist shall possess two years of experience in a psychiatric setting and either a master's degree or a bachelor's degree or shall be a registered professional nurse.]
- (b) The crisis intervention specialist shall possess, at a minimum, the requirements listed at N.J.A.C. 10:31-3.4(c), with the exception provided for under N.J.A.C. 10:31-3.4(d) (peer advocates).

[(b)](c)The duties of the crisis intervention specialist shall include, but are not limited to, the following:

1. – 2. (No change.)
3. Assessment, referral and linkage, including referral to a screening service, if indicated; and
4. (No change.)

[(c)](d)[The Division recommends, but does not require, that at least] At a minimum, one crisis intervention specialist shall be a registered professional nurse. In addition to the duties listed above, the registered professional nurse shall:

1. – 2. (No change.)

3.

Provide education to [ES] AES staff regarding health care issues.

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) The duties of the psychiatrist shall include, but not be limited to, the following activities with documentation:

1. Psychiatric [assessment] evaluation and management;
- 2.-3. (No change.)
4. Consultation with screeners and crisis intervention specialists, when appropriate; [and]
5. Consultation with and provision of support for families and/or significant others regarding emergency services received by clients[.];
6. Consultation with other treating psychiatrists;
7. Consultation with emergency room physicians involved in the case and those at the receiving facility;
8. Completion of the screening certificate; and
9. As appropriate, other duties as defined in a Division-approved affiliation agreement.

SUBCHAPTER 5. SYSTEMS REVIEW IN THE ACUTE CARE SYSTEM

10:31-5.1 [Development of acute] Acute care system review

- (a) [Each]The screening service in each geographic area, [shall develop access to] in consultation with the Division, shall monitor the provision of acute care services. [The development of this process shall be coordinated by the screening center in consultation with the Division. Technical assistance shall be provided by the Division as necessary.
1. The monitoring process shall be accomplished by a committee,
known as the systems review committee, which shall meet[s]
monthly.
 2. The screening service shall coordinate with the systems review
committee to ensure the discussion of relevant issues and
follow-up with the Division and the county mental health
board.
 3. Technical assistance shall be provided by the Division as
necessary.

- [(b) The monitoring process shall be integrated with the system-wide quality assurance process where the quality assurance process exists.]

10:31-5.2 Composition of the systems review committee.

- (a) The systems review committee shall be made up of representatives from:

1. (No change.)
2. The State or county psychiatric hospital, STCF and affiliated voluntary psychiatric inpatient unit, as well as special psychiatric hospitals;
3. The county mental health board and the Division; [and]
4. Family and consumer organizations concerned with the quality and provision of acute care services, and/or consumers and family members of consumers who have been recipients of acute care services[.]; and

5. Any additional entity who is deemed appropriate and necessary by the Systems Review Chair, who shall be a screening coordinator, and upon prior approval of the Division;

i. The Division shall base its decision upon a determination that the additional party would contribute a perspective that is unique or without existing representation on the SRC and that the additional party is knowledgeable and experienced in issues relating to the screening system.

[(b) Confidentiality shall be observed by all committee members.]

(b) All committee members shall comply with all state and federal laws regarding confidentiality of consumer records.

10:31-5.3 Role of the systems review committee

(a) The systems review committee shall perform the following functions:

(1) (No change.)

(2) Monitor utilization of acute care resources to ensure that services are fairly and appropriately [distributed] accessed;

- (3) Ensure that clients receive the highest quality of care in the most appropriate, least restrictive environment, including the effectiveness of referrals and linkages to other mental health and social services;

4.-7. (No change.)

- (8) Study the medication monitoring services within the geographic area and make recommendations for change when necessary[; and].

- (9) In a case conferencing subcommittee, [Review] review disputed or problem cases which are indicative of possible service gaps and need systems change.

- i. The composition of the case conferencing subcommittee shall be limited to relevant parties and dependent upon the prior approval of the Systems Review Chair.

- (10) Conduct data analysis.

(Agency Note: N.J.A.C. 10:31-6 is proposed for recodification with amendments as N.J.A.C. 10:31-10.)

SUBCHAPTER [7.1]6. TERMINATION OF SERVICES

10:31-[7.1]6.1 Standards for termination of services

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

1. The [person] consumer does not meet the standard for involuntary commitment and refuses further services;
2. The crisis has been resolved;
3. The [person] consumer has [been successfully linked to] an appointment with another service or accepted for [clinical case management] ICMS or PACT;
4. The [person] consumer has been voluntarily admitted to a hospital or other treatment facility; or
5. The [person] consumer has been involuntarily committed to [a] an STCF, State psychiatric hospital or county Psychiatric hospital.

