# SENATE, No. 3096

# STATE OF NEW JERSEY

## 219th LEGISLATURE

INTRODUCED NOVEMBER 5, 2020

**Sponsored by:**
**Senator PATRICK J. DIEGNAN, JR.**
**District 18 (Middlesex)**
**Senator LINDA R. GREENSTEIN**
**District 14 (Mercer and Middlesex)**

**Co-Sponsored by:**
**Senators Gopal and Pou**

**SYNOPSIS**

"Improved Suicide Prevention, Response, and Treatment Act."

**CURRENT VERSION OF TEXT**

As introduced.

**(Sponsorship Updated As Of: 11/9/2020)**

**AN ACT** concerning the prevention of suicides in the State, the law enforcement response to persons who are or may be suicidal, and the provision of assessment and counseling services to address and mitigate suicidal tendencies in psychiatric patients and persons in crisis, supplementing Titles 26, 30, and 52 of the Revised Statutes, and amending P.L.1989, c.3.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) P.L. , c. (C. ) (pending before the Legislature as this bill) shall be known, and may be cited, as the "Improved Suicide Prevention, Response, and Treatment Act."

2. (New section) As used in P.L. , c. (C. ) (pending before the Legislature as this bill):

"At-risk patient" means a patient who has attempted suicide or who has suicidal ideations, behaviors, or tendencies, as indicated by a formal suicide risk assessment conducted pursuant to subsection c. of section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill).

"Care transition" means the transfer or transition of a patient from one health care or behavioral health care provider to another.

"Mental health screener" means the same as that term is defined by section 2 of P.L.1987, c.116 (C.30:4-27.1 et seq.).

"NJ Hopeline" means the Statewide suicide prevention hotline that is provided in partnership with Rutgers University Behavioral Health Care and the Division of Mental Health and Addiction Services in the Department of Human Services.

"Outpatient treatment provider" means a community-based mental health facility or center, including but not limited to, a suicide treatment center, that is licensed or funded by the Department of Human Services to provide outpatient mental health treatment services.

"Person who is or may be suicidal" means a person who is experiencing a mental health crisis, is experiencing or expressing suicidal ideations or tendencies, or is undertaking or contemplating suicidal actions, but who has not yet been subject to a formal suicide risk assessment conducted pursuant to subsection c. of section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill).

"Psychiatric facility" means a State psychiatric hospital listed in R.S.30:1-7, a county psychiatric hospital or the psychiatric unit of a county hospital, a short-term care facility, a special psychiatric hospital, or the psychiatric unit of a general hospital or other health

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.**

**Matter underlined <u>thus</u> is new matter.**

care facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Rapid referral" means the taking of appropriate steps by a psychiatric facility, prior to an at-risk patient's discharge from inpatient care, to facilitate the at-risk patient's immediate access to an appropriate outpatient treatment appointment as soon as is practicable, and preferably within 48 hours, after discharge; or the taking of appropriate steps by an outpatient treatment provider to facilitate an at-risk patient's immediate access to an appointment with another outpatient treatment provider or an inpatient psychiatric facility as soon as is practicable, and preferably within 48 hours, after referral thereto.

"Screening service" means the same as that term is defined by section 2 P.L.1987, c.116 (C.30:4-27.1 et seq.).

"Suicide prevention counselor" means a licensed psychiatrist, clinical psychologist, or other mental health professional, or a properly qualified paraprofessional crisis counselor, who has specialized certification or has completed specialized training in the standardized assessment of suicide risk and the provision of suicide prevention counseling to at-risk patients.

"Supportive contacts" means brief communications with a patient that occur during care transitions or when a patient misses an outpatient appointment or unexpectedly drops out of outpatient treatment, and which show support for the patient and are designed to promote a patient's feeling of connection to treatment and willingness to collaboratively participate in treatment. "Supportive contacts" may include the sending of postcards, letters, email messages, and text messages, the making of phone calls, or the undertaking of home visits either by the mental health care professional or suicide prevention counselor that is providing care to the patient or by an outside organization, such as a local crisis center, with which the psychiatric facility or outpatient treatment provider has a contract or other agreement.

"Warm hand-off" means a safe care transition that connects a patient directly with a new health care provider or interim contact, such as a crisis center worker or peer specialist, before the patient's first appointment with the new health care provider, or that connects a patient directly with a screening service or mental health screener for the purposes of determining whether involuntary commitment to treatment is warranted pursuant to P.L.1987, c.116 (C.30:4-27.1 et seq.).

