(d) The patient's demonstrated ability to participate in treatment activities by virtue of a greater degree of self-initiated responsible participation shall result in involvement and assignment to more off-ward activities and programs. To maximize the probability of success in the change in the treatment regimen, these off-ward activities shall be structured and supportive with staff escort at all times. On-ward therapies and activities, however, shall utilize the patient's developing sense of responsibility and initiative as staff provides less direct supervision and structure while continuing to evaluate progress frequently.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
In (b): added "but are not limited to" to clarify listing of medical condition criteria.
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
Inserted new (c), and recodified existing (c) and (d) to (d) and (e).
Recodified from N.J.A.C. 10:36-1.5 and amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section. Former N.J.A.C. 10:36-1.6, Level III definition, criteria and program structure, recodified to N.J.A.C. 10:36-1.7.

10:36–1.7 Level III definition, criteria and program structure

(a) Patients at Level of Supervision III are those who generally are able to control dangerous impulses and who thus require less supervision than that present at Level II.

(b) Programming and services are provided on-ward and off-ward (on or off hospital grounds) with an increasing emphasis upon off-ward programming. The frequency, duration and types of unescorted off-ward activities are determined by the treatment team. The patient's participation in each scheduled off-ward program and on hospital grounds shall be defined by time accountability and the clinical relevance of the program. Participation in unescorted off-ward activities shall be implemented incrementally. Staff-escorted community activities are permitted at this level. Brief home visits are permitted at this level if the family is capable and willing to provide the level of supervision considered necessary by the treatment team in consideration of the clinical needs of the patient.

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

1. Minimal psychotic or mood disordered symptoms, or if chronic residual symptoms are still present, does not act in response to them;

2. Oriented and aware of surroundings;

3. Cooperative with established plan and schedule of activities;

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

5. Minimal elopement/walkaway risk;

6. Able to control impulses except when severely stressed;

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

8. History of anti-social behavior;

9. History of sexually inappropriate behavior;

10. History of elopement or walkaway risk;

11. History of criminal behavior;

12. History of violent behavior directed toward others;

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

14. Medical problems requiring only intermittent evaluation by ward staff.

(d) The patient's responsible and cooperative participation in activities both on-ward and off-ward but on hospital grounds, and escorted off hospital grounds activities is expected to result in the team encouraging more independent activity by gradually increasing the number of unescorted off-ward programs. These programs and activities generally include centralized (off-ward) social and rehabilitative programs and activities. Staff shall monitor Level III patients to ensure program participation.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
In (b): added "but are not limited to" to clarify listing of medical condition criteria.
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
Inserted new (c), and recodified existing (c) and (d) to (d) and (e).
Recodified from N.J.A.C. 10:36-1.6 and amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section. Former N.J.A.C. 10:36-1.7, Level IV definition, criteria and program structure, recodified to N.J.A.C. 10:36-1.8.

10:36–1.8 Level IV definition, criteria and program structure

(a) Patients at Level of Supervision IV are those who pose no or minimal risk of harm to self, others or property and who may be discharged upon finalization of after-care and housing plans.

(b) Attendance and appropriate participation at any approved activity on-ward, off-ward, or off-grounds is expected through the self-initiated behavior of the patient, and is without staff escort. Determination of recommended programs and activities is the responsibility of the treatment team.

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

1. No recent instances of substance abuse;

2. Oriented to and capable of utilizing community or transportation services;

3. Patient exhibits sound judgment under reasonable conditions;

4. Patient exhibits accountability and responsibility through adherence to treatment plan program schedule;

5. History of alcohol and substance abuse or of treatment non-compliance;

6. Past history of violence, threats towards identifiable third parties; or

7. No physical/medical contraindications.

(d) Programming and activities at this level are the least structured. While staff shall evaluate the patient's behavior for compliance with the schedule, direct supervision shall be decreased. Most often, community-based programs and activities (for example, transitional programs, community day programs, community trips), as well as larger group activities, shall be part of the individual's overall program at Level IV.

Recodified from N.J.A.C. 10:36–1.7 and amended by, R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

SUBCHAPTER 2. CLINICAL REVIEW PROCEDURES FOR SPECIAL STATUS PATIENTS

10:36–2.1 Statement, purpose and scope

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

(b) The purpose of this procedure is to establish a mechanism which provides a comprehensive review of the clinical treatment and management of special status patients through ensuring appropriate treatment interventions, levels of supervision and planning at the time of movement to less restrictive settings, decrease of structures and security, or discharge, and to ensure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges. However, nothing in these procedures is intended to alter the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients and with the Patient Bill of Rights at N.J.S.A. 30:4–24.2.