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

1. The [person] consumer has been linked to the screening [center] service for further evaluation or commitment;
2. The [person] consumer does not meet the standard for involuntary commitment and refuses further services;
3. (No change.)
4. The [person] consumer has been successfully linked to another service or accepted for [clinical case management] ICMS or PACT;
or
5. The [person] consumer has been voluntarily admitted to a hospital or other treatment facility.

SUBCHAPTER [8.]Z. POLICE INVOLVEMENT

10:31-[8.1]Z.1 Transportation of [clients] consumers

- (a) A [certified] screener may request that a law enforcement officer transport an individual to a screening [center] service if the screener has, as part of a screening outreach visit, evaluated the individual and signed [a] the form prepared by the Division for [the] this purpose

(founds at N.J.A.C. 10:31 Appendix D incorporated herein by reference), indicating that the individual may meet the commitment standard and requires further evaluation at the screening center.

(b) The screening service shall maintain written policies and procedures delineating the circumstances under which a police response to a mental health crisis or outreach is to be considered and the procedures to be followed in such a case. The fact that a location is a private residence shall not be, without additional factors, a justification for police involvement.

[(b)] (c) When a [certified] screener has reasonable cause to believe that an individual may be in need of involuntary commitment, the screener may [also] request that a law enforcement officer investigate the situation, but shall not state or imply to the officer that transport is being authorized by the screener. If, on the basis of personal observation, the law enforcement officer has reasonable cause to believe that the individual is in need of involuntary commitment, the individual shall be transported to the screening [center] service by the law enforcement officer for further evaluation. The screening service staff shall maintain contact with the law enforcement agency to determine the outcome of the investigation for those consumers who are not brought to the screening service.

10:31-[8.2]Z.2 Police request for evaluation

- (a) A screening [center] service shall evaluate an individual who is brought to the screening [center] service by a law enforcement officer if, based on personal observation, that officer has reason to believe that the individual meets the commitment standard.

- (b) A screening [center should] service shall provide, whenever possible, mobile screening outreach at the request of a law enforcement officer if the screening [center] service determines that, based on clinically relevant information provided by a law enforcement officer with personal knowledge of the individual subject to screening, that the person may need involuntary commitment and is unwilling or unable to come to the screening [center] service for an assessment.

10:31-[8.3]Z.3 Provision of security

- (a) A screener may request that a law enforcement officer shall remain at the screening [center] service whenever his other presence is necessary to protect the safety of the [client] consumer or other individuals. He or she shall request that the officer remain at the screening [center] service until the situation is secured.

- (b) The screening service shall have written procedures describing the circumstances under which a screener may request continuation of police involvement at a screening service.

SUBCHAPTER [9.]8. [CLIENT'S] CONSUMERS' RIGHTS

10:31[9.1]8.1 [Client's] Consumers' rights

[P.L.1991] P.L. 1991 c. 233 establishes rights for [certain clients] consumers receiving screening services, including psychiatric emergency services provided in a general hospital unit pursuant to a written affiliation agreement with a screening service. These services shall be provided in compliance with [those] all applicable statutory and regulatory provisions.

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. The screening service or AES coordinator or designee is responsible for implementing the monitoring and evaluation process.

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, and systems review data.

SUBCHAPTER [6.]10. PLANNING

10:31-[6.1]10.1 Designation of screening [centers] services

(a) [A designated] Pursuant to N.J.S.A. 30:4-27.4, the Division shall designate a screening [center [shall be named]] service in each geographic area. Although a geographic area will usually consist of a county, depending on geographic size, population, demographics or other factors, the Division may designate a portion of a county or a multi-county area as a geographic area.

(b)Beginning in 2011, and in each year thereafter, the Division shall designate a screening service for each of the State's geographic areas for a period of up to seven years at the conclusion of the process concerning the awarding of public contracts through public solicitation of bids or, in accordance with emergency designation procedures delineated in N.J.A.C. 10:31-10.2.

1. In the year prior to the year of designation, the Division shall notify the public, through a notice published in the New Jersey Register and news media and posted on its website, that it is accepting applications for screening service designation in certain geographic areas.

[(e)] (c) Once designated, the screening service shall have, for the period of designation, the sole authority to provide screening in, and for, the geographic area in which it is located, and shall assume all of the functions listed in N.J.A.C. 10:31-2.1.

1. Screening contracts shall be funded on a yearly basis, consistent with the legislature's annual funding appropriation.

(d)In order to maintain its designation status, a screening service shall demonstrate compliance with the standards of this chapter and satisfactory performance of the screening functions in the region, including but not limited to:

1.clinical assessment, crisis stabilization, referral, linkage, and mobile outreach services;

2. Documentation and recordkeeping requirements such as data reporting and performance measurement specifications
3. State and Federal confidentiality laws;
4. Implementation of wellness and recovery and cultural competency principles;
5. Maintenance of appropriate working relationships with all components of the Statewide acute care system; and
6. Maintenance of appropriately trained and credentialed staff.