3. (New section) a. (1) Each psychiatric facility in the State shall require suicide prevention counselors on the facility's staff to: (a) assess each patient's level of suicide risk, as provided by subsection c. of this section; (b) immediately provide individualized, one-on-one suicide prevention counseling to each patient deemed at risk of suicide; and (c) provide ongoing suicide

prevention counseling to each at-risk patient at the facility, on a daily basis or more frequently as may be commensurate with the results of the patient's suicide risk assessment, until such time as the patient is discharged from inpatient care or is deemed to be no longer at risk of suicide, whichever is sooner.

(2) Each outpatient treatment provider in the State shall require suicide prevention counselors on the provider's staff to: (a) assess each patient's level of suicide risk, as provided by subsection c. of this section; (b) immediately provide individualized, one-on-one suicide prevention counseling to each patient deemed at risk of suicide; (c) in cases where inpatient treatment may be necessary to address an at-risk patient's suicidal ideations, behaviors, or tendencies, either effectuate the voluntary admission and warm hand-off of the at-risk patient to an inpatient psychiatric facility or, if the patient refuses voluntary inpatient admission, effectuate a warm hand-off of the patient to a screening service or mental health screener to determine whether involuntary commitment to treatment, as provided by P.L.1987, c.116 (C.30:4-27.1 et seq.), is warranted; and (d) reengage and provide individualized, one-on-one counseling to each at-risk patient remaining in outpatient care, commensurate with the results of the patient's suicide risk assessment, whenever the patient has a subsequent clinical encounter with the outpatient provider.

(3) A psychiatric facility shall ensure that a sufficient number of suicide prevention counselors are available, on-site, 24 hours a day, seven days a week, and an outpatient treatment provider shall ensure that a sufficient number of suicide prevention counselors are available, on-site, during all hours of operation, to perform the suicide risk assessments and provide the individualized counseling required by this subsection.

b. (1) Each psychiatric facility and outpatient treatment provider shall establish policies and protocols to provide for the effective, compassionate, and responsible discharge of at-risk patients from care and the smooth transition of at-risk patients through the continuum of care using warm hand-offs, rapid referrals, and supportive contacts.

(2) Each outpatient treatment provider shall additionally adopt policies and protocols providing for the warm hand-off of an at-risk patient to an inpatient psychiatric facility or to a screening service or mental health screener, as appropriate and in accordance with subparagraph (c) of paragraph (2) of subsection a. of this section, in any case where the patient's suicide prevention counselor or attending clinician has reason to believe that the patient may require commitment to inpatient treatment to address the patient's suicidal ideations, behaviors, or tendencies or associated mental health issues.

(3) A psychiatric facility or outpatient treatment provider may enter into contracts or memoranda of understanding with outside

organizations, including local crisis centers and other psychiatric facilities and providers, to facilitate the smooth and effective care transition of at-risk patients as provided by this subsection.

(4) In no case shall a staff member of a psychiatric facility or a staff member of an outpatient treatment provider: (a) discharge an at-risk patient into a homeless situation; or (b) have an at-risk patient arrested or incarcerated in a jail or prison, unless the at-risk patient poses an otherwise uncontrollable risk to others.

c. (1) A suicide risk assessment shall be conducted at the following times: (a) immediately upon a patient's initial admission to a psychiatric facility or upon a patient's first clinical encounter with an outpatient treatment provider; (b) whenever there is reason for attending staff at a psychiatric facility or outpatient treatment provider to believe that a patient is developing new suicidal ideations, behaviors, or tendencies while under the care of the facility or provider; (c) within three days prior to the discharge of an apparently non-suicidal patient from inpatient care; (d) whenever a suicide prevention counselor is called to assess a patient in a hospital emergency department, pursuant to section 4 of P.L. , c. (C. ) (pending before the Legislature as this bill); and (e) whenever a suicide prevention counselor is dispatched, pursuant to section 10 of P.L. , c. (C. ) (pending before the Legislature as this bill), to assess a person at an emergency scene.

(2) A suicide risk assessment shall be performed using a standardized tool, methodology, or framework, and shall be based on data obtained from the patient, as well as pertinent observations made by the attending clinician, assigned suicide prevention counselors, and other staff members having direct contact with the patient, and, to the extent practicable, any other information about the patient's history, the patient's past, recent, and present suicidal ideation and behavior, and the factors contributing thereto that is available from all other relevant sources, including outside treatment professionals, caseworkers, caregivers, family members, guardians, and any other persons who are significant in the patient's life. The suicide risk assessment shall include an evaluation of the patient's current living situation, housing status, existing support systems, and close relationships and shall indicate whether there is any evidence that the patient is being subjected to abuse, neglect, exploitation, or undue influence by family members, caregivers, or other persons.

d. Counseling and treatment provided to address an at-risk patient's suicidal ideations, behaviors, or tendencies shall be supplemental to any other treatment that is received by the patient for the patient's other mental health issues.

e. The results of a patient's suicide risk assessment and notes regarding the progress of suicide prevention counseling provided to an at-risk patient shall be documented in the patient's health record.