(c) Special status patients are those who satisfy the definition of the term at N.J.A.C. 10:36–1.2.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
In (b), added text to clarify responsibility of hospital staff.
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (b), added "and to insure that hospital staff conduct an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties when special status patients are given privileges" at the end of the first sentence, and added a reference to the Patient Bill of Rights at the end of the second sentence.
Amended by R.2003 d.2367, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

10:36–2.2 Special Status Patient Review Committee composition

(a) The Clinical Director/Medical Director shall appoint the members comprising the Special Status Patient Review Committee ("SSPRC" or "Committee") and shall designate a Committee Chairperson.

(b) The composition of the SSPRC shall include, but need not be limited to: the Medical/Clinical Director or Chief of Psychiatry, the Director of Psychology, the Director of Nursing Services, the Director of Rehabilitation Services, and the Director of Social Services. One of these individuals shall be a psychiatrist. These individuals may appoint designees to the Committee who are of sufficient experience to appropriately review these matters. Such designees shall not endorse recommendations they may have already made as a treatment team member.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
Revised to add flexibility to the composition of the Clinical Review Committee.
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (a), substituted a reference to the Clinical Director/Medical Director for a reference to the Clinical Director; and in (b), inserted a reference to the Clinical Review Committee, added "who are of sufficient experience to appropriately review these matters" at the end of the second sentence, and added a third sentence.
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

10:36–2.3 Procedures

(a) Whenever a patient objects to the treatment team's recommendation regarding the levels determination, the SSPRC Chairperson shall designate a committee member to interview the patient within the 10–day time frame for the SSPRC's decision-making established in (d) below.

(b) The treatment team shall prepare and forward to the SSPRC Chairperson/designee in as timely a manner as possible the information concerning the patient whose status requires clinical review. Whenever a recommendation regarding a level of supervision is forwarded to the SSPRC and the special status patient has an opinion that differs from his or her treatment team, a statement by the patient and/or a summary of the patient's opinion shall be included in the information forwarded to the SSPRC.

(c) The SSPRC Chairperson may designate a committee member to interview the patient prior to the committee review whenever, in his or her judgment, the situation warrants. One of the special status patient's treatment team members familiar with the current level recommendation shall meet with the SSPRC during their review process.

(d) The SSPRC shall meet and review the team proposals within 10 working days of receipt of the information.

(e) The SSPRC Chairperson or designee shall forward the committee's recommendations in response to the team proposals to the Clinical Director within two working days.

(f) The Clinical Director/Medical Director shall review the SSPRC recommendations regarding endorsement of the team proposals and respond to the Chairperson within two working days by either endorsing the SSPRC recommendation, or withholding endorsement. The Clinical Director/Medical Director may request additional information from the treatment team; however, such request and the team's response shall be made within the same two-day period. All recommendations must be endorsed by the Clinical Director/Medical Director prior to implementation.

(g) The Clinical Director/Medical Director shall periodically attend SSPRC meetings in his or her institution in order to monitor the thoroughness and quality of clinical recommendations and compliance with this policy and procedure. Additionally, the Quality Assurance Department within each hospital or other designee of the hospital CEO shall also monitor the hospital's compliance with the rules within this subchapter.

(h) Whenever a hospital treatment team and the hospital's SSPRC recommend the granting of a supervision decrease to Level III or Level IV or the discharging of any patient subject to the hospital's SSPRC's review procedures, the documentation regarding those supervision and discharge reviews shall be forwarded to the Division Medical Director and his or her designee by the SSPRC Coordinator within two days of finalizing such recommendation to ensure that an appropriate risk/benefit assessment balancing the patient's need for effective treatment and the safety needs of all parties has been performed. Final Division Medical Director action shall be communicated to hospital staff no more than five working days after receipt of the hospital Clinical/Medical Director approval.

(i) Whenever N.J.S.A. 30:4–27.17b requires written notice to a county prosecutor or deputy attorney general who participated in a patient's commitment, a designated hospital staff member shall notify the appropriate individual in accordance with that statutory provision.

(j) The rationale supporting the levels decision shall be entered into the SSPRC's meeting minutes and the patient's records.

Amended by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
Added new subsection (g).
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (f) and (g), substituted references to the Clinical Director/Medical Director for references to the Clinical Director; and added (h) and (i).
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

10:36–2.4 SSPRC Coordinator

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

1. Consultation with treatment teams regarding preparation of information to be submitted to the SSPRC;

2. Maintaining files on all cases presented to the SSPRC;

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

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

Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

10:36–2.5 (Reserved)

Repealed by R.1993 d.58, effective February 1, 1993.
See: 24 N.J.R. 4232(a), 25 N.J.R. 583(b).
Section was "Quality assurance activities."