(e) The Department shall ensure the participation of the county mental health board in the [The following procedure shall be used for] designation of the geographic areas and screening [centers] services:

1. [The] Geographic areas: Whenever the Division is considering a change to the existing designated geographic areas, the Division shall so notify the affected counties and each county mental health board shall make a recommendation to the Division regarding the

boundaries of the geographic area to be covered by the screening [center] service. [2.] The Division shall designate the geographic area after consideration of this recommendation; and

2. Screening service designation: The Division shall include in the competitive designation process participation by the relevant county mental health board(s). Specifically, prior to Division designation, the county mental health board shall [recommend] review all proposals and at a public meeting, take and make a record of all public comments concerning the entities that applied for designation before making a written recommendation of an agency to be designated as the screening [center] service, based on, but not limited, to the following factors:

i.– iv. (No change.)

[(b) In order to assure the availability and provision of necessary medical services, a designated screening center shall be physically located in a hospital, and shall be either directly operated by or formally affiliated by written agreement with said hospital.]

[(c) (b)The Division shall designate a screening [center] service after reviewing all public comments and the mental health board's recommendation [and

evaluating the proposed agency or hospital's] considering the ability of all entities applying to comply with this chapter, as identified in the Request For Proposal. [Continued designation is contingent upon the center's ability to perform mandated functions.]

- [(d) Re-designation shall be required after the first year of operation and every two years thereafter.

- (e) Once designated, the screening center shall have the sole authority to provide screening in, and for, the geographic area in which it is located, and shall assume all of the functions listed in N.J.A.C. 10:31-2.1.

- (f) If capital construction costs exceed Certificate of Need thresholds, a Certificate of Need (CN) may be required. The New Jersey Department of Health Certificate of Need program staff should be contacted regarding applications for CN.]

10:31-10.2 Withdrawal of designation as screening service

(a) The Division may act to withdraw designation status before expiration thereof

if:

2. the screening service notifies the Division of its intent to terminate its contract for no cause;

3. the Division notifies the screening service that the contract will be terminated for cause or because of default;

i. For purposes of this provision, “default” shall mean that the screening service has materially failed to fulfill or comply with the terms and conditions of its contract with the Division to provide screening services for a geographic area;

4. the screening service has failed to comply or is no longer able to comply with the screening law (N.J.S.A. 30:4-27.1 et seq.) or this chapter;

4. the screening service has made a willful misstatement of or omitted revealing a material fact or facts in its dealings with the Division or the public that have or could have impacted on its receipt of designated status in the first instance;

5. the screening service failed to provide all information required by these regulations or requested by the Division;

6. the screening service acted or failed to act in a manner that was or could have been detrimental to the Department, consumers, screening service or hospital staff, or the general public, including but not limited to adjudged criminal activity that has been committed by the screening service staff, board members or officers;

7. continued designation threatens the efficient and expeditious operation of the screening service's mission in the Statewide acute care system, such that it interferes with the delivery of vital psychiatric services to consumers; or

8. continued designation presents a risk of harm to the health, safety or welfare of consumers, staff or the general public.

(b) The screening service shall be advised of the following in the Division's written notice:

1. that its designation status is being withdrawn;

2. the effective date of the withdrawal;

3. that within five days of its receipt of the notice, the screening service may request a meeting with the appropriate Regional Assistant Director and Regional Coordinator to informally review the grounds for the withdrawal; and

4. that a request for an informal review of the withdrawal does not stay the withdrawal of designation.

(c) After conclusion of the informal review process, the screening service may request further review by the Assistant Commissioner for Mental Health Services or his or her designee.

1. The decision of the Assistant Commissioner or the designee shall be the final agency decision.

2. Any challenge to the Division's final agency decision applying the criteria in N.J.A.C. 10:31-10.2(a)3 through 8 may be appealed this decision to the Appellate Division of the Superior Court of New Jersey.

3. Any challenge to the Division's decision to withdraw designation based on N.J.A.C. 10:31-10(a)(1) or (e)2 may be

challenged by bringing an action pursuant to the New Jersey Contractual Liability Act.