4. (New section) a. Each physician in a hospital's emergency department who has reason to believe that a patient under the physician's care is or may be suicidal shall, as soon as is practicable after the patient is stabilized and conscious, ensure that the patient is met in the emergency room by a suicide prevention counselor from the hospital's psychiatric ward, who shall:

(1) perform an on-site suicide risk assessment, in accordance with the provisions of subsection c. of section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill);

(2) immediately provide the patient with individualized, one-on-one suicide prevention counseling, commensurate with the results of the suicide risk assessment, prior to the patient's discharge from the emergency room; and

(3) immediately link the person who is or may be suicidal to appropriate treatment facilities, programs, and services, through the use of warm hand-offs and supportive contacts, as deemed by the suicide prevention counselor to be appropriate based on the results of the on-site suicide risk assessment.

b. If the suicide prevention counselor concludes that inpatient psychiatric treatment may be necessary to address and mitigate the at-risk patient's suicide risk and tendencies, the suicide prevention counselor shall recommend, and the attending emergency room physician shall effectuate, the patient's voluntary admission and warm hand-off to the hospital's psychiatric ward immediately following the completion of the patient's emergency care.

c. If the patient refuses to be admitted to the hospital's psychiatric ward, the attending emergency room physician shall effectuate the warm hand-off of the patient to a screening service or mental health screener to determine whether involuntary commitment to treatment, as provided by P.L.1987, c.116 (C.30:4-27.1 et seq.), is necessary to address the patient's suicidal ideations behaviors, and tendencies or associated mental health issues.

5. (New section) The Commissioner of Human Services shall require each suicide hotline and crisis hotline in the State, including, but not limited to, the NJ Hopeline and each community-based suicide hotline established pursuant to section 2 of P.L.1985, c.195 (C.30:9A-13), to identify callers to the hotline who are or may be suicidal, provide immediate suicide prevention counseling to each such caller, and ensure that a sufficient number of suicide prevention counselors are available on staff, at all times during the hotline's operation, to provide such counseling.

6. (New section) a. Any suicide prevention counselor or other staff member employed by a psychiatric facility, outpatient treatment provider, or suicide or crisis hotline, and any other health care professional, when interacting with an at-risk patient, shall:

(1) treat the at-risk patient with the same dignity and respect that is shown to other patients;

(2) adopt a stance that reflects empathy, compassion, and an understanding of the ambivalence the at-risk patient may feel in relation to the patient's desire to die;

(3) treat the at-risk patient in an age-appropriate manner and using methods of communication that the patient can understand;

(4) attempt to engender confidence in the at-risk patient that there is an alternative to suicide, and encourage the patient to use all available services and resources to empower the patient to choose such an alternative;

(5) not engage in activities or communication methods that may result in the increased traumatization or re-traumatization of the at-risk patient;

(6) with the exception of suicide assessments performed pursuant to P.L. , c. (C. ) (pending before the Legislature as this bill), not engage in the psychological testing of a patient who is in crisis or who has recently been lifted out of a crisis situation; and

(7) not engage in behavior that discriminates against or stigmatizes the patient.

b. A psychiatric facility or outpatient treatment provider shall require and facilitate the biennial training of all staff on the following issues:

(1) the fundamentals of the facility's or provider's suicide prevention policies and protocols;

(2) the particular suicide care policies and protocols that are relevant to each staff member's role and responsibilities;

(3) the signs and symptoms that can be used by both clinical and non-clinical staff to identify existing patients who may be developing new suicidal ideations, behaviors, or tendencies;

(4) the importance of, and methods and principles to be used in, ensuring the safe and responsible discharge and care transition of at-risk patients; and

(5) the respectful treatment of, effective communication with, and de-stigmatization of, at-risk patients.

7. (New section) a. If either the Commissioner of Health or the Commissioner of Human Services has reason to believe that a facility or provider under its jurisdiction, or any staff member employed thereby, is failing to comply with the provisions of P.L. , c. (C. ) (pending before the Legislature as this bill) or any of the internal suicide care policies or protocols adopted pursuant thereto, the commissioner shall order the facility or provider, as appropriate, to undertake corrective action, within a reasonable timeframe, as may be deemed by the commissioner to be necessary to ensure future compliance with P.L. , c. (C. ) (pending before the Legislature as this bill) or the suicide prevention policies and protocols adopted pursuant thereto, as the

case may be. If the facility or provider denies that a violation exists or has occurred, it shall have the right to apply to the commissioner for a hearing, and any such hearing shall be held, and a decision rendered, within 48 hours after receipt of the request.