SUBCHAPTER 3. TRANSFERS OF INVOLUNTARILY COMMITTED PATIENTS BETWEEN STATE PSYCHIATRIC FACILITIES

10:36–3.1 Purpose

The purpose of this subchapter is to define the factors to be used by State psychiatric facility staff in evaluating the need for inter-hospital transfers among the facilities cited in N.J.A.C. 10:36–3.2. The subchapter also delineates the procedures related to such transfers.

10:36–3.2 Scope

(a) The rules of this subchapter apply in all instances to involuntarily committed patients who are residing at and being considered for transfer to any of the following facilities specified in N.J.S.A. 30:4–160:

1. Greystone Park Psychiatric Hospital;

2. Trenton Psychiatric Hospital;

3. Ancora Psychiatric Hospital;

4. The Ann Klein Forensic Center; and

5. The Senator Garrett W. Hagedorn Psychiatric Hospital.

(b) Prior to a patient's initial commitment hearing, only emergency transfers may be made. Regardless of a patient's transfer to another State hospital, the initial commitment hearing shall take place within 20 days of initial inpatient admission to the original facility and shall not be postponed by the request of staff at the receiving hospital, except in the event that security concerns or a patient's condition requires an adjournment.

Amended by R.1991 d.453, effective September 3, 1991.
See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).
Added new subsection (b).
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (a)6, substituted "Gero-Psychiatric Hospital" for "Center for Geriatrics".
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
In (a), deleted 3 and recodified former 4 through 6 as 3 through 5 with amendments; rewrote (b).

10:36–3.3 Factors

(a) Any of the factors described below may serve as a basis for the transfer of a patient from and to any facility cited in N.J.A.C. 10:36–3.2:

1. To place him or her in closer proximity to family members;

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

2. To place the patient in the appropriate hospital according to the patient's residence (catchment area);

3. To provide a new clinical and personal relationship in exceptional circumstances when a treatment impasse has developed over a sustained period of time;

4. To provide greater or less clinical structure or security;

5. To participate in a specialized medical or psychiatric service that is offered at another hospital or in the community that is more accessible from the receiving hospital;

6. As a result of a change in legal status;

7. To spare patients the consequences of overcrowding at a specific mental health facility;

8. In response to natural catastrophes, fires, or other life-safety concerns which necessitate transfer; or

9. As a consequence of inter-regional consolidation of services.

(b) A patient's stated preference for treatment at a particular State psychiatric facility shall always be a relevant consideration in transfer decisions. Transfers over the objection of a patient are permitted, however, when a clinical determination has concluded that the transfer is in the transferee's clinical best interest or necessary for the safety of other patients or administratively necessary due to a factor listed in (a) above. A transfer is permitted only when, in the judgment of the treatment team, the transfer's permissible purpose outweighs any potential harm to the patient from the transfer.

1. When a transferring facility is capable of meeting the clinical or administrative purpose for a proposed transfer as contained in the factors at (a) above, an objecting patient shall not be transferred.

2. Transfers shall be to the least restrictive available treatment alternative available to achieve the purposes of the transfer request as contained in the factors at (a) above.

Amended by R.1991 d.453, effective September 3, 1991.
See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).
Added new (a)1i and subsection (b).
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
In (a)5, inserted "medical or" preceding "psychiatric"; in (b)2, substituted "available" for "necessary" following "alternative".

10:36–3.4 General procedures

(a) This section delineates the conditions and procedures applicable to all transfers to and from State psychiatric hospitals.

(b) Each CEO shall designate a staff member to function as a transfer coordinator who, for purposes of transfer arrangement, shall report directly to the CEO.

(c) A written request for transfer, supported by a statement of the factors justifying the request, shall be forwarded from the transfer coordinator of the sending hospital to the transfer coordinator of the receiving hospital. All requests for transfers shall be supported by clinical considerations.

(d) Transfers occurring as a result of overcrowding, life-safety concerns, natural catastrophes, or consolidation of services shall require the approval of the Director, Division of Mental Health Services.

(e) The following procedures shall be followed in cases of non-emergent transfers:

1. The transfer coordinator of the sending hospital shall consult with the transfer coordinator of the receiving hospital. If they agree to the transfer, they shall arrange for a specific date and time for the transfer to occur.

2. Hospital staff shall actively promote resident input into non-emergency transfer decisions.

3. At least seven days prior to the transfer date, staff at the sending institution shall notify the relevant County Adjusters, family and attorney of the patient being transferred of the transfer decision, the reason for the transfer and the procedural rights in this chapter.

5. It is the responsibility of the hospital initiating the transaction to make arrangements for transporting the patient from one facility to the other.