10:31-10.3 Emergency termination or suspension of designation status and interim designation

(a) The Division may act immediately to suspend or designation status of a screening service without following the procedures delineated in N.J.A.C. 10:31-10.2, in the event that the Division determines that one of the following emergent circumstances exist and threatens public health, safety, and welfare:

1. A screening service has failed to perform its responsibilities in a manner that is consistent with the screening law (N.J.S.A. 30:4-27.1 et seq.) and this chapter, including, but not limited to, failure to comply with the terms of a waiver or waiver conditions;
2. A screening service has lost the capacity to comply with the screening law (N.J.S.A. 30:4-27.1 et seq.) and this rule;
3. A significant change in conditions has occurred since designation of the screening service that has impaired its ability to perform its responsibilities as a designated screening service.

(b) A screening service whose designation status has been suspended or terminated on an emergency basis may appeal such suspension or emergency termination by complying with the following procedures:

1. The screening service and other interested parties may request a meeting with the appropriate regional assistant director and Regional Coordinator within three business days of the suspension or emergency termination to resolve the issues;

2. If the parties fail to timely resolve the dispute by mutual agreement, the screening service may submit, within three business days of its meeting with the regional Division representative, a written appeal request to the Assistant Commissioner for Mental Health Services. In this written appeal request, the screening service shall justify its position that its screening designation should not be suspended or terminated;

3. The Assistant Commissioner for Mental Health Services shall issue a final agency decision within seven days after receiving the request, upholding the suspension or

termination or reversing it and reinstating the screening designation; and

4. An adverse final agency decision may be appealed to the Appellate Division of the Superior Court of the State of New Jersey.

(c) Where the emergent termination or suspension of screening service status leaves a geographic area without a requisite screening service, the Division may designate screening service status, on an interim basis, to an entity that meets the qualifications of N.J.S.A. 30:4-27.1 et seq. and this chapter, without invoking the full process for designation delineated at N.J.A.C. 10:31-10.1.

1. Interim designation shall be of a duration sufficient to provide screening services to the relevant area until a new screening service can be designated under the procedures set forth in N.J.A.C. 10:31-10.1.
2. Where necessary and according to the Division's determination, interim designation may be issued with one or more waivers in accordance with the standards delineated at N.J.A.C. 10:31-11.1.

SUBCHAPTER 11. WAIVER

10:31-11.1 Waiver standards

(a) The Division, in accordance with the intent and purpose of N.J.S.A. 30:4-27.1 et seq. and this chapter, may act to relax or waive, with or without conditions, sections of this chapter in the specific circumstances presented if the Division finds the following:

1. The rule is not mandated by any provision of N.J.S.A. 30:4-27.1 et seq.;
2. The provision of screening services in accordance with the purpose and procedures contained in N.J.S.A. 30:4-27.5 would not be compromised if the waiver were to be granted; and
3. No significant risk to the welfare and safety of individuals subject to screening services or the staff of designated screening or emergency services or the general public, would result from the grant of the waiver.

(b) Every waiver granted by the Division shall state the specific provision(s) waived, all conditions placed on the waiver and the time period for the waiver. The Division shall not permit the waiver of this chapter in its entirety.

10:31-11.2 Procedures for all but personnel-related waivers

(a) A screening service seeking a waiver shall submit a written request at the time of the annual renewal of its contract, at the designation of its status as a screening service, or at any time should circumstances arise that necessitate a waiver .

(b) A screening service seeking a waiver of any provision of this chapter, with the exception of the standards delineated at N.J.A.C. 10:31-3 and 4, shall submit its request in writing to the appropriate Division regional office and shall comply with the following procedures:

1. A screening service's written waiver request shall:

- i. Specify the rule(s) or part(s) of the rule(s) for which a waiver is requested;
- ii. Explain the reasons for requesting a waiver, including a statement specifying the type and degree of hardship (including, but not limited, to funding limitations) that would result if the waiver is not granted;
- iii. state the period of time the waiver is need and outline a plan to make the waiver unnecessary and a timetable for doing so; and

iv. include all documentation supporting the waiver request; and

2. The screening service shall simultaneously send copies of its waiver request to its county's mental health board and systems review committee, as well as all mental health providers, hospitals, acute care or long-term care facilities treating mental illness or co-occurring disorders and any locally active, mental health family, consumer and advocacy organizations in the geographic area to be served, as determined by the county mental health board. The screening service shall also inform these parties of the address of the Division regional office and the county mental health board where comments may be sent for at least 30 days from the date of the waiver request. The notice shall also include the time, location and date of the first county mental health board meeting scheduled after the 30-day comment period. The screening service shall submit to the Division documentation indicating compliance with this provision;

(c) The screening service's waiver request will be reviewed according to the following procedure:

1. The waiver request, and any comments received pertaining thereto, shall be discussed at the first county mental health board meeting after the

close of the 30-day comment period, as a part of the regular agenda and in an open public meeting that includes an opportunity for public comment on the waiver request. Public comments shall be recorded. By motion, the county mental health board will either endorse the waiver request or record its objections to the granting of the waiver by the Division;