b. Any psychiatric facility or outpatient treatment provider that fails to comply with an order of the commissioner, which is issued pursuant to subsection a. of this section, shall be liable to a civil penalty of not more than $2,500 for a first offense and not more than $5,000 for a second or subsequent offense, to be collected in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

c. Any staff member of a psychiatric facility or outpatient treatment provider who violates the provisions of paragraph (4) of subsection b. of section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill), and any staff member of a psychiatric facility, staff member of an outpatient treatment provider, staff member of a suicide or crisis hotline, or other health care professional who violates the provisions of subsection a. of section 6 of P.L. , c. (C. ) (pending before the Legislature as this bill), shall be liable to pay a civil penalty of not more than $500 for a first offense, not more than $1,000 for a second offense, and not more than $2,500 for a third or subsequent offense, to be collected in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). Any such person shall also be subject to: (1) potential criminal liability and civil lawsuits, including lawsuits for punitive damages, for any injury that is proximately caused thereby; (2) the suspension or revocation of the person's professional license or certification; (3) the revocation of the person's mental health accreditation; and (4) the termination of the person's employment.

8. (New section) a. A carrier that offers a health benefits plan in this State shall provide coverage for costs associated with the suicide risk assessments that are performed, and the suicide prevention counseling services that are rendered, pursuant to P.L. , c. (C. ) (pending before the Legislature as this bill).

b. The coverage shall be provided to the same extent as for any other health care services under the health benefits plan.

c. As used in this section:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or any entity contracted to administer health benefits in connection with the State Health Benefits Program or School Employees' Health Benefits Program.

9. (New section) a. Each county and municipal law enforcement officer in the State shall annually complete at least two

hours of in-service training on the appropriate response to emergencies that involve a person who is or may be suicidal.

b. The in-service training course required pursuant to this section shall, at a minimum:

(1) include instruction on: (a) the importance of, and need for, law enforcement officers to engage in calm, gentle, and respectful interactions with a person who is or may be suicidal; (b) the importance of, and need for, law enforcement officers, to the greatest extent practicable, to avoid the use of unnecessary force and to instead use verbal methods of communication and other non-violent means to de-escalate an emergency situation involving a person who is or may be suicidal; and (c) specific techniques, means, and methods, consistent with the principles identified under this subsection, that are to be employed by law enforcement officers when approaching, communicating with, engaging in physical contact or the use of force with, and de-escalating a situation involving, a person who is or may be suicidal; and

(2) require training program participants to engage in various simulated role-playing scenarios to demonstrate their ability to effectively interact with, and de-escalate emergency situations involving, a person who is or may be suicidal.

c. Each instructor who is assigned to teach the in-service courses required by this section shall have received at least 40 hours of training in mental health crisis intervention from a nationally recognized organization that educates law enforcement officers in the use of appropriate emergency response methods.

d. As used in this section, "person who is or may be suicidal" means the same as that term is defined by section 2 of P.L. , c. (C. ) (pending before the Legislature as this bill).

10. (New section) a. The governing body of each county shall appoint a suicide prevention response coordinator to facilitate and coordinate the deployment of qualified suicide prevention counselors to emergency scenes involving persons who are or may be suicidal.

b. A local suicide prevention response coordinator, appointed pursuant to this section, shall compile and maintain an up-to-date list of qualified suicide prevention counselors in the county. To the extent practicable, whenever a law enforcement officer is dispatched to an emergency scene involving a person who is or may be suicidal, as determined by the emergency call-taker pursuant to section 11 of P.L. , c. (C. ) (pending before the Legislature as this bill), the suicide prevention response coordinator shall coordinate the contemporaneous dispatch of a suicide prevention counselor to the emergency scene.

c. A suicide prevention counselor dispatched to an emergency scene, pursuant to this section, shall:

(1) provide assistance to the law enforcement officer at the emergency scene, as may be necessary to facilitate the non-violent de-escalation of the emergency situation;

(2) perform an on-site suicide risk assessment of the person who is or may be suicidal, in accordance with the provisions of subsection c. of section 3 of P.L. , c. (C. ) (pending before the Legislature as this bill); and