6. If the transfer coordinators do not agree on the transfer, the matter shall be referred to the CEOs of the respective institution for resolution.

7. If the CEOs do not agree, the case shall be referred for resolution to the appropriate regional Assistant Directors, Division of Mental Health Services, who may, in making their decision, request clinical and technical input from hospital central office staff. Resolution, in instances of continuing disagreement, rests with the Division Director or the Director's designee.

8. All transfer requests are to be handled in a timely manner.

9. The basis for the transfer decision shall be documented in the patient's record.

(f) The following procedures shall be followed in cases of emergency transfers:

1. Emergency shall be defined, for the purposes of this subchapter, as imminent danger of serious bodily harm to self or others, as evidenced by a recent incident or a change in psychiatric status which less restrictive available treatment alternatives other than transfer cannot adequately address and which requires removal from the patient's current setting. Only the factors in N.J.A.C. 10:36–3.3(a)4 or 8 may serve as the basis for an emergency transfer.

2. Emergency transfers shall take place only upon prior agreement between the CEOs of the institutions.

3. Staff at the sending hospital shall notify the relevant County Adjuster(s), family, and attorney of the resident being transferred of the transfer and the reason for the transfer as soon as possible after the transfer decision has been made.

4. The transfer coordinator or, when unavailable, the administratively responsible person of the sending hospital must contact directly the CEO or transfer coordinator at the receiving institution and transmit verbally the factors supporting the transfer, as well as the reasons for the emergent nature of the transfer. Supporting documentation must be faxed prior to the final decision to transfer.

5. If, after transfer, the CEO of the receiving hospital objects to an emergency transfer, he or she shall review the case with the CEO of the sending institution. If agreement cannot be reached, the matter shall be referred to the Assistant Director of the receiving region.

6. That Assistant Director shall consult with his or her counterpart from the sending region to resolve the issue.

7. If agreement cannot be reached by the Assistant Directors, the issue shall be referred for resolution to the Director or the Director's designee.

8. The basis for the transfer decision shall be documented in the patient's record.

Amended by R.1991 d.453, effective September 3, 1991.
See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).
In (b), added "treatment impasse" to list of situations.
Revised subsection (d)1.
Deleted subsection (d)4 on "clinical urgency," recodifying existing 5.–7. as 4.–6. with no change in text.
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (b), deleted "and Hospitals" and added "Services"; and in (c)6, deleted "and Hospitals" and added "Services".
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.

10:36–3.5 Procedures when patients object to transfer

(a) Regarding non-emergency transfers, the following apply:

1. If a patient objects to such a transfer, he or she shall be provided an opportunity to state the basis for his or her objection, and present any relevant facts including statements by other individuals, with or through a representative if so desired, before an individual who is not a member of the treatment team seeking transfer. The hospital's Clinical Director/ Medical Director shall designate this individual, who may be a member of the office of the hospital's clinical director or other hospital staff member capable of providing an independent review of the need for the proposed transfer.

2. The individual who reviews the proposed transfer shall have the authority to approve or disapprove the proposed transfer.

3. Patients and their representatives may submit in writing their views regarding a non-emergency transfer prior to its implementation. Upon request by or consent of the patient, the patient and his or her representatives may request an opportunity to discuss the proposed, non-emergency transfer with a Division representative prior to implementation of the transfer.

(b) Regarding emergency transfers, the following apply:

1. In an emergency as defined at N.J.A.C. 10:36–3.4(e)1, a patient may be transferred in accordance with procedures outlined at N.J.A.C. 10:36–3.4(e).

2. If a patient or a representative of the patient objects to such a transfer, they may submit their position in writing to the Division after implementation of the transfer. A designee of the Division Director shall review

the basis for the transfer after the transfer, and shall provide the patient or his or her representative with an opportunity to state the basis for their objection and present any relevant facts or statements. The designee shall not be a member of the patient's treatment team at either the sending or receiving hospital and shall provide an independent review of the need for the proposed transfer. The designee shall have the authority to approve or disapprove the proposed transfer. This decision shall be in writing and shall become part of the patient's clinical record.

New Rule, R.1991 d.453, effective September 3, 1991.
See: 23 N.J.R. 1652(a), 23 N.J.R. 2637(a).
Amended by R.1998 d.62, effective January 20, 1998.
See: 29 N.J.R. 3763(b), 30 N.J.R. 386(a).
In (a)2, substituted a reference to the Clinical Director/Medical Director for a reference to the Clinical Director.
Amended by R.2003 d.236, effective July 7, 2003.
See: 34 N.J.R. 4290(a), 35 N.J.R. 2903(a).
Rewrote the section.