2. The Division shall review each waiver request, public comments on the waiver request and the mental health board's endorsement or objection to the waiver request, in accordance with the standards delineated in this section. The Division may deny, grant with or without conditions, or grant in part and deny in part a waiver for a period of up to one year. This decision shall be based on the full record, which shall include any public comments and discussion that occurred at the mental health board meeting, the motion approved by the board, and any written comments received by the Division;

3. Within 14 days of its receipt of the county mental health board's recommendation, the Division, through the appropriate regional assistant director, shall communicate in writing to the screening service indicating which provisions of this chapter, if any, have been waived, the expiration date of the waiver, and any conditions or limitations that have been placed on the waiver;

4. The screening service may appeal denial by the regional assistant director of its waiver request by submitting an appeal to the Assistant Commissioner for Mental Health Services. The screening service that originally requested the waiver, and other interested parties, may communicate their opinions about the appeal of the waiver denial to the Assistant Commissioner for Mental Health Services prior to his or her final decision. The Assistant Commissioner for Mental Health Services shall uphold or reverse the original waiver denial by the regional assistant director and communicate the decision to the screening service in a written final agency decision; and

5. Failure to comply with any conditions contained in the waiver shall constitute grounds for emergency suspension of screening service designation, in accordance with N.J.A.C. 10:31-10.2.

10:31-11.3 Procedures for personnel waivers

(a) Any requested waiver of the screening and screening outreach personnel requirements delineated at N.J.A.C. 10:31-3 or the affiliated emergency service personnel requirements delineated at N.J.A.C. 10:31-4 shall be known as a personnel waiver. In the interests of preserving a job candidate's privacy and to

avoid undue delay in the hiring process, a screening service's request for a personnel waiver shall not be required to follow the procedures delineated in N.J.A.C. 10:31-11.1 and 11.2, but shall be required to meet the following requirements.

1. The screening service shall submit its written request only to the Division's regional office. The request need not undergo the public review procedures delineated at N.J.A.C. 10:31-11.2.

2. The personnel waiver request shall contain the information delineated in N.J.A.C. 10:31-11.2(b)1 and shall include clear clinical or programmatic justification.

(b) The Division shall issue a written decision within 14 days of receipt of the personnel waiver request.

(c) The Division shall base its decision to grant or deny a personnel waiver request, according to whether it meets the standards set forth in N.J.A.C. 10:31-11.1(a).

1. A decision granting a personnel waiver request

shall indicate which personnel requirements have been waived, the expiration date and any relevant conditions or limitations.

2. A personnel waiver may be for a maximum time period of one year, subject to renewal upon a request made in accordance with the process delineated at N.J.A.C. 10:31-11.4.

10:31-11.4 Renewal requests and extensions

(a) To renew a waiver originally granted for one year, a screening service shall submit a written request to the appropriate Division regional office 60 days prior to the waiver's expiration. This request shall meet the standards delineated in N.J.A.C. 10:31-11.1(a) or 11.3, as applicable.

(b) The screening service may request an extension of a waiver granted for less than one year by submitting a written request to the appropriate Division regional office 60 days prior to its expiration. This request shall meet the standards delineated in N.J.A.C. 10:31-11.1(a) or 11.3, as applicable.

(c) Notwithstanding the procedure set forth in (a) and (b) above, the Division, upon written request of a screening service, may issue a new waiver or renew an existing waiver. The Division may also extend a waiver and/or waiver conditions

on an emergent basis the Division determines that public health and safety concerns require immediate action. Such an issuance or extension shall be issued prior to public notice and comment and shall be limited to the time period necessary to complete the waiver decision process.

SUBCHAPTER 12. CONFIDENTIALITY OF CONSUMER RECORDS

10:31-12.1 Confidentiality of consumer records held by screening services

(a) Consumer records held by screening services are confidential protected health information (PHI).

(b) Screening service staff and affiliated emergency services (AES) staff shall comply with all State and Federal confidentiality laws to maintain the confidentiality of consumer PHI, including, but not limited to, the protections mandated by N.J.S.A. 30:4-24.3 and 26:5C-7; the Federal privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, as they apply to the release of and access to PHI ; 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; 34 CFR 361.38 Vocational Rehabilitation Protection, Use and Release of Patient Information; and the Federal Fair Housing Amendments of 1988, 42 U.S.C. 3601 et seq.

10:31-12.2 Disclosure upon the consumer's written authorization

(a) Consumer private health information may be disclosed to the extent permitted by a valid, written, unrevoked authorization, signed by the consumer or the consumer's legal guardian or mental health care representative.

(b) The authorization must conform to the requirements of the HIPAA privacy rule at 45 CFR 164.508(a).