(3) immediately link the person who is or may be suicidal to appropriate treatment facilities, programs, and services, through the use of warm hand-offs and supportive contacts, as deemed by the suicide prevention counselor to be appropriate based on the results of the on-site suicide risk assessment. If the suicide prevention counselor concludes that inpatient psychiatric treatment may be necessary to address and mitigate the person's suicidal risk and tendencies, the suicide prevention counselor, in cooperation with the on-site law enforcement officer, as appropriate, shall effectuate the person's voluntary admission and warm hand-off to a psychiatric facility as soon as is practicable after the immediate crisis is resolved. If such person refuses to be admitted to a psychiatric facility, the suicide prevention counselor, in cooperation with the on-site law enforcement officer, as appropriate, shall effectuate the warm hand-off of the person to a screening service or mental health screener to determine whether involuntary commitment to treatment, as provided by P.L.1987, c.116 (C.30:4-27.1 et seq.), is necessary to address the person's suicidal ideations, behaviors, and tendencies or associated mental health issues.

d. The Attorney General, in consultation with the Commissioner of Human Services, shall:

(1) establish the necessary qualifications for a person to be appointed as a county suicide prevention response coordinator pursuant to this section; and

(2) establish guidelines and protocols to be used by each county suicide prevention response coordinator in: (a) establishing a list of qualified and locally available suicide prevention counselors pursuant to subsection b. of this section; and (b) facilitating the coordinated and contemporaneous dispatch of at least one suicide prevention counselor to each emergency scene involving a person in crisis who is or may be suicidal, as provided by this section, whenever a law enforcement officer is dispatched to such emergency scene.

e. As used in this section, "mental health screener," "person who is or may be suicidal," "screening service," "suicide prevention counselor," "supportive contacts," and "warm hand-off" mean the same as those terms are defined by section 2 of P.L. , c. (C. ) (pending before the Legislature as this bill).

11. (New section) a. In addition to any other requirements that have been established by law, rule, or regulation for PSAP call-

takers, the PSAP call-taker of each 9-1-1 call shall evaluate whether a request for emergency services involves a person who is or may be suicidal.

b. Whenever a PSAP call-taker determines that a request for emergency services involves a person who is or may be suicidal, the call-taker shall:

(1) if the PSAP serves as the dispatch point for the emergency call, directly notify the local suicide prevention response coordinator, appointed pursuant to section 10 of P.L. , c. (C. ) (pending before the Legislature as this bill), that the call involves a person who is or may be suicidal; or

(2) if the PSAP does not serve as the dispatch point for the emergency call, directly notify the dispatching entity, upon transfer of the call thereto, that the request for emergency services involves a person who is or may be suicidal. Any dispatching entity so notified, pursuant to this paragraph, shall directly notify the county suicide prevention response coordinator, appointed pursuant to section 10 of P.L. , c. (C. ) (pending before the Legislature as this bill), that the call involves a person who is or may be suicidal.

c. Any notice that is provided to a local suicide prevention response coordinator, pursuant to subsection b. of this section, shall be provided either contemporaneously upon or immediately prior to the dispatch of law enforcement to the emergency scene.

d. As used in this section, "person who is or may be suicidal" means the same as that term is defined by section 2 of P.L. , c. (C. ) (pending before the Legislature as this bill).

12. Section 3 of P.L.1989, c.3 (C.52:17C-3) is amended to read as follows:

3. a. There is established in the Office of Information Technology an Office of Emergency Telecommunications Services.

b. The office shall be under the immediate supervision of a director, who shall be a person qualified by training and experience to direct the work of the office. The director shall administer the provisions of this act subject to review by the Chief Technology Officer and shall perform other duties as may be provided by law. The director shall be appointed by the Chief Technology Officer, but the commission shall advise the Chief Technology Officer on the qualifications of the director. The Chief Technology Officer is authorized to appoint, in accordance with Title 11A of the New Jersey Statutes, clerical, technical, and professional assistants, and also may designate any available personnel as shall be necessary to effectuate the purposes of this act.

The office shall designate a staff member from within the Office of Information Technology to be designated as a professional spectrum manager. The professional spectrum manager shall be responsible for approving all applications for public safety spectrum

allocations in the State to ensure that the State fully complies with Federal Communications Commission rules that impact frequency allocation for public safety use. The spectrum manager may be chosen from among the current employees of the office and the chosen employee may continue the duties and responsibilities of their current position in addition to the duties and responsibilities of spectrum manager as provided in this section.

The office shall designate a staff member from within the Office of Information Technology to be designated the Statewide Interoperability Coordinator to coordinate interoperable communications grants and projects consistent with the National Communications Plan. The coordinator may be chosen from among the current employees of the office and the chosen employee may continue the duties and responsibilities of his current position in addition to the duties and responsibilities of coordinator as provided in this section.

The office shall, subject to review by the commission and the Chief Technology Officer, and in consultation with the council, the telephone companies, the Board of Public Utilities and the wireless telephone companies, and with the assistance of the Office of Information Technology in but not of the Department of the Treasury, continue to plan, design, implement, and coordinate the Statewide emergency enhanced 9-1-1 telephone system to be established pursuant to this act as well as any changes to that system needed to provide wireless enhanced 9-1-1 service.