(c) Authorizations for the release of psychotherapy notes, HIV/AIDS information and individual drug and alcohol abuse information must specifically identify those records as being subject to release.

10:31-12.3 Disclosure upon court order

Consumer protected health information may be disclosed pursuant to a court order.

10:31-12.4 Disclosure of consumer protected health information without authorization or court order

(a) In the absence of the consumer's authorization or a court order, screening staff may disclose consumer PHI for the purposes and in accordance with the following conditions:

1. Treatment of the consumer: Professional screening staff may disclose the minimum necessary consumer PHI that is relevant to a consumer's treatment and/or referral for treatment, pursuant to N.J.S.A. 30:4-27.5(c), to staff at a community mental health agency, as defined in N.J.S.A. 30:9A-2, another screening service or a short-term care or psychiatric facility or special psychiatric hospital, as defined at N.J.S.A. 30:4-27.2;

2. Payment related to the consumer's care: Screening staff may disclose consumer PHI to the extent necessary to conduct an investigation into the financial ability to pay of the consumer or his or her chargeable relatives pursuant to the provisions of N.J.S.A. 30:1-12;

3. Individuals directly involved in the consumer's care: Screening staff may make the following types of disclosure to the parties indicated in (a)3i and ii below, provided that they first comply with (d) or (e) below, as applicable:

i. Screening staff may disclose to a family member, other relative, or a close personal friend of the consumer or any other person identified by the consumer, consumer PHI directly relevant to the person's involvement in the consumer's care or payment related to the consumer's care; and

ii. Screening staff may use or disclose consumer PHI to notify or assist in the notification of (including identifying or locating) a family member, a personal representative of the consumer or another person responsible for the care of the consumer, of the consumer's location, general condition or death;

4. Disclosures where the consumer is present: If the consumer is present for or otherwise available prior to a disclosure permitted by (c) below and has the capacity to make mental health care decisions, screening staff may disclose the consumer's PHI if they first:

i. obtain the consumer's verbal agreement;

ii. provide the consumer with the opportunity to object to the disclosure, and the consumer does not express an objection;

or

iii. reasonably infer from the circumstances, based on the exercise of professional judgment, that the consumer does not object to the disclosure; and

5. Limited disclosures when the consumer is not present: If the consumer is not present, or the opportunity to agree or object to the use or disclosure cannot practically be provided because of the consumer's incapacity or an emergency circumstance, screening staff may, in the exercise of professional judgment, determine whether the disclosure is in the best

interest of the consumer and, if so, disclose only the consumer PHI that is directly relevant to the person's involvement with the consumer's care. Screening staff may use professional judgment and their experience with common practice to make reasonable inferences of the consumer's best interest in allowing a person to act on behalf of the consumer to pick up filled prescriptions, medical supplies, x-rays or other similar forms of PHI;

(b) All disclosures of consumer PHI shall be documented in the consumer's record, and shall describe the consumer PHI disclosed, the individual to whom the consumer PHI was disclosed, the date of disclosure and the basis upon which the decision to disclose was made.

(c) All decisions to disclose consumer PHI pursuant to this section shall be made individually, on a case-by-case basis.

(d) A disclosure of consumer PHI under this section does not authorize, or provide a basis for, future or additional disclosures.

10:31-12.5 Denials of access to consumer protected health information (PHI)

(a) Screening staff shall comply with the following procedures and standards in the event that a consumer request to review the consumer's own PHI is denied:

1. The screening service's decision to deny a consumer access to his or her own PHI shall be in writing and given to the consumer. The written denial shall state the reason for the denial and shall describe the consumer's right to a review of the denial and how the review can be obtained. The written denial shall comply with the additional requirements of the HIPAA privacy rule set forth in 45 CFR 164.524;

2. Consumers shall be given access to the consumer PHI that is not part of the denial;

3. Upon the consumer's request, the denial decision shall be reviewed by a supervisory licensed health care professional who was not directly involved in the initial denial decision;

4. The reviewing official shall uphold the denial decision if:
 - i. The requested information was obtained from someone other than a health care provider under a promise of confidentiality, and where the access requested would be reasonably likely to reveal the source of the information;

 - ii. disclosure of the requested information, in the professional judgment of a licensed health care professional, is

reasonably likely to endanger the life or physical safety of the consumer or another person; or

iii. The requested information which makes reference to another person (unless such other person is a health care provider), and in the professional judgment of a licensed health care professional, access is reasonably likely to cause substantial harm to such other person; or

5. Screening staff shall provide written notice to the consumer of the reviewing official's determination and shall perform whatever other action is necessary to carry out the reviewing official's determination.

10:31-12.6 Fees

Consistent with the Health Insurance Portability and Accountability Act, a reasonable, cost-based fee may be charged for the duplication and production of the consumer PHI (45 CFR 164.524(c)).

APPENDIX A
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
SCREENING DOCUMENT FOR ADULTS
(Pursuant to N.J.S.A. 30:4-27.1, et seq.)

I. Instructions

New Jersey Court Rule 4:74-7 (b) states in part that:

“All clinical and screening certificates shall be in the form prescribed by the Department of Human Services....the certification shall state with particularity the facts upon which the psychiatrist, physician or mental health screener relies in concluding that (1) the patient is mentally ill, (2) that mental illness causes the patient to be dangerous to self or others or property as defined by N.J.S.A. 30:4-27.2h and -2i, and (3) appropriate facilities or services are not otherwise available.”

Chapter 4 of Title 30 of the New Jersey Statutes states in part that:

1. “Screening” means the process by which it is ascertained that the individual being considered for commitment meets the standards for mental illness and dangerousness as defined in P.L. 1987, c.116 (N.J.S.A. 30:4-27.1et seq.) and that all less restrictive stabilization options have been ruled out or exhausted.

2. "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. (N.J.S.A. 30:4-27.2p).

3. "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 development disability unless it results in the severity of impairment described herein. (N.J.S.A. 30:4-27.2r).

4. "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 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 s/he is able to satisfy such needs with the supervision and assistance of others who are willing and available. (N.J.S.A. 30:4-27.2h)

5. "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 the person's history, recent behavior and any recent act or threat. (N.J.S.A 30:4-27.2i)

6. "In need of involuntary commitment" means that the person is mentally ill, that the mental illness causes the person to be dangerous to self or dangerous to others or property and where s/he is unwilling to be admitted to a facility voluntarily for care, and who needs care at a short term facility, psychiatric facility or special psychiatric hospital because services are not appropriate or available to meet the person's mental health care needs. (N.J.S.A 30:4-27.2m)

7. "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, holding bed with medication monitoring or emergency stabilization regimes, 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 systems.

8. "Consensual" means the type of admission applicable to a person who has received a face-to-face assessment from a certified screener and screening psychiatrist at a designated screening center, 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 STCF for stabilization and treatment. (N.J.A.C. 10:37G-1.2)

Use of the following document is restricted to the purpose of a certified screener documenting a person's eligibility for involuntary commitment or consensual hospitalization only.

II. Findings

This document is being prepared as a:

() SCREENING DOCUMENT (Pursuant to N.J.S.A. 30:4-27, et seq.)

() CONSENSUAL ADMISSION DOCUMENT (Pursuant to N.J.A.C. 10:37G-2.1)

Name of Client _____

Date of Birth _____ Sex _____ M _____ F _____

English language abilities:

A. Speaks English: _____ Yes _____ No _____

_____ Few Words _____ Conversationally _____ Fluent _____

B. If not English, what is the person's Native Language?

Native language abilities (circle for yes)

Speaks Reads Writes

C. Did you interview the person in English? _____ Yes _____ No _____

D. Describe the person's mental illness (refer to the definition in N.J.S.A. 30:4-27.2r.)

E. 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 provide reason for screening:

F. Check all that apply:

Dangerous to self/suicidal

Describe the danger. Include history, threats, plans, intent, availability, and lethality of means, behavior and actions:

Dangerous to self/not suicidal

Describe the danger. Include history, threats, actions, plans, which would make it probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future:

Dangerous to others

Describe the danger. Include history, threats, actions, plans, intent, availability and lethality of means, behavior and intended victim(s):

___ Dangerous to property

Describe the danger (s), (include history, threats, actions, plans, intent, availability of means, behavior and previous attempts):

G. 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 Available Available Not Available

Existing Support System

Referral & Linkage to
Community Services

Crisis Intervention
Counseling

Outpatient Services
Medication Monitoring

Acute Partial Care

PACT

ICMS

Extended Crisis Evaluation
Bed with Medication
Monitoring

Voluntary Admission to
Non-STCF inpatient unit

Crisis Housing

Referral to other non-mental
health 24 hour
facility

Other (describe):

H. If involuntary or consensual hospitalization is recommended, briefly explain why no less restrictive intervention/service was appropriate and available.

III. Certification

I am a NJ Certified Mental Health Screener and an employee of

_____. I have interviewed

_____ on this date and

reviewed the available clinical records. It is my opinion that at this

time the named person shows evidence of mental illness and is

___ Dangerous to self

___ Dangerous to others or property

(Fill out only one side)

SCREENING DOCUMENT

CONSENSUAL ADMISSION DOCUMENT

Signature of Screener .