To this end the office shall establish, after review and approval by the commission, in consultation with the council, a State plan for the emergency enhanced 9-1-1 system in this State, which plan shall include:

(1) The configuration of, and requirements for, the enhanced 9-1-1 network. The office with the approval of the commission and the Chief Technology Officer, in consultation with the council, only as provided herein, and assistance and advice of the Office of Information Technology in but not of the Department of the Treasury is empowered to enter into contracts for the provision of this network.

(2) The role and responsibilities of the counties and municipalities of the State in the implementation of the system, consistent with the provisions of this act, including a timetable for implementation.

(3) Technical and operational standards for the establishment of public safety answering points (PSAPs) which utilize enhanced 9-1-1 network features in accordance with the provisions of this act and in alignment with the Next Generation 9-1-1 Planning by the National 9-1-1 Office within the United States Department of Transportation, National Highway Traffic Safety Administration. Those entities having responsibility for the creation and management of PSAPs shall conform to these standards in the

design, implementation and operation of the PSAPs. These standards shall include provision for the training and certification of call-takers and public safety dispatchers or **[**for**]** the adoption of **[**such**]** a training program. Any training provided under this paragraph shall include, but need not be limited to, training for call-takers to evaluate whether a request for emergency services involves a person who is or may be suicidal.

The office, after review and approval by the commission and the Chief Technology Officer, in consultation with the council, only as provided herein, may update and revise the State plan from time to time.

The office may inspect each PSAP to determine if it meets the requirements of this act and the technical and operational standards established pursuant to this section. The office shall explore ways to maximize the reliability of the system.

The plan or any portion of it may be implemented by the adoption of regulations pursuant to subsection b. of section 15 of this act.

The State plan shall require the consolidation of PSAPs as appropriate, consistent with revisions in the plan to upgrade the enhanced 9-1-1 system and shall condition the allocation of moneys dedicated for the operation of PSAPs on the merging and sharing of PSAP functions by municipalities, counties and the State Police, consistent with the revised plan. The Treasurer may establish, by regulation, a 9-1-1 call volume minimum that may be utilized as a factor in determining which PSAP functions are to be consolidated under the State plan.

The State plan shall limit the use of sworn law enforcement officers to provide dispatch services and the office shall condition the receipt of moneys dedicated for the operation of PSAPs on the limited use of sworn law enforcement officers, except for officers returning to active duty from an injury or other physical disability.

The office shall plan, implement and coordinate a Statewide public education program designed to generate public awareness at all levels of the emergency enhanced 9-1-1 system. Advertising and display of 9-1-1 shall be in accordance with standards established by the office. Advertising expenses may be defrayed from the moneys appropriated to the office.

c. (Deleted by amendment, P.L.1999, c.125).

d. To this end, the office shall, subject to review and approval by the commission and the Chief Technology Officer, and in consultation with the council, develop a Statewide Communications Interoperability Plan, which shall include:

(1) the strategy to most effectively provide interoperability and coordinate public safety communications between and among State, county and municipal public safety agencies. The office shall submit recommendations and proposals, as appropriate, to the

Regional Planning Committees to which the State is assigned by the Federal Communications Commission; and

(2) the role and responsibilities of the counties and municipalities of the State in the implementation of the New Jersey Interoperable Communications System, consistent with the National Communications Plan and the provisions of this act, including a timetable for implementation.

e. The office, after review and approval by the commission and the Chief Technology Officer, in consultation with the council, only as provided herein, may update and revise the State plan as needed. The plan or any portion of it may be implemented by the adoption of regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

f. The office, after review and approval by the commission and the Chief Technology Officer, only as provided herein, shall submit a report to the Senate Revenue, Finance and Appropriations Committee and the Assembly Appropriations Committee, or their successors, not later than February 15 of each year, concerning its progress in carrying out the provisions of this act and the expenditure of moneys appropriated thereto and appropriated for the purposes of installation of the Statewide enhanced 9-1-1 network and the New Jersey Interoperable Communications System.

(cf: P.L.2011, c.4, s.2)

13. a. The Commissioner of Human Services and the Commissioner of Health, in consultation with each other, shall adopt rules and regulations applicable to the facilities or providers under each commissioner's respective jurisdiction, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of sections 1 through 7 of P.L. , c. (C. through C. ) (pending before the Legislature as this bill).

b. The Commissioner of Banking and Insurance shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of section 8 of P.L. , c. (C. ) (pending before the Legislature as this bill).

c. The State Attorney General, in consultation with the Commissioner of Human Services, shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of sections 9 through 12 of P.L. , c. (C. ) (pending before the Legislature as this bill).

14. This act shall take effect immediately, and section 8 of this act shall apply to all health benefits plans that are in effect in the State, are delivered, issued, executed, or renewed in this State, or are approved for issuance or renewal in this State by the

Commissioner of Banking and Insurance either on or after the effective date of this act.

STATEMENT

This bill would amend and supplement the law to improve the suicide assessment, response, and treatment system in the State and strengthen the obligations of health care providers, law enforcement officers, and insurers with respect to suicide prevention, response, and care.

The bill would provide, in particular, for each psychiatric facility, each outpatient mental health treatment provider, and each suicide or crisis hotline operating in the State to have specially trained suicide prevention counselors on staff, during all hours of operation, to assess patients' suicide risk and provide suicide prevention counseling to patients who are deemed to be at risk of suicide. The bill would further require the attending physician at a hospital emergency department to have an on-site suicide prevention counselor assess and provide assistance to any emergency room patient who is or may be suicidal, and it would additionally provide for the governing body of each county to appoint a local suicide prevention response coordinator, who will be responsible for deploying at least one qualified and locally available suicide prevention counselor to assist law enforcement at any emergency scene involving a person who is or may be suicidal. Finally, the bill would require all health insurance carriers to provide coverage for the costs that are associated with the suicide prevention assessments performed and counseling services rendered pursuant to the bill's provisions.

The bill provides for suicide prevention counselors to perform a formal suicide risk assessment of a patient at the following times: 1) immediately upon a patient's initial admission to a psychiatric facility or upon a patient's first clinical encounter with an outpatient treatment provider; 2) whenever there is reason for attending staff at a psychiatric facility or outpatient treatment provider to believe that a patient is developing new suicidal ideations, behaviors, or tendencies while under the care of the facility or provider; 3) within three days prior to the discharge of an apparently non-suicidal patient from inpatient care; and 4) whenever a suicide prevention counselor is called to assess a patient in a hospital emergency department or at the scene of an emergency, as provided by the bill.

Each suicide risk assessment conducted under the bill is to be performed using a standardized tool, methodology, or framework, and is to be based on data obtained from the patient, as well as pertinent observations made by the attending clinician, assigned suicide prevention counselors, and other staff members having direct contact with the patient, and, to the extent practicable, any

other information about the patient's history, the patient's past, recent, and present suicidal ideation and behavior, and the factors contributing thereto that is available from all other relevant sources, including outside treatment professionals, caseworkers, caregivers, family members, guardians, and any other persons who are significant in the patient's life. The suicide risk assessment is to include an evaluation of the patient's current living situation, housing status, existing support systems, and close relationships, and is to indicate whether there is any evidence that the patient is being subjected to abuse, neglect, exploitation, or undue influence by family members, caregivers, or other persons.

The results of a patient's suicide risk assessment and notes regarding the progress of suicide prevention counseling provided to an at-risk patient are to be documented in the patient's health record. The bill further specifies that any counseling and treatment provided to address an at-risk patient's suicidal ideations, behaviors, or tendencies is to be supplemental to any other treatment that is received by the patient for the patient's other mental health issues.

If a suicide prevention counselor, when assessing a patient outside of an inpatient psychiatric setting, determines that inpatient treatment may be necessary to address an at-risk patient's suicidal ideations, behaviors, or tendencies, the counselor will be required to either effectuate the voluntary admission and warm hand-off of the at-risk patient to an inpatient psychiatric facility or, if the patient refuses voluntary inpatient admission, effectuate a warm hand-off of the patient to a screening service or mental health screener to determine whether involuntary commitment to treatment is warranted. In cases where the counselor is providing on-site assistance at an emergency scene or in a hospital's emergency department, the on-scene law enforcement officers or attending physician may assist in the warm hand-off of the patient for these purposes. For any at-risk patient remaining in outpatient care, suicide prevention counselors at the outpatient treatment provider will be required to reengage and provide individualized, one-on-one counseling to each such patient, commensurate with the results of the patient's suicide risk assessment, whenever the patient has a subsequent clinical encounter with the outpatient treatment provider.

The bill provides that, whenever a law enforcement officer is dispatched in response to a request for emergency services that involves a person who is or may be suicidal, the police dispatcher will be responsible for notifying the local suicide prevention response coordinator, appointed by the county's governing body under the bill, and the suicide prevention response coordinator will be responsible for ensuring the contemporaneous deployment of a suicide prevention counselor to the scene of the emergency. A 9-1-1 call-taker is to determine whether each request for emergency

services involves a person who is or may be suicidal, and the bill provides for call-takers to undergo training to enable them to make this determination. Upon deployment to an emergency scene, a suicide prevention counselor will be required to: 1) provide assistance to law enforcement on the scene, as may be necessary to facilitate the non-violent de-escalation of the emergency situation; 2) perform an on-site suicide risk assessment of the person in crisis; and 3) immediately use warm hand-offs and the assistance of law enforcement, as needed, to link the at-risk person to appropriate treatment facilities, programs, and services, including voluntary or involuntary inpatient treatment, where warranted.

Under the bill's provisions, each county and municipal law enforcement officer in the State will be required to complete at least two hours of in-service training in identifying the signs of mental illness and appropriate response techniques to be followed when interacting with a person who is or may be suicidal. The training is required to include: (1) the importance of approaching a suicidal person in a calm, gentle, and respectful manner; (2) the importance of avoiding the use of unnecessary force and the importance of using verbal methods of communication and other non-violent means to de-escalate an emergency situation involving a person who is or may be suicidal; and (3) specific techniques, means, and methods, consistent with the principles identified in the bill, that are to be employed by law enforcement officers when approaching, communicating with, engaging in physical contact or the use of force with, and de-escalating a situation involving, a person who is or may be suicidal. The in-service training is also to include simulated role-playing scenarios, which will allow trainees to demonstrate their ability to effectively interact with, and de-escalate emergency situations involving, a person who is or may be suicidal.

The bill would require each inpatient psychiatric facility and each outpatient mental health treatment provider to establish policies and protocols to provide for the effective, compassionate, and responsible discharge of at-risk patients from care and the smooth transition of at-risk patients through the continuum of care using warm hand-offs, rapid referrals, and supportive contacts. Each outpatient provider will additionally be required to adopt policies and protocols providing for the warm hand-off of an at-risk patient to an inpatient psychiatric facility or to a screening service or mental health screener, as appropriate, in any case where the patient's suicide prevention counselor or attending clinician has reason to believe that the patient may require voluntary or involuntary commitment to inpatient treatment to address the patient's suicidal ideations, behaviors, and tendencies or associated mental health issues. The bill authorizes a facility or provider to enter into contracts or memoranda of understanding with outside organizations, including local crisis centers and other psychiatric

facilities and providers, in order to facilitate the smooth and effective care transition of at-risk patients as provided by the bill.

The bill also requires a psychiatric facility or outpatient treatment provider to facilitate the biennial training of all staff on the following issues: 1) the fundamentals of the facility's suicide prevention policies and protocols; 2) the particular suicide care policies and protocols that are relevant to each staff member's role and responsibilities; 3) the signs and symptoms that can be used by both clinical and non-clinical staff to identify existing patients who may be developing new suicidal ideations, behaviors, or tendencies; 4) the importance of, and methods and principles to be used in, ensuring the safe and responsible discharge and care transition of at-risk patients; and 5) the respectful treatment of, effective communication with, and de-stigmatization of, at-risk patients.

The bill would prohibit a staff member of a psychiatric facility or outpatient treatment provider from: 1) discharging an at-risk patient into a homeless situation; or 2) having an at-risk patient arrested or incarcerated in a jail or prison, unless the at-risk patient poses an otherwise uncontrollable risk to others.

The bill would additionally require a suicide prevention counselor and any other staff member employed by a psychiatric facility, by an outpatient treatment provider, or by a suicide or crisis hotline, as well as any other health care professional, when interacting with an at-risk patient, to:

1) treat the at-risk patient with the same dignity and respect that is shown to other patients;

2) adopt a stance that reflects empathy, compassion, and an understanding of the ambivalence the at-risk patient may feel in relation to the patient's desire to die;

3) treat the at-risk patient in an age-appropriate manner and using methods of communication that the patient can understand;

4) attempt to engender confidence in the at-risk patient that there is an alternative to suicide, and encourage the patient to use all available services and resources to empower the patient to choose such an alternative;

5) not engage in activities or communication methods that may result in the increased traumatization or re-traumatization of the at-risk patient;

6) not engage in the psychological testing of an at-risk patient who is in crisis or who has recently been lifted out of a crisis situation (except in the case of a suicide risk assessment performed pursuant to the bill); and

7) not engage in behavior that discriminates against or stigmatizes the patient.

Any person who violates these minimum standards of compassionate care will be personally liable to pay a civil penalty of not more than $500 for a first offense, not more than $1,000 for a second offense, and not more than $2,500 for a third or subsequent

offense, to be collected in a summary proceeding. Such person will also be subject to: 1) potential criminal liability and civil lawsuits, including lawsuits for punitive damages, for any injury that is proximately caused thereby; 2) the suspension or revocation of the person's professional license or certification; 3) the revocation of the person's mental health accreditation; and 4) the termination of the person's employment.