Screener Number

Date

Time

DMHS Form #SCR-1

Revised: 12-1-2002

Signature of Screener

Screener Number

Date

Time

APPENDIX B

DIVISION OF MENTAL HEALTH SERVICES
DEPARTMENT OF HUMAN SERVICES

CERTIFICATION FOR RETURN FOLLOWING CONDITIONAL RELEASE

I, _____ (Name of Screener), a screener certified by the State of New Jersey to examine individuals to determine if they are in need of involuntary commitment to psychiatric inpatient care, and employed for that purpose by _____

_____ (Name/address of Designated Screening Service)

a Designated Screening Service as defined in N.J.S.A. 30:4-27.4, certify the following:

I have interviewed and reviewed all available records for:

1. Consumer's Name: _____
2. Name of hospital from which consumer was conditionally released: _____

3. List of conditions: _____
4. Date of conditional release: _____
5. Name, address, and phone number of designated Mental Health Agency (example: ICMS/PACT or other assigned follow up program):

6. Name of case manager (ICMS/PACT) or other designated contact reporting the violation(s):

7. Identify the primary source of this information (i.e. mother, police):

8. Describe the specific condition violated and the nature of each violation: _____

9. Means by which the patient was brought to the Screening Service (check):
Police _____, Family_____, Agency Personnel_____, Self_____,
Residential Provider_____. Transport was authorized by Judge
_____by verbal order at_____pm/am on_____,
20_____.

10. Evidence of mental illness and dangerousness including facts,
observations, and basis for recommending re-hospitalization:_____

11. Recommendations to the court (can include STCF, County Hospital, State
Hospital):

12. Name of judge receiving certification:_____

13. Date and time sent or phoned to the judge:_____

I certify that the above information is true. I am aware that if any of the foregoing
statements made by me are willfully false, I am subject to punishment.

Certified Screener _____ Date _____

Certification Number _____

APPENDIX C

<u>In the Matter of the Commitment of</u>	<u>State of New Jersey</u>
_____	<u>Superior Court</u>
_____	<u>County of</u>
_____	<u>Docket No.</u>

ORDER FOR TEMPORARY RE-
HOSPITALIZATION FOLLOWING
CONDITIONAL RELEASE

This matter having been opened to the Court by _____, a certified mental health screener employed by a screening service designated pursuant to N.J.S.A. 30:4-27.4, by submission of a Certification for Re-hospitalization Following Conditional Release executed on _____, 20____, and the Court having reviewed and considered said certification, attached hereto and made part hereof, and it appearing to the Court that:

1. The subject of the certification was transported to the screening service: _____ by order of Judge _____, which is appended hereto _____ pursuant to N.J.S.A. 30:4-27.6 a. or b. _____ other _____

and

2. The subject's clinical condition, as certified by the screener, is such that s/he is mentally ill and the illness causes the subject to be a danger to self, others, or property based on the following facts:

and

3. It further appears that the patient has failed to meet one or more conditions of release, and for good cause shown,

It is on this _____ day of _____, 20____, ORDERED that:

1. The patient shall be hospitalized at _____, pending a plenary hearing within twenty days of admission to the hospital.*

2. This order shall be immediately transmitted to the county adjuster who shall schedule the hearing, and no later than ten days prior to said hearing, serve the patient, and the attorneys, relatives, and other persons who received notice of the next most recent commitment hearing, with notice of the place, date and time of the hearing, and a copy of this Order and attachments; by personal service upon the patient and by regular mail upon all other persons.

3. Nothing herein shall be construed to prohibit the hospital from releasing the patient prior to the hearing, in accordance with N.J.S.A. 30:4-27.17a, either without conditions or upon the same conditions previously ordered by the Court.

(Judge)

APPENDIX D

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
Division of Mental Health Services

SCREENING OUTREACH
Authorization for Police Transport pursuant to N.J.S.A. 30:4-27.5

Certification of mental health screener:

I am a New Jersey Certified Mental Health Screener and an employee of

_____, a designated screening service. I

(name of screening service)

have interviewed _____ *(name of subject/client)*

during a screening outreach visit and on the basis of that interview I believe that s/he is dangerous to self, others, or property as defined in NJSA 30:27.2 h., - 27.2i, and in the case of a minor N.J.R.Ct. 4:74-7A (3). I certify that therefore s/he may be in need of involuntary commitment and I request that s/he be taken to the screening service at _____ *(name of screening service)*.

Signature of Screener

{print} name of screener

_____ Date: _____ Time: _____ am/pm

Under N.J.S.A. 30:4-27.6, _____ P.D. is required to take custody of and immediately transport the above-named consumer directly to a screening service, and to remain at the screening service as long as necessary to protect the safety of the person in custody and the safety of the community.

I certify that the above information is true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Certified Screener

